Early Career Award Paper

SPR’s Early Career Award is given to investigators who have shown outstanding productivity and promise within 10 years of completing their research training. Brent Mallinckrodt received this award in 1996. We asked him to write this paper about his program of research. We instituted this occasional feature in the journal to give readers a chance to peer into the minds of some of the field’s most promising investigators, to see how they think about their work and where they are trying to take the field of psychotherapy research.

The Editors

ATTACHMENT, SOCIAL COMPETENCIES, SOCIAL SUPPORT, AND INTERPERSONAL PROCESS IN PSYCHOTHERAPY

Brent Mallinckrodt
University of Missouri

According to the Social Competencies in Interpersonal Process (SCIP) model, social competencies include (a) skills needed to recruit and maintain satisfying and supportive relationships, and (b) trait-like dispositions that govern use of these skills. Attachment theory explains how social competencies develop in early interactions with caregivers. Most adult clients’ presenting problems can be viewed as maladaptive patterns of interpersonal interaction—patterns that the SCIP model holds are maintained by social competency deficits. Available social support is significantly determined by individual differences in social competencies. Because a productive therapy relationship requires a broad range of these competencies, a client’s deficits and maladaptive patterns are soon evident. The relationship itself can then become a vehicle for change. This article summarizes my research testing aspects of the SCIP model. I conclude by presenting ideas for future research and suggestions for specific corrective attachment experiences in the therapy relationship that may facilitate client change.

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Correspondence concerning this article should be addressed to Brent Mallinckrodt, Department of Educational and Counseling Psychology, 16 Hill Hall, University of Missouri, Columbia MO 65211. E-mail: mallinckrodtb@missouri.edu.
My research has focused on interpersonal psychotherapy, by which I mean therapy that (a) views maladaptive relationship patterns as the primary cause of many client presenting problems, (b) aims to improve a client’s functioning in current or prospective relationships, and (c) makes explicit use of the psychotherapy relationship as a means of facilitating change. The explicitly interpersonal aspects of psychotherapy interest me most. In conducting this research I evolved a framework that I now call the Social Competencies in Interpersonal Process (SCIP) model. My research on the SCIP model was acknowledged in 1996 with the Society for Psychotherapy Research Early Career Award. I am grateful for the invitation from the editors of *Psychotherapy Research* to contribute this article summarizing my work. Elsewhere (Mallinckrodt, in press), the SCIP model is described in more detail and with more supporting evidence from other researchers than it is possible to provide in this article. Figure 1 depicts the current version of the model.

The boxes in the SCIP model do not represent static states, but instead refer to related sets of constructs, processes, and empirical findings. The arrows connecting boxes suggest a causal flow by which a given set of processes is believed to influence another set of processes. The first purpose of this article is to describe the evolution of my thinking and the work of other scholars that has influenced development of this model. Second, I describe some of my own research testing aspects of the model. Finally, I suggest some new areas for research applying attachment theory and the SCIP model that might lead to greater understanding of change processes in psychotherapy.

**INTERPERSONAL ASPECTS OF STRESS AND COPING**

My initial research interest was the impact of social support on the relationship between stressors and psychological or physiological distress. Stressors can be conceptualized as an accumulation of daily hassles, or less frequent but more serious life event changes. My first studies used samples of persons experiencing a similar set of life change stressors, for example, graduate school (Mallinckrodt & Leong, 1992; Mallinckrodt, Leong, & Kralj, 1989) or job loss (Mallinckrodt & Bennett, 1992; Mallinckrodt & Fretz, 1988). Social support can have both direct and indirect benefits. For example, for graduate students we found that tangible support (e.g., financial aid, office space) was directly related to lower anxiety for men, but not women. However, for women, those with the most social support from their families tended not to report increased anxiety or depression, even in the face of higher levels of stressful life events (Mallinckrodt & Leong, 1992). This interaction effect is evidence of the well-known buffering effect of social support, in which high levels of social support appear to shield individuals from the full impact of a stressor. In Figure 1 this effect is shown by the path from (A) stressors to (C) psychological and physiological symptoms, shown as an arrow decreasing in width as it passes through (B) moderating effects.

Buffering effects are most likely when a particular functional type of social support is well-matched to the coping demands of a given stressor (Cohen & Wills, 1985; Cutrona & Russell, 1990). Thus, in most studies I used the multidimensional functional measure of social support developed by Cutrona and Russell (1990), based on Weiss’ (1974) Social Provisions model. This model proposes the six functional types of social support shown in Figure 1 as (D) social support and quality of social relationships. My dissertation study of unemployed professionals found evidence of direct effects, but not buffering effects of social support (Mallinckrodt & Fretz, 1988), whereas a subsequent study of blue-collar workers (Mallinckrodt & Bennett, 1992)
FIGURE 1. The Social Competencies in Interpersonal Process (SCIP) model.
found both direct and buffering effects. As I collected data in agencies offering support groups and job search skills, I heard clients' stories illustrating a wide range of reactions to unemployment. It seemed that a worker's family and friends could exacerbate, as well as ameliorate, the impact of job loss, and a worker's cognitive appraisal and negative or positive emotional outlook could greatly influence the development of stress symptoms. Research suggests that factors such as negative cognitive appraisal (Lazarus & Folkman, 1984) or negative affectivity (Rhodewalt & Zone, 1989) can exacerbate the impact of a stressor. To account for all the moderating effects that can either lessen or magnify the impact of a stressor, Figure 1 shows an oval (B) moderating effects to depict these processes, and arrows passing through B that both increase and decrease in thickness as a result of these moderating effects.

During my internship my interest in social support prompted me to study group therapy. Using a pre/post design I found that social support perceived by clients from sources outside the group had a stronger positive association with symptom improvement than support from fellow group members (Mallinckrodt, 1989). In this study, I noticed that the within-group variance in social support perceived from fellow members was surprisingly large compared to the between-groups variance. At first this was puzzling because, although I expected large between-group differences based on group composition and therapist skill, I had naively assumed that members of a given therapy group would experience roughly the same level of support because they experienced roughly the same therapeutic environment. During internship I served as a process observer for some of the groups I studied and as cofacilitator for others. I began to suspect that there were important differences among clients' abilities to make use of the support available in their group, and differences in clients' interpersonal behaviors that led to support or rejection by fellow group members. My observations and my data led me to conclude that perceptions of support from fellow group members were as much a function of individual differences in the perceiver as they were a function of the group environment.

In my first studies I interpreted negative correlations between perceived support and stress symptoms in terms of only the positive range of social support. As Coyne and Bolger (1990) suggested, I implicitly assumed "that the crucial distinction between the relationships of people who evaluate themselves as high in support is that they offer something positive that is missing from the relationships of people who evaluate themselves as low in support; and, by implication . . . what is most needed by persons who are doing badly in stressful circumstances is an increase in social support" (p. 149). However, the negative association between support and symptoms could reflect the negative range of perceived support scores; that is, increased interpersonal conflict might lead to increased symptoms, whereas the effect of positive support may be fairly neutral. Perceived social support may be as strongly influenced by negative as by positive components of a relationship (Fiore, Becker, & Coppel, 1983). Helpful interactions with friends are not as strongly associated with symptoms of depression and social network satisfaction as are upsetting interactions (Pagel, Erdly, & Becker, 1987; Weissman, 1987). Even well-intentioned offers of support do sometimes have harmful effects (Lehman, Ellard, & Wortman, 1986). These findings suggest a negative buffering effect in which upsetting interactions are associated with increased symptoms such as depression, whereas helpful interactions may have no significant association (Kiecolt-Glaser, Dyer, & Shuttleworth, 1988).

The question of what accounts for the widely observed negative correlation between social support and symptoms is, of course, a crucial one for therapeutic
interventions. Coyne and Bolger (1990) argued that the stereotype of the social isolate who lacks positive social interactions has been overemphasized. Persons low in social support include an important subgroup “who suffer from involvement in relationships that are conflictual, insecure, or otherwise not sustaining... and for many persons the costs of involvement in such destructive relationships may be greater than that of being alone, even if the latter state is unthinkable to them” (p. 155). I was strongly influenced by this article, and began to question my optimism about support groups as a panacea for most clients. Rather than developing new social connections, persons described by Coyne and Bolger may benefit much more—especially initially—from acquiring skills such as conflict resolution, problem solving, and the strength to disengage from harmful social connections.

I had viewed social support as an aspect of the environment, either more or less available depending on circumstances outside the individual. However, many studies in the mid- to late 1980s suggested that perceived support should also be considered a function of individual differences (Sarason, Pierce, & Sarason, 1990). For example, conversation partners who rated themselves higher in social support were rated by judges as more socially skilled and interpersonally attractive (Sarason, Sarason, & Shearin, 1986). In another study, persons who rated themselves higher in social support were rated by dyad partners as more socially skilled, and by trained raters as more skilled and attractive (Sarason, Sarason, Hacker, & Basham, 1985). Perceptions of social support can be virtually unrelated to the amount of enacted support received from others (Lakey & Heller, 1988), and may be less a function of available support in the environment than characteristics of the perceiver (Lakey & Dickinson, 1994) or person × environment interactions (Lakey, McCabe, Ficicaro, & Drew, 1996).

I found this research persuasive and intriguing. It offered explanations for the individual differences observed in my studies of social support. Up to this point my research had focused on the links in Figure 1 between elements (A) stressors, (B) moderating effects, (C) symptoms, and (D) social support and relationship quality. A major turning point came when I began investigating the individual differences involved in recruiting and maintaining supportive personal relationships, variables shown in Figure 1 as (E) social competencies.

THE IMPORTANCE OF SOCIAL COMPETENCIES

I define social competencies as all the factors within an individual that influence relationship quality and are necessary for recruiting and maintaining supportive close personal relationships. Clearly this definition covers a great deal of territory, and the list of social competencies in box (E) of Figure 1 is not comprehensive. Rather it represents only constructs that I have studied so far, or believe to be promising avenues for future research. Under the collective term “social competencies” it is useful to distinguish dispositions from skills. Within the skills category, basic skills are behaviors such as maintaining appropriate eye contact or conversational topic following that can be fully demonstrated during a single psychotherapy session. Complex skills are built upon basic skills, but require repeated contact with a target person over days or months to achieve desired results. Complex skills include the ability to develop an initial acquaintance into a supportive friendship, the ability to build emotional intimacy, or the ability to resolve relationship conflict. Social dispositions are relatively stable trait-like characteristics that influence the acquisition of basic or complex skills, and influence the circumstances under which a skill will be used. The dispositions listed in Figure 1 should not be considered discrete constructs,
but rather as overlapping and interlocking perspectives for construing individual differences.

These elements interact in complex ways. For example, using a common set of stimulus vignettes, we found that attributions for blame and recommendations for resolving family conflict differed significantly between persons from the Samoan islands who ascribe to collectivistic cultural beliefs and persons in the United States who had individualistic cultural beliefs (Poasa, Mallinckrodt, & Suzuki, 2000). Thus, as dispositions, cultural beliefs determine whether a given set of social skills will be employed. In some cases culturally based dispositions determine whether a skill such as interpersonal assertiveness is ever acquired, and in other cases cultural belief determines the appropriate circumstances under which previously acquired assertiveness skills will be used (Wood & Mallinckrodt, 1990).

The distinction between social dispositions and skills can be blurred, as exemplified in the case of conflict resolution. Resolving conflict involves an array of complex social skills, but individuals also show a trait-like conflict resolution style in their consistent preference for using only a subset of these skills (Rahim & Magner, 1994). We found that persons who prefer a mutually focused “win-win” approach to marital conflict, compared to those who prefer to either dominate or oblige their spouse, tended to possess a greater capacity for perspective-taking and a higher level of social self-efficacy. The complex skill of perspective-taking and the disposition of social self-efficacy, in turn, were associated with higher levels of security in adult attachment (Gorcoran & Mallinckrodt, in press). In other research, we found that social self-efficacy, the belief that persistent efforts to form supportive friendships will eventually pay off, was associated with higher social support, whereas external locus of control for social outcomes was negatively related to social support (Mallinckrodt, 1992).

I believe the distinction between skills deficits and what could be termed dispositional resistance is not always adequately appreciated. For example, a therapist who determines that a client lacks intimate relationships must further assess whether the client has deficits in requisite skills, such as the ability to deepen acquaintances into more supportive friendships, or whether the client is dispositionally opposed to developing more intimate contacts, or both. It may seem obvious that teaching skills to a client with a personal aversion to employing the skill is counterproductive, or that even after a client makes hard-won core personal changes, long periods of avoidance have created social-skill deficits that remain to be addressed in therapy. Nevertheless, it is common to read case accounts and prescriptive literature that address the domain of skills or of dispositions, but not both.

The SCIP model acknowledges that disposition-based avoidance leads to skill deficits, but also that repeated failures due to inadequate skills eventually lead to aversion and dispositional resistance to further attempts to employ the skill. Of course, dispositions develop in ways other than through skill deficits. The essential point is that a therapist seeking, for example, to encourage a husband to use more mutually focused conflict resolution methods must assess whether the husband lacks the ability to take the perspective of his wife and empathically communicate his understanding, or whether he believes that to do so would only leave him open to “a stab in the back.” The SCIP model holds that for many clients it will be necessary to simultaneously address both dispositional resistance and skill deficits because each reinforces persistence of the other.

Social competencies are also important for interpersonal psychotherapy because, as Figure 1 shows, there are four separate pathways by which these variables can
cause distress. “Social competencies deficits” in this usage refers to both a lack of social skills and maladaptive dispositions. (These four paths are labeled outside the boxes as “social competency deficits” in Figure 1.) Moving from left to right, the first path (E → A; social competencies → stressors) suggests that maladaptive dispositions and skill deficits expose individuals to more stressors. Note that this path does not involve differences in perception of events, but rather different absolute levels of risk for experiencing stressors. For example, individuals with poor problem solving or conflict resolution skills often do not adequately resolve a problem or conflict. The initial failure to dispose of the stressor exposes these persons to increased risk for new stressors (Dixon, Heppner, Burnett, & Anderson, 1993). Similarly, we found that dispositions to adult attachment anxiety in newly arrived international students was associated with reports of more stressful life events (Chen, Mallinckrodt, & Mobely, 2000). (Of course, without independent observation, it is impossible to disentangle differences in actual experience from differences in perceptions of self-reported events.) Because the essential feature in this pathway is greater exposure to stressors, it is termed an increased risk influence of social competencies deficits.

The second pathway (E → B; social competencies → moderating effects) depicts the moderating effects that some dispositions and social skills have apart from social support and relationship quality, for example, the ameliorating effects of resilient forms of cognitive appraisal and problem solving (Dixon, Heppner, & Rudd, 1994; Heppner, Cook, Strozier, & Heppner, 1991) or exacerbating effects of negative affectivity (Rhodewalt & Zone, 1989). Exacerbating effects in this pathway are considered a magnified response influence of social competency deficits.

A third pathway (E → D → B; social competencies → quality of relationships → moderating effects) represents the moderating effects of relationship quality and social support on the connection between stressors and symptoms. Through this mechanism, social competencies affect symptoms indirectly by influencing the social coping resources available to a client. Thus, this pathway is termed a decreased resources/ increased vulnerability influence of social competency deficits.

The last pathway of the “four-way threats” posed by social competency deficits passes through social support and relationship quality directly to symptoms (E → D → C). We have seen how social competencies may influence relationship quality, and how supportive relationships reduce symptoms of distress—but the converse influence should also be appreciated. Personality dispositions that lead to poor quality relationships can be an indirect cause of distress and presenting problems. This is simply a way of restating the central proposition of models such as Luborsky’s Core Conflictual Relationship Theme (CCRT) approach to conceptualizing client presenting problems (Luborsky, 1977; Luborsky & Crits-Christoph, 1998). In fact, it has been argued that many psychological symptoms, including depression and anxiety, can be reconceptualized in terms of interpersonal problems (Horowitz, 1979). A growing body of research suggests that the interpersonal behavior of depressed persons elicits negative reactions that increase the likelihood of rejection and serve to maintain the depressive symptoms (Coyne, Burchill, & Stiles, 1990; for a comprehensive review see Joiner & Coyne, 1999). Thus, the fourth pathway is termed a relationship mediated symptom influence of social competency deficits.
An example will illustrate how all four pathways can operate to increase distress. Assume that a young man with a disposition toward attachment anxiety and preoccupation with abandonment seeks therapy after the recent break-up of his romantic relationship. Further assume that his disposition toward anxiety in attachments has limited his social competencies for recruiting mutually supportive relationships (E → D; competencies → support) and that he currently has few supportive friendships. His few acquaintances are exasperated with his one-sided bids for support. Through the increased risk influence (E → A; competencies → stressors), his attachment anxiety may lead to hasty and poor choices of partners who are, in fact, more likely to abandon him. Through the magnified response influence (E → B; competencies → moderating effects), a disposition toward negative appraisal, negative affectivity, poor problem-solving orientation, or low social self-efficacy may cause him to interpret his break-up as a disaster with far-reaching consequences from which he will never recover, and about which nothing can be done to improve his prospects for happiness. Hence, his affective response of depression and hopelessness is increased. Through the decreased resources/increased vulnerability influence (E → D → B; competencies → support → moderating effects), his lack of social competency has left him without confidants or other sources of social support that could otherwise lessen the impact of his breakup. Finally, through the relationship-induced symptom influence (E → D → C; competencies → support → symptoms), when he turns to his few acquaintances to seek comfort, their exasperation at his earlier lack of reciprocity and his current ruminative obsession with the lost partner may cause some of them to reject him—and thus add a new experience of abandonment and source of distress.

As this example illustrates, there are multiple potential causal paths by which social competency deficits may cause or exacerbate a client’s presenting problems. For this reason, social competencies (both skills and dispositions) can be an effective target for psychotherapy interventions. Discovering how these competencies develop is a critical area for study. Through my research on individual differences in social competencies, I was drawn to the power of attachment theory as a framework for explaining their development.

SOCIAL COMPETENCIES, ATTACHMENT, AND EARLY FAMILY EXPERIENCE

According to attachment theory, working models are cognitive templates formed early in development of (a) others as either generally benevolent and helpful or disappointing and harmful, and (b) the self as the type of person either worthy or unworthy of comfort and care. Working models become increasingly resistant to change as development proceeds, because new information that does not fit into existing structures is difficult to process and may be defensively excluded (Bowlby, 1969, 1973; Bretherton, 1985). A large body of research suggests that attachments in infancy have a profound influence on the development of social competencies in children and the quality of early peer interactions (Coble, Gantt, & Mallinckrodt, 1996). The issue of continuity of working models from infancy into adulthood is a matter of debate, but there is growing evidence that childhood experiences with caregivers are associated with adult attachment patterns, and may influence the quality of adults’ personal relationships (for reviews see Feeney, 1999; Hazan & Zeifman, 1999; Lopez, 1995; Mohr, 1999; Rothbard & Shaver, 1994; Simpson & Rholes, 1998). Attachment theory holds that caregiver responsiveness leads to secure attachment and internal-
ized positive working models of self and others (Bretherton, 1985). When an infant’s communication efforts are successful at eliciting care and comfort from caregivers, the beginnings of social self-efficacy develop (Tronick, 1989). Similarly, in my research, adults’ memories of parents as being emotionally expressive were related to both social self-efficacy and social support (Mallinckrodt, 1992). Other researchers have reported links between memories of parents’ emotional responsiveness and social support (Flaherty & Richman, 1986; Sarason, et al., 1986). Conversely, in a sample of women who had been sexually abused, we found that memories of poor emotional bonds with both parents were related to lower social support, capacity for intimacy, emotional self-awareness, and social network size (Mallinckrodt, McCreary, & Robertson, 1995).

Alexithymia is a disorder of affect regulation with marked deficits in the ability to differentiate affective states, identify what one is feeling, and express emotions (Taylor, Bagby, & Parker, 1997). Alexithymia has been linked to adult memories of feeling emotionally unsafe in one’s family and a lack of positive communication and warm emotional expression (Berenbaum & Taryn, 1994). According to structural family theorists, healthy emotional development depends on consistent and clear interpersonal boundaries between family members, a strong parental marital bond, and parents refraining from forming inappropriate coalitions with a child to oppose the other parent (Haley, 1979). We found that adults’ memories of parents’ marital conflict, parental role-reversal, and fears of separation were associated with alexithymia (King & Mallinckrodt, 2000), whereas memories of family cohesion, emotional expression and encouragement of independence were associated with higher levels of emotional awareness and affective expression.

Taken together, this research suggests that early childhood experience influences development of social competencies (F → E), and social competencies in turn affect the quality of adult relationships (E → D). Clearly, the constructs I have termed social competency deficits or maladaptive social dispositions overlap considerably with the construct of transference (Gelso & Hayes, 1998), and the concept of core conflictual themes (Luborsky & Crites-Christoph, 1998), to name just two formulations. I acknowledge that the SCIP model does not contain newly minted constructs. The chief distinction from other formulations, I believe, is the emphasis the SCIP model places on attachment theory, and the perspective that maladaptive patterns involve trait-like dispositions and specific skills deficits.

RESEARCH ON THE WORKING ALLIANCE

After 1991, in my roles as Training Director and Coordinator of the in-house training clinic of the Counseling Psychology program at the University of Oregon, I became heavily involved in training students in an interpersonal process model of therapy (Teyber, 1997). My teaching and clinical supervision were influenced by Gelso and associates’ (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998) adaptation of Greenson’s (1967) concept of the psychotherapy relationship as composed of a transference/countertransference configuration, working alliance, and real relationship. Because meta-analysis suggests that the quality of the working alliance accounts for a significant proportion of the variance in therapy outcome (Horvath & Symonds, 1991), I became interested in studying the working alliances developed between student therapists and clients in our training clinic. As a clinical supervisor, I observed that trainees tended to first acquire skills for building rapport with clients, then to master
specific therapeutic interventions, and only near the end of their graduate training were they able to articulate a personal theory of psychotherapy to guide selection of treatment goals and techniques for reaching those goals.

I tested the hypothesis that students acquire at different rates proficiency for forming the “bonds,” “tasks,” and “goals” components of the working alliance identified by Bordin (1979). The 50 therapists who agreed to participate in this study (Mallinckrodt & Nelson, 1991) were designated as: (a) novices, graduate students in their first semester of supervised practicum; (b) advanced trainees, graduate students in their second practicum or beyond, up to and including internship; and (c) experienced therapists, postdoctoral full-time staff at the three participating agencies. As expected, findings suggested here were no differences between the three training levels regarding client ratings of the alliance bond. Advanced trainees were rated significantly higher then novices by their clients on the task dimension of the alliance. Both experts and advanced trainees were rated as superior to novices by their clients on the goals dimension. Contrary to expectations, experts were not rated significantly higher than advanced trainees by their clients on either the tasks or goals dimension. However, experts rated themselves higher on these two dimensions than advanced trainees rated themselves.

Several models of psychotherapy change hold that the middle phase of successful therapy is a time of considerable turmoil as the agents of change postulated by the model make their influence felt in clients. Among these frameworks are Mann’s (1973) model of short-term therapy, Tracey’s (1993) complementarity model, Gelso and Hayes’s (1998) psychotherapy relationship model, and Stiles’s model of problem assimilation (Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Stiles et al., 1990). Drawing from these models, in my practica classes I encourage graduate trainees to think of the first phase of short-term therapy as a time to accumulate positive “chips” by forging a strong working alliance—a process Tryon (1990) calls working alliance engagement—and then not being afraid to “spend” some of these chips in the middle phase of therapy when the truly difficult work begins. Spending chips means embracing inevitable ruptures in the working alliance and seeing these as opportunities for therapeutic progress (Safran, 1993; Safran, Muran, & Wallner-Samstag, 1994). In my experience, beginning students whose strongest motivation is to be helpful often find it difficult in the middle phase of therapy to engage in techniques (e.g., process-experiential work, interpretation of transference) that are often met with a client’s resistance instead of gratitude.

I tested these ideas in a study of working alliance, therapy outcome, and session-by-session ratings of session impact, using the Session Evaluation Questionnaire (Stiles & Snow, 1984). As expected, depth and smoothness in the initial sessions were correlated with favorable client ratings of the early working alliance. In turn, strength of the early alliance was positively correlated with client-rated session depth in the middle phase of therapy, and with both depth and positivity in the termination phase. Session arousal and depth in the middle phase was positively correlated with therapy outcome. Favorable outcomes were related to average session positivity only in the termination phase, and not in the initial or middle phases of the therapy (Mallinckrodt, 1993). I interpreted these findings as support for my students to (a) work for depth and engagement in early sessions to build a strong working alliance foundation, and (b) in the middle phase trust this foundation and do not fear evoking a client’s anxiety in the service of therapeutic gain, because arousing and deep sessions are probably more valuable than positive or smooth ones in the middle phase.
ATTACHMENT, SOCIAL COMPETENCIES, AND THERAPY PROCESS

SOCIAL COMPETENCIES, RELATIONSHIP QUALITY, AND THE WORKING ALLIANCE

Given my interest in how early childhood experience affects social competencies, the next logical step in studying the working alliance pointed to investigating how clients’ social competencies and early experience with parents affect development of their working alliance. This research has been criticized for relying on clients’ memories of their early relationships with parents. Of course, these memories can be influenced by a host of possible confounds. On the other hand, a client’s current construction of the past may have more influence on her/his current functioning than the “true past” (Mahoney, 1991), assuming this past could be accurately determined. Because an earlier study (Mallinckrodt, 1991) suggested that social self-efficacy and perceptions of social support for nonclients were related to the scales of the Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979), I decided to use this measure in a study of clients in therapy. Over 100 clients at about the third session of therapy completed the PBI, the Working Alliance Inventory, and the Social Provisions Scale as a proxy measure for the general quality of their social relationships. Contrary to expectations, emotional responsiveness from neither mother nor father was related to social support (as it had been in the earlier study of undergraduates). However, memories of mother’s intrusive control were negatively associated with social support for these clients. As expected, client-rated working alliance was positively correlated with social support, but contrary to expectations no aspect of parental bonds was significantly correlated with client-rated working alliance (Mallinckrodt, 1991).

Considering these mixed findings, I was eager to conduct a new study of parental bonds, social competencies, and working alliance. Clients in the next study, as before, completed the PBI and the Working Alliance Inventory. However, to assess social competencies this study used a measure of self-efficacy (Sherer & Adams, 1983) and the Adult Attachment Scale (AAS; Collins & Read, 1990). The AAS contains three subscales to measure willingness to trust others and rely on them to be available if needed (Depend), comfort with intimacy (Close), and fears of being abandoned in relationships (Anxiety). Only the data from female clients were analyzed in this study because there were too few male participants. Results indicated that fathers’ emotional expressiveness was related to the willingness to depend on others, and intrusive “overprotection” was negatively related to comfort with intimacy. Interestingly, fathers’ intrusive control was significantly negatively associated with working alliance. Among social competencies, only anxiety about abandonment was associated with working alliance. Hierarchical multiple regression suggested that parental bonds accounted for 23% of the unique variance in client-rated working alliance, whereas social competencies accounted for 14% of the unique variance (Mallinckrodt, Coble, & Gantt, 1995).

In terms of the SCIP model, findings of the previous study supported a link between parental bonds and social competencies (F → E), and a link between (E) social competencies and (G) the psychotherapy relationship. However, the strongest relationship found in the Mallinckrodt, Coble, and Gantt (1995) study was between parental bonds and the psychotherapy relationship. This link, F → G, is shown with a dashed line in Figure 1 to indicate its tentative nature. It is possible that the association between childhood experience and the psychotherapy relationship can be entirely accounted for by the mediating effects of social competencies. In other words, if it were possible to measure the total effect of childhood experience on all
social competencies, and the effect of all social competencies on the psychotherapy relationship, there would be no remaining significant unique association between childhood experience and the psychotherapy relationship. Some readers may see this possibility as an indictment of the social competencies construct because it is so broad as to be virtually meaningless. I acknowledge that the construct is indeed broad, but I believe it remains very useful because the construct allows us to reframe the question posed by the dashed $F \rightarrow G$ (early experience $\rightarrow$ therapy relationship) link in Figure 1 as, given that social competencies include all factors internal to an individual necessary for recruiting and maintaining quality personal relationships, are there any influences that childhood experience has on the psychotherapy relationship apart from the general influence early experience has on social competencies and personal relationships? I look forward to further studies that pursue these questions with a diverse battery of social competencies measures.

The SCIP model recognizes that therapists often become a temporary direct source of social support for their clients ($G \rightarrow D$; therapy relationship $\rightarrow$ social support). However, the model also holds that lasting change occurs only when there has been a change in the client’s social competencies. To test the $G \rightarrow E$ (therapy relationship $\rightarrow$ social competencies) link in Figure 1, I used a pre/post design to measure changes in clients’ social support, symptoms of distress, and working alliance in brief therapy (Mallinckrodt, 1996). Findings suggested that improved working alliance over the course of therapy was related to gains in clients’ satisfaction with social support. Improvement in working alliance and improvement in social support both, in turn, were related to successful therapy outcome. However, change in social support had the stronger of the two influences on change in symptoms. As predicted by the SCIP model, it appears that the working alliance may have an important indirect influence on symptoms through the mediating effect of facilitating increased client social support. Note, however, some research suggests that different approaches to therapy, consistent with their theoretical underpinnings, differ as to whether change is facilitated by positive change in the alliance, or a consistent relatively positive alliance from the outset (Westerman, Foote, & Winston, 1995).

Findings of the Mallinckrodt (1996) study are consistent with the notion that attempts to build or repair breaches in the working alliance help clients acquire critical social competencies. Other research provides more detailed support for the hypothesized links between social competencies and the psychotherapy relationship. Kivlighan and Schmitz (1992) found that therapists’ increased focus on the here-and-now, as well as a willingness to challenge the client’s viewpoint, distinguished working alliances that began poorly, but improved, from those that remained poor. These studies suggest specific techniques that therapists can employ to repair inevitable breakdowns in their working relationships with clients. Although breaches in the alliance can be expected with any client (Safran & Muran, 1998), I have been very interested in studying individual differences that may make a productive working alliance particularly difficult for some clients. This interest prompted me to study applications of attachment theory to understanding the psychotherapy relationship.

ATTACHMENT AND THE PSYCHOTHERAPY RELATIONSHIP

Bowlby (1988) speculated that the generalized expectations about others and beliefs of self that form working models in early attachment experience may pro-
foundly influence the therapeutic relationship, which, he pointed out, shares important similarities to caregiver-infant attachment. Attachment theory is so appealing that there is a danger of overgeneralizing it to apply to any close relationship (Mallinckrodt, 1995). Before uncritically accepting the assertion that psychotherapy is an attachment relationship, it is well to consider an operational definition of what constitutes an adult attachment relationship. According to West and Sheldon-Keller (1994), drawing upon the work of Weiss (1982), adult attachments are: (a) “dyadic relationships in which proximity to a special and preferred other is sought or maintained to achieve a sense of security” (p. 19); (b) relationships of emotional partnership; (c) relationships whose loss gives rise to grief and protest; and (d) relationships in which the attachment partner is irreplaceable. From this definition, it is apparent that although not every form of counseling or psychotherapy qualifies, when the client is able to engage fully in interpersonal psychotherapy, the relationship does involve processes of adult attachment. Nevertheless, there are distinctions between therapeutic and parent-child attachments (e.g., duration, reciprocity, limitations of access) that have important consequences for the therapy, especially because these differences can be a focus for client transference reactions (Farber, Lippert, & Nevas, 1995).

In adults, working models of attachment consist of four elements: (a) autobiographical memories of social interactions; (b) expectations about self and others in interpersonal situations; (c) relationship goals that guide one’s responses in social situations; and (d) strategies for attaining these goals and regulating distress produced by lack of goal attainment (Collins & Read, 1994). Thus, if psychotherapy is a form of attachment, the relationship will be influenced by both the client’s and the therapist’s (a) memories of past attachments, (b) expectations about how self and other will behave in the therapy relationship, (c) strategies for attaining goals in the therapeutic attachment, and (d) strategies for regulating distress when the goals are frustrated. Thus, attachment theory offers a useful framework for understanding therapist countertransference and client transference (Gelso & Hayes, 1998).

To understand the particular meaning of attachment goals and strategies in the context of psychotherapy, it is necessary to review other basic concepts from attachment theory. For infants the “set goal” of the attachment behavioral system is maintaining proximity to the attachment figure (Hazan & Shaver, 1994; Kobak, 1999). The function of attachment behavior is to promote a sense of “felt security” (Sroufe & Waters, 1977) through regulating physical proximity. With this sense of security, infants are freed from constraining fears and are able to explore their physical surroundings. Thus, the attachment figure functions as a “secure base” for exploration. When faced with external threat or compromised internal well-being (i.e., illness, fatigue), infants cease exploration and ideally seek closer proximity to the attachment figure, who then functions as a “safe haven” (Bowlby, 1979). As a child grows, internalized mental representations increasingly substitute for actual physical proximity. Thus, by adolescence, emotional intimacy has largely taken the place of physical proximity, although the set goal of attachment behavior even for adults remains proximity (albeit primarily emotional proximity), and the function of proximity is still a sense of felt security (West & Sheldon-Keller, 1994).

When working models are activated under conditions of stress, especially interpersonal distress, so also are templates and expectations about relationships that trigger emotional reactions, in a process termed “schema-triggered affect” (Fiske & Pavelchak, 1986). The specific affective response is governed by a process of interpretation and appraisal of the event determined by internal working models. This explains why a seemingly similar relationship event may lead to two quite different affective responses.
for clients who assign different meanings to the event based on their differing working models. Finally, parallel to the strategies for achieving goals for proximity, working models also consist of patterned coping responses when the goals are frustrated. In adults, these coping strategies are essentially methods of affect regulation (Collins & Read, 1994; Mikulincer, 1998).

Concepts from control theory have been used to develop a model that ties together the preceding concepts of working models, relationship proximity, and affect regulation (Kobak, Cole, Ferenz-Gillies, Fleming, & Gamble, 1993). According to this model, a history of relatively consistent responsiveness from caregivers prompts children (and also adults) to predict future favorable responsiveness. Thus, when persons with secure attachment feel threatened, they display a normal activation of their attachment behavioral system (i.e., seeking proximity and soliciting comfort from attachment figures). However, Kobak et al. (1993), drawing from the work of Main (1990), theorized that individuals who do not have a secure attachment history respond to threatening situations in one of two distinct ways. Individuals who, based on previous experience, expect attachment figures to ignore or reject their bids to solicit comfort learn over time to deactivate normal attachment responses, mainly through cognitive and affect regulation processes that divert attention from both the distress-evoking stimuli and attachment related thoughts and feelings (Fraley, Davis, & Shaver, 1998). In contrast, persons who, based on previous experience, expect attachment figures to respond inconsistently learn to keep their attachment system in a state of hyperactivation through continuously monitoring attachment figures for signs of impending abandonment, fixing attention on distress-evoking stimuli, and magnifying their expressions of distress and attempts to maintain proximity and solicit comfort. In support of this model, Kobak et al. (1993) identified three distinct clusters of secure, hyperactivating, and deactivating adolescents in a laboratory observation of mother-teen dyads who performed a problem-solving task. Adolescents classified as securely attached engaged in the task with considerably less dysfunctional anger and less problem-solving avoidance than adolescents classified in the other two attachment groups.

A growing body of evidence supports the hyperactivation/deactivation model proposed by Kobak and his associates (Dozier & Kobak, 1992; Kobak et al., 1993). For example, persons with a preoccupied attachment style (i.e., presumed hyperactivating attachment strategy) may experience greater emotional intensity and attend more to their feelings than those with a secure or dismissing style, whereas those with a dismissing style (i.e., presumed deactivating strategy) may express emotions less, report less affective intensity, and devote less attention to their emotional experience (Searle & Meara, 1999). Persons with a preoccupied attachment style were found to react with more intrusive thoughts to a stressful event than persons with either a secure or fearful style (Kemp & Neimeyer, 1999). Evidence of the
activation of relational schemata in adult attachment styles has been observed in “lexical decision” experimental research. Subjects with secure attachment were faster in identifying words suggesting positive interpersonal circumstances than neutral or negative words, whereas subjects with insecure attachment were significantly faster at identifying words describing a negative relationship outcome than neutral or positive words (Baldwin, Fehr, Keedian, Seidel, & Thomson, 1993). Persons who were comfortable with intimacy and felt they could depend on others interpreted a standard set of negative relationship event vignettes in ways that maintained confidence in their relationship and their partner, and in general interpreted the events in ways that minimized the long term negative implications. In contrast, persons with high anxiety in their attachments were more likely to interpret the events as indications that the relationship itself was in jeopardy, that their partner was unresponsive, not trustworthy, and purposely rejecting. In general, their interpretations tended to magnify the negative implications of the vignettes (Collins, 1996). Persons with anxious attachments appear more likely to seek security in their close relationships, whereas persons with avoidant attachments were found to place more emphasis on gaining control in the relationship (Mikulincer, 1998).

Starting from the assumption that psychotherapy involves an attachment relationship, with my research team, we developed a measure intended to tap the attachment constructs of proximity seeking, safe haven, emotional regulation, and secure base as they unfold in the psychotherapy relationship. The details of instrument development are reported elsewhere (Mallinckrodt, Gantt, & Coble, 1995). Exploratory factor analyses were conducted on data collected from over 130 clients. The resulting Client Attachment to Therapist Scale (CATS) consists of three subscales. The first factor captures security in a client’s attachment to the therapist, with perceptions of the therapist as responsive and consistently emotionally available. The factor includes components of secure base (e.g., “My counselor helps me to look closely at the frightening or troubling things that have happened to me.”) and safe haven (e.g., “My counselor is a comforting presence to me when I am upset.”). The second factor (Avoidant/Fearful) captures distrust of the therapist, feeling humiliated, unsafe, or patronized, strong reluctance to self-disclose or become more intimate in therapy, and the sense that the therapist’s level of engagement is contingent on how the client behaves. The third factor (preoccupied/merger) captures clients’ longing to be “at one” with their therapist, spend more time together, be the therapist’s favorite client, and have the therapist become more close and personal. The CATS Secure subscale was positively correlated with the working alliance, and negatively correlated with several object relations deficits. In contrast, the Avoidant/Fearful subscale was negatively correlated with working alliance, and positively correlated with the object relations deficits of social incompetence and alienation. The Preoccupied/merger subscale had a significant (but weak) positive correlation with only the Bond aspect of the working alliance, and with only a single object relations deficit, insecure attachment. Both the Avoidant/Fearful and the Preoccupied/merger subscales were negatively correlated with self-efficacy.

A second study of the CATS included measures of clients’ dysfunctional family environment and alexithymia, thus investigating links between elements F, E, and G of Figure 1 (social competencies, childhood experience, and the therapy relationship). Clients’ recollections of dysfunctional family environment were assessed with the Family Structure Survey (FSS; Lopez, Campbell, & Watkins, 1988). We found that both FSS role reversal and fear of separation were significantly associated with alexithymia. Alexithymia, especially difficulty identifying feelings, was negatively
associated with the CATS secure factor, and positively associated with the avoidant and preoccupied factors (Mallinckrodt, King, & Coble, 1998). Most intriguing was evidence for somewhat different “signatures” of family dysfunction for each of the three CATS subscales. Fear of separation (i.e., enmeshment) had the broadest association—negative with Secure attachment to therapist, and positive with Avoidant/Fearful and Preoccupied/merger attachment. Marital conflict was significantly associated with only the two insecure types of attachment, and parent-child role reversal was significantly associated only with Avoidant/Fearful attachment to therapist.

ATTACHMENT THEORY AS A UNIFYING FRAMEWORK

For me, one of the most exciting aspects of applying attachment theory in the research described above is the power of the theory to provide a single conceptual framework that ties together independent lines of research. Attachment theory, by suggesting points of convergence, offers both a unifying conceptual language and a fresh perspective for understanding important previous findings. For example, one point of convergence is between patterns of client attachment to therapist and the hyperactivation/deactivation attachment regulation model (Dozier & Kobak, 1992; Kobak et al., 1993). Perhaps the three subscales that emerged in the exploratory factor analysis leading to development of the CATS correspond to each of the three attachment regulation strategies identified by Kobak et al. (1993). The secure CATS subscale may reflect the secure proximity regulation strategy. Items of the Avoidant/Fearful CATS subscale suggest aspects of the deactivating attachment strategy (e.g., “I don’t like to share my feelings with my counselor,” “My counselor wants to know more about me than I am comfortable talking about”), including aspects suggesting dysfunctional anger at the attachment figure (e.g., “I feel humiliated in my counseling sessions”). Items loading on the Preoccupied/merger CATS factor may reflect clients’ hyperactivating attachment strategy (e.g., “I would like my counselor to feel closer to me,” “I wish my counselor could be with me on a daily basis”).

A second point of convergence comes from research on CCRTs in client narratives (Luborsky & Crites-Christoph, 1998). CCRTs involve three elements: (a) the client’s wishes or needs from the relationship partner, (b) how the partner responds to the wish, and (c) how the client responds to the partner’s response. Thus, CCRT narratives provide a “royal road” for assessing a client’s attachment patterns because the method taps all four aspects of working models, namely: autobiographical memories, expectations of self and others, strategies for attaining relationship goals, and strategies for regulating distress when goals are not met. A survey of 33 clients found that two wishes were by far more numerous in CCRT relationship narratives than other client wishes. These were the wish “to be close to other,” the predominant wish of 39% of the clients, or “to assert myself and to be independent,” the predominant wish of an additional 30% of the sample (Luborsky, Barber, Schaffler, & Cacciola, 1998). Perhaps not surprisingly, the most common themes of responses from others in the clients’ lives to these wishes were negative in the sense that the original wish was not met. Interestingly, among the most frequent complete sequences were: (a) the wish “to be close or loved,” (b) the response of other “rejecting and opposing,” and (c) the counter-response of self, “helpless,” “disappointed and depressed,” or “ashamed or anxious.” A second, high-frequency CCRT sequence was the wish “to assert myself and to be independent,” followed by a “rejecting,” “upset,” or “controlling” response of other. Perhaps the high frequency CCRT wish, “to be independent,” is part of the deactivating attachment.
coping strategy, whereas the high frequency CCRT wish, “to be close,” reflects the hyperactivating coping strategy.

A third point of convergence is posed by new empirical evidence suggesting that adult attachment should not be conceptualized as qualitatively different categories, but rather in terms of the two orthogonal dimensions of insecure attachment “avoidance” and “anxiety” (Brennan, Clark, & Shaver, 1998). The anxiety dimension appears to encompass the working model of self construct, whereas the avoidance dimension encompasses the working model of others construct. Methodologically quite sophisticated research has failed to uncover evidence for qualitatively different “taxa” of attachment (Fraley & Waller, 1998), and has provided further support for the two underlying continuous dimensions. Recent studies suggest that adult attachment is associated with specific configurations of interpersonal problems that clients present in therapy (Horowitz, 1994). Dismissing attachment style (i.e., the attachment avoidance dimension) has been associated with problems in the dominant-hostile quadrant of the interpersonal circumplex, whereas a Preoccupied attachment style (i.e., the attachment anxiety dimension) was associated with problems in the submissive-affiliative quadrant of the circumplex (Horowitz, Rosenberg, & Bartholomew, 1993).

In preliminary analyses of data from over 350 undergraduates (Mallinckrodt & Wei, 2000), we found that attachment avoidance (and presumed deactivation) measured as a continuous dimension was most strongly correlated with interpersonal problems in the hostile/dominant quadrant of the circumplex, and with conflictual relationship themes involving low wishes for support and high wishes to be in conflict, very low loving responses of other, and very low caring or feeling valued responses of self. Attachment anxiety (and presumed hyperactivation) was most strongly correlated with interpersonal problems in the dominant/affiliative circumplex quadrant, and with conflictual relationship themes involving high wishes not to be abandoned, high controlling and hurtful responses of other, and high anxious and dependent responses of self.

The final point of convergence comes from the Second Sheffield Psychotherapy Project (Hardy, Stiles, Barkham, & Startup, 1998). Clients were classified on the basis of self-reported interpersonal problems as having either an overinvolved, underinvolved, or balanced interpersonal style. Therapists, tended to use more affect- and relationship-oriented interventions with the overinvolved clients, and more cognitive interventions with the underinvolved clients. These tendencies were moderated by interactions with the treatment to which clients were assigned, either psychodynamic-interpersonal or cognitive-behavioral. Interestingly, the groups based on interpersonal style did not differ in terms of working alliance and treatment outcome, suggesting that the therapists’ differential application of techniques produced equivalent outcomes because they were well-matched to clients’ differing needs.

Taken together, this research has important implications for case conceptualization. The two fundamental dimensions of anxiety and avoidance in adult attachment, at elevated levels, appear to reflect, respectively, the coping strategies of hyperactivation and deactivation of the attachment system. Deactivation of a client’s attachment system appears to arise early in childhood as an adaptive response to the perception of caregivers as unavailable, whereas hyperactivation develops as an adaptive response when caregivers are inconsistently available. Because working models involve expectations about the anticipated responses of future caregivers—expectations that are maintained by defensive exclusion of contradictory information—it is apparent that the most frequent patterns of clients’ CCRT wish, response of other, and response of self parallel either the hyperactivation or deactivation strat-
gies of managing distress. These strategies also appear to underlie configurations of interpersonal circumplex problems clients present in therapy. In childhood, hyperactivation or deactivation strategies serve to regulate physical proximity; in adults these strategies serve to regulate affect and emotional proximity in relationships, including perhaps the emotional proximity between client and therapist measured by the CATS (Mallinckrodt, Gantt, & Coble, 1995).

Convergence of these lines of research around the themes of maladaptive attachment hyperactivation or deactivation also has important implications for therapy. For example, in clinical supervision I use these concepts as a framework to help students determine (a) how a client’s maladaptive patterns are manifested in the therapy relationship, (b) potential responses that the client pulls from the therapist, (c) experiences the client is attempting to fend off, and (d) what type of emotional attachment experience could be corrective for the client. Clients frequently express needs that would be counterproductive for their therapist to meet. There are also certain topics and therapeutic techniques that would be useful for therapists to pursue, but that the client fears and resists. Thus, to oversimplify, two basic clinical situations, “client desires X” and “client fears X,” are combined with two basic therapeutic decisions, “therapist provides/pursues X” and “therapist withholds/avoids X,” The four resulting combinations are depicted in the Therapeutic Gratification, Relief, Anxiety, or Frustration (T-GRAF) scheme shown in Table 1.

To make the scheme easy to remember for my practicum students, I have given the cells in Table 1 tongue-in-cheek labels that represent what a client might exclaim in each situation, at least with an inner voice. The “Ahhhh!” cell represents the therapist’s gratification of a client’s need, and the “Whew!” cell represents the relief a client feels when the therapist decides to withhold an intervention that would be anxiety-provoking. Considerable therapeutic progress is possible in these two diagonal cells, because, of course, clients have legitimate needs and fears that a therapist does well to gratify or assuage. However, this diagonal of the T-GRAF model tends not to be a focus of therapeutic struggle because operating from these two cells does not inject much tension into the therapeutic relationship. More problematic is the “Oh No!” cell, which represents a therapist’s insistence on the client engaging in an anxiety-provoking intervention, and the “Waaaah! Give me!” cell, which represents a therapist’s refusal to gratify the client’s need. Thus, sometimes a corrective experience involves planfully withholding what the client wants (i.e., “therapeutic frustration”), or providing precisely what the client fears (i.e., “therapeutic anxiety”). Hardy et al. (1998) arrive at similar conclusions in explaining successful outcomes in the Second Sheffield Psychotherapy Project, despite differences in clients’ interpersonal style, “appropriate responsiveness does not necessarily imply that the therapist does whatever the client wishes” (p. 304). Finally, I have speculated that the low tension “Ahhhh!” and “Whew!” diagonal tends to produce smooth, positive sessions that may be most important in the alliance-building early phase of therapy, but that working in the high-tension “Oh No!” and “Give Me!” diagonal is necessary to produce the deep and arousing sessions in the middle phase that promote client change.

Recent findings provide tentative evidence suggesting specific corrective emotional experiences that may be effective for clients with hyperactivating or deactivating attachment strategies (Dozier, Cue, & Barnett, 1994; Hardy et al, 1998; Mallinckrodt et al., 1998; Tyrrell, Dozier, Teague, & Fallot, 1999). I term these “Counter-complimentary attachment proximity strategies” (CCAPS), because they require the therapist to manage attachment proximity in the psychotherapy rela-
tionship by responding to the client “against type,” that is, in a way that breaks with clients’ expectations and past maladaptive patterns. Clients with a deactivating strategy seek avoidant attachments to their therapist, seek to increase interpersonal distance, and tend to elicit disengaging and distancing behavior from others. Thus, a counter-complimentary (CCAPS) therapist response that might provide a corrective emotional experience for these clients would be to increase attachment proximity by gently, patiently insisting on a deepening emotional engagement, while at the same time carefully monitoring the client’s tolerance for anxiety and encouraging the client not to deactivate attachment related thoughts and feelings. This corrective experience requires frequent forays into the therapeutic anxiety (“Oh No!”) cell of the T-GRAF model. In contrast, clients with a hyperactivating strategy manifest aspects of preoccupied attachment to the therapist, seek to reduce interpersonal distance, and—through communicating their sense of helplessness and dependency—tend to strongly elicit rescuing behavior from others. Thus, a corrective CCAPS response in this case would be for the therapist to maintain or increase attachment distance by providing only a measured amount of support and encouragement—again assiduously monitoring the client’s tolerance for the resulting anxiety and gently insisting that the client take a leading role in addressing the presenting problems, while the therapist resists the client’s pulls for rescuing and overengagement. This corrective experience involves the therapeutic frustration (“Give me!”) cell of the T-GRAF model.

Two key features of this approach place extraordinary demands on therapists: (a) offering a counter-complimentary level of attachment proximity while disconfirming a client’s maladaptive working model expectations—in the face of the client’s perhaps unwitting, but often ingenious bids to recreate a maladaptive level of attachment proximity; and (b) monitoring the client’s tolerance for anxiety and adjusting the therapeutic frustration or anxiety accordingly. With students I have used the analogy of control rods in a nuclear reactor to symbolize this process of monitoring anxiety. If the rods are inserted too far, the energy source (client anxiety) is over-controlled, all reactions cease, and the reactor core cools. If the rods are withdrawn too far the energy source becomes uncontained and a “meltdown” ensues. It can be

<table>
<thead>
<tr>
<th>Client’s manifest wish for the therapist</th>
<th>Therapist’s decision</th>
<th>Therapist’s decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide X</td>
<td>Provide or pursue X</td>
<td>Withhold or avoid X</td>
</tr>
<tr>
<td>1. Gratification, “Ahhhh!”</td>
<td>Therapist meets client’s need for X. Client’s need is satisfied, perhaps only temporarily.</td>
<td></td>
</tr>
<tr>
<td>2. Frustration, “Waaaaah, Give me!”</td>
<td>Therapist refuses to provide X. Client protests and increases bids to obtain X, or may withdraw sullenly.</td>
<td></td>
</tr>
<tr>
<td>Don’t provide X</td>
<td>2. Anxiety, “Oh no!”</td>
<td></td>
</tr>
<tr>
<td>2. Anxiety, “Oh no!”</td>
<td>Client fears X, but therapist provides it or pursues the topic anyway. Client may “refuse delivery” and resist at first.</td>
<td></td>
</tr>
<tr>
<td>3. Relief, “Whew!”</td>
<td>Client fears X, and feels great relief when the therapist does not provide it or pursue the topic.</td>
<td></td>
</tr>
</tbody>
</table>
helpful for students to view client anxiety as something not to be avoided, but rather to be managed collaboratively with clients, and a sign that powerful reactions are taking place.

In a study with important implications for supervision and training, Dozier et al. (1994) found that the ability of clinical case managers to provide what I have described here as a counter-complimentary response (i.e., engaging a deactivating client or maintaining appropriate distance from a hyperactivating client) was associated with the attachment style of the case managers. These clinicians showed a narrower range of attachment profiles than clients, but within the range exhibited by case managers, those with the most secure attachments themselves tended to provide (presumably) more helpful counter-complimentary responses, whereas case managers with less secure attachments tended to gratify a hyperactivating client's needs for close engagement, or colluded in a deactivating client's bids to keep the intervention superficial. In related research, Tyrrell et al. (1999) studied clients with serious psychiatric disorders and found that they functioned best and had the most positive working alliances after long term contact with case managers whose levels of deactivation ran counter to their own, that is, more deactivating clients did best with less deactivating managers and vice versa.

These findings are relevant for the final elements of the SCIP model which emphasize that therapists contribute their own social competencies to the psychotherapy relationship in addition to technical skills (H \rightarrow G); that therapists themselves can gain social competencies (G \rightarrow H) through interactions with their clients, especially when the therapy relationship requires competencies that do not come easily for some therapists (e.g., tolerating the client's hostility and frustration); that the supervision relationship is a vehicle for building both technical skills and social competencies (I \rightarrow H); and that the therapist's own childhood experiences influence both the supervision relationship (J \rightarrow I) and what the therapist contributes to the psychotherapy relationship (J \rightarrow H). For therapists, here I expand social competencies to encompass dispositions and relationship qualities, such as empathy, genuineness, and self-awareness, that previous research has shown promote therapeutic change.

Recent research provides tentative support for some of these connections. For example, experience level of therapist trainees was not significantly related to quality of the working alliance when clients were relatively comfortable with close attachments, but only more experienced trainees were able to form positive alliances with clients who were uncomfortable with closeness (Kivlghan, Patton, & Foote, 1998). Favorable client ratings of working alliance were negatively correlated with therapists' introjected (i.e., self-directed) hostility, and positively correlated with therapists' self-reported level of social support, as well as comfort with closeness and willingness to depend on others (Dunkle & Friedlander, 1996). Qualitative research also suggests that therapists' unresolved attachment issues are, in fact, a source of countertransference reactions (Hayes et al., 1998). Preliminary results suggest that the childhood experience of parents' emotional responsiveness is associated with therapists' tendency to disaffiliate from certain clients (Hilliard, Henry, & Strupp, 1995). It has been suggested that supervisees' attachment style influences the supervision relationship (Pistole & Watkins, 1995), but to my knowledge there are no empirical findings on this question. Thus, there has been little research testing elements of the SCIP model concerning therapist individual differences. These are among the areas that could be fruitful directions for future research.
FUTURE DIRECTIONS FOR RESEARCH IN ATTACHMENT AND THE SCIP MODEL

At the level of basic research, presently we are analyzing data from a survey of several hundred undergraduates to examine a wider range of SCIP model links in a single study (Mallinckrodt & Wei, 2000). We are investigating links between parental bonds, adult attachment anxiety and avoidance, social competencies, interpersonal circumplex problems, and central relationship themes. This study adds a new measure of parental bonds called the “Love Withdrawal Scale,” designed to assess memories of contingent parental responsiveness similar to Rogers’ concept of conditions of worth. Family structure and interpersonal theory (Teyber, 1997) lead us to expect that love withdrawal may have an especially detrimental influence on social competencies. In a second ongoing project with a more applied focus (Chen & Mallinckrodt, 2000), we are investigating how therapy group members with differing attachment styles perceive one another in terms of interpersonal circumplex behavior.

Other important questions of applied research stem from the distinction made in the SCIP model between social skills and dispositions. The relevance of this distinction can be illustrated with an analogy from the field of computer programming. Programmers are sometimes faced with a software malfunction bug concealed somewhere in millions of lines of code. The conditions that give rise to the malfunction and the specific results of the bug are much easier to specify than the actual location of the problematic code. By expending considerable time and effort, a programmer might be able to locate the source of the bug, but a more expedient solution is merely to graft into the software a new section of code called a “workaround,” attempting to counteract the effects of the bug without correcting the source of the malfunction. After this type of repair, both the problematic bug and the new workaround code coexist in the program. The solution may not be elegant, but it is functional and expedient.

The computer-to-human analogy should not be stretched too far, but the concept of a workaround is relevant for psychotherapy in an era of managed care and rationing of services. Therapists often simply are not permitted the resources to address the source of interpersonal problems (i.e., social dispositions in the SCIP model). A practical question in need of empirical investigation is under what conditions and to what degree it is possible in brief therapy to effect a workaround by addressing social skills deficits rather than attempting major change in underlying dispositions? For example, can clients with hyperactivating attachment strategies be helped significantly by being taught affect regulation and anxiety management skills, without attempting major change in their fundamental negative working model of self and relationship templates? Can dispositions be changed just enough so that a client is willing to acquire and use new skills, despite the attendant anxiety in exercising the skills? Conversely, can addressing skills deficits in brief therapy have secondary positive effects on attachment style?

At a more basic level of research, little is known about the degree to which maladaptive attachment patterns change over the course of therapy, and what might be the active ingredients of change. Do skills change first and then dispositions, or the converse? Research is needed to study the change processes involved in CCAPS (i.e., more engagement for deactivating clients, maintaining appropriate distance for hyperactivating clients). How do these potentially corrective emotional experiences
in a client’s attachment to the therapist alter the client’s working models of self and others? For example, does the therapist’s example of counter-complimentary engagement shift the deactivating client’s negative working model of others to a more positive template? Does the therapist’s counter-complimentary supportive insistence on independence shift a hyperactivating client’s negative model of self to a more positive appraisal? How are T-GRAF elements of therapeutic gratification, relief, anxiety, and frustration related to session depth, smoothness, positivity and arousal?

Researchers are just beginning to consider therapist countertransference reactions to client attachment styles (Gelso & Hayes, 1998). Theorists have speculated that because clients with dismissing (i.e., deactivating) attachment styles “lock out” therapists from entering their emotional experience or engaging in a mutually collaborative relationship, the therapist is left feeling hopeless about the prospects of change or attaining intimacy with the client—in essence as the client once felt as a child “angry, unacknowledged, silly, and inept” (Slade, 1999, p. 588). Whereas clients with preoccupied (i.e., hyperactivating) attachment styles may present therapists with their dependency and an overwhelming “devouring” sense of crisis, thus leaving the therapist feeling in essence as these clients once felt as children “swamped, angry, helpless, confused, and dysregulated” (Slade, p. 588). As yet, there is no empirical evidence to support this intriguing speculation.

Sable (1997) pointed out the benefit of helping clients with insecure attachment patterns to accept that the working models and affective reactions they evolved were understandable, adaptive responses, given the behavior of their caregivers. Effective therapy involves helping clients acknowledge that these patterns were successful—perhaps ingenious—adaptations in childhood, but that these working models have been overgeneralized as adults. A shift toward more adaptive and flexible working models must be accompanied by helping clients process emotional experience related to early attachment that has previously been defended against and excluded from full awareness (Slade, 1999). Inflexible working models lead not only to the defensive exclusion of past traumatic experience, but may also lead to an inability to trust and integrate the current positive relationship conditions offered by a therapist, if these do not fit a client’s model of others. Future studies may show that basic therapist qualities such as transparency and genuineness are effective, in part, because they promote interpersonal feedback that allows clients to gradually correct the accuracy of attachment-mediated automatic (and erroneous) interpretations of relationship events in therapy. The technique of psychodynamic interpretation of transference can be reconceived and studied in attachment theory terms as the client gaining an understanding of his or her own working models and schema-triggered affective patterns.

Thus, if clients during the course of therapy gradually integrate previously unprocessed affective components of past attachment experience and change current relationship schemas, the changes will necessarily involve a fundamental realignment of cognitive structures and modes of affect regulation (Safran & Segal, 1990). Therefore, the change process involves a gradual assimilation of what are initially “not like me” and “not like most others” schemas into a new self-consistent accommodation in the client’s working models. An assimilation model may provide a framework for tracking this change process (Stiles, 1999; Stiles et al., 1990). Indeed, attachment theory provides an explanation for a major source of the problematic unassimilated experiences. Consistent with the framework presented in this article, I believe that some of the most change-evoking experiences a client is compelled to assimilate arise from corrective experiences in the therapy relationship. Dissonance
is introduced into a deactivating client's negative model of others when the client experiences a therapist (or fellow psychotherapy group member) as trustworthy, consistent, and patiently willing to engage—and when, instead of the feared outcomes, decreased proximity brings liberating relief from isolation. Similarly, dissonance is experienced in a hyperactivating client's negative model of self when a therapist responds supportively, but as though the client has considerable capacity to address problems without the therapist's help—and when instead of the feared experience of abandonment this appropriate distance brings an empowering sense of self-efficacy.

I believe that we have entered an exciting period for psychotherapy research in which insights from attachment theory can lead to a better understanding of the forces that give rise to interpersonal problems, as well as how clients experiencing these problems can be helped through corrective attachments formed in the process of psychotherapy. I hope that by giving an account of how I arrived at this conviction, I can be helpful to others engaged in this research, including some who might be future recipients of the SPR Early Career Award.

REFERENCES


Mallinckrodt, B., & Bennett, J. (1992). Social sup-
Mallinckrodt, B. (in press). Interpersonal pro-
Mallinckrodt, B., Coble, H. M., & Gantt, D. L.
Mallinckrodt, B., Gantt, D. L., & Coble, H. M.
Mallinckrodt, B., & Fretz, B. R. (1988). Social sup-
Mallinckrodt, B. (1993). Session impact, working
Mallinckrodt, B. (1992). Childhood emotional bonds
Mallinckrodt, B. (1989). Social support and the
264 MALLINCKRODT
Main, M. (1990). Cross-cultural studies of attach-
ment and the impact of job loss in dislocated
community psychology
Mikulincer, M. (1998). Attachment working mod-
els and the sense of trust: An exploration of interaction goals and affect regulation. Journal of Personality and Social Psychology, 74, 1209–
1224.
In J. Cassidy & P. R. Shaver (Eds.), Handbook of attachment: Theory, research, and clinical appli-
cations (pp. 378–394). New York: Guilford.
Parker, G., Tupling, H., & Brown, L. B. (1979) A
Causal attributions for problematic family inter-
actions: A qualitative cultural comparison of Western Samoa, American Samoa, and the U.S.
Counseling Psychologist, 28, 32–60.
and discriminant validity of the Rahim Organiza-
tional Conflict Inventory-II. Psychological Re-
ports, 74, 55–39.
Rhodewalt, F., & Zone, J. B. (1989). Appraisal of
life change, depression, and illness in hardy and nonhardy women. Journal of Personality & So-
cial Psychology, 56, 81–88.
ATTACHMENT, SOCIAL COMPETENCIES, AND THERAPY PROCESS


Zusammenfassung

Résumé
Selon le modèle SCIP (« Compétences Sociales dans le Processus Interpersonnel »), les compétences sociales comprennent (a) des capacités nécessaires au recrutement et au maintien de relations satisfaisantes et soutenantes, et (b), des dispositions de caractère qui gouvernent l’application de ces capacités. La théorie de l’attachement explique comment les compétences sociales se développent à travers les interactions avec les personnes significatives de la petite enfance. La plupart des problèmes présentés par le client adulte peuvent être vus comme des patterns d’interaction interpersonnelle inadaptés—des patterns que le modèle SCIP considère être maintenus par des compétences sociales déficitaires. L’accès au soutien social est déterminé clairement par des différences individuelles concernant les compétences sociales. Comme une relation thérapeutique efficace exige un large spectre de ces compétences, les déficits et les patterns inadaptés du patient deviennent rapidement évidents. La relation elle-même peut ensuite devenir véhicule du changement. Cet article résume ma recherche pour vérifier des aspects du modèle SCIP. Je conclu en proposant des idées pour des recherches futures et en suggérant des expériences correctrices spécifiques d’attachement dans la relation thérapeutique pouvant favoriser un changement chez le client.

Resumen
De acuerdo con el modelo de “Habilidades sociales en el proceso interpersonal (SCIP)”, estas habilidades incluyen (a) el conocimiento práctico para lograr y mantener relaciones de apoyo satisfactorias, y (b) los rasgos disposicionales que gobiernan el uso de estas habilidades. La teoría del apego explica cómo se desarrollan estas habilidades a partir de las interacciones tempranas con los cuidadores. La mayoría de los problemas que presentan los clientes adultos se consideran resultantes de pautas de interacción interpersonal fallida—que, según el modelo SCIP, se perpetúan debido a déficit en las habilidades sociales. El apoyo social disponible está significativamente determinado por diferencias individuales en las habilidades sociales. Debido a que una relación terapéutica productiva requiere un amplio repertorio de estas habilidades, los déficit y fallas del cliente son fácilmente detectables. Esta relación puede, entonces, ser un vehículo de cambio por sí misma. Este artículo resume mi investigación de estos aspectos del modelo SCIP. Concluyo presentando ideas para una investigación futura y sugerencias específicas de experiencias correctoras de apego en la relación terapéutica que pueden facilitar el cambio en el cliente.