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El Modelo del Apego en la Práctica Actual: Avances y Nuevas Direcciones en la Intervención Clínica

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Universidad Nacional de Educación a Distancia (UNED)

Editorial

El Modelo del Apego en la Práctica Actual: Avances y Nuevas Direcciones en la Intervención Clínica

The Attachment Model in Current Practice: Advances and New Directions in Clinical Intervention

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La teoría del apego, formulada inicialmente por John Bowlby, ha evolucionado hasta convertirse en un marco interdisciplinario y transteórico que amplía la comprensión de la psicopatología y optimiza la intervención clínica.

Entre los desarrollos recientes destaca el Modelo Dinámico-Maduracional del Apego y la Adaptación (DMM) de Patricia Crittenden, una propuesta innovadora que redefine las estrategias de apego como respuestas adaptativas a contextos de peligro. Este modelo, no patologizante y basado en fortalezas, ofrece herramientas para comprender cómo estrategias cruciales para la supervivencia en la infancia pueden transformarse en conductas desadaptativas en la adultez.

Los artículos de este número, detallados a continuación, profundizan en las bases teóricas del DMM y sus aplicaciones prácticas en áreas como la evaluación clínica, la formulación terapéutica y la intervención en poblaciones vulnerables:

Systematic Review of the Impact of Parent-Child Separation on Children's Mental Health and Development (Milozzi, 2025): Un análisis exhaustivo del impacto de la separación temprana entre padres e hijos en la salud mental y el desarrollo infantil.

Completando el Mapa de la Terapia Cognitiva: Apego y el Trabajo con lo Negativo (Serván, 2025): Una exploración sobre el trauma y las experiencias irrepresentables en la clínica terapéutica.

Una Aproximación Metacognitiva Relacional al Apego en Psicoterapia (Mirapeix, 2025): Introducción a la terapia metacognitiva relacional, que combina mindfulness con narrativas interpersonales.

Rethinking Developmental Trauma Using the Child Attachment and Play Assessment (Farnfield, 2025): Replanteamiento del trauma del desarrollo, destacando el uso del juego como herramienta terapéutica a través del CAPA.

Vínculos de Apego en Familias Homoparentales (Balma y De Grandis, 2025): Reflexión sobre los desafíos y oportunidades específicas en estas estructuras familiares.

Introduction to the Dynamic-Maturational Model of Attachment and Adaptation: A Function-Based Approach to Understanding Developmental Psychopathology (Baim, 2025a): Presentación de los principios básicos del DMM como enfoque funcional para comprender la psicopatología del desarrollo.

Clinical Applications of the Dynamic-Maturational Model of Attachment and Adaptation: Assessment, Formulation, and Principles of Care (Baim, 2025b): Una guía sobre la formulación de casos desde el DMM, con énfasis en sus instrumentos de evaluación y estrategias de abordaje clínico.

Revisión Sistemática sobre el Apego Adulto y la Repercusión en la Satisfacción de las Relaciones de Pareja (Vizcaí et al., 2025): Análisis de la relación entre las estrategias de apego adulto y la satisfacción en las relaciones de pareja.

El Rol del Apego en el Desarrollo del Lenguaje y la Comunicación a lo Largo de la Vida (Rivas Martínez, 2025): Exploración de cómo las pautas de apego temprano influyen en las habilidades comunicativas a lo largo del ciclo vital.

Desde las consecuencias de la separación parental en la infancia hasta la satisfacción en las relaciones de pareja en la adultez, pasando por las aplicaciones clínicas del DMM en contextos de trauma y adversidad, los trabajos aquí presentados muestran cómo el apego sigue siendo un eje transversal para comprender las interacciones humanas y su impacto en el bienestar.

Un aspecto crucial que une estas contribuciones es la capacidad del modelo del apego para integrarse con diferentes enfoques psicoterapéuticos, ofreciendo una perspectiva rica y flexible para abordar la diversidad de experiencias humanas. Como demuestran los artículos de este número, el apego no solo es relevante en la psicoterapia individual, sino también en la comprensión y tratamiento de dinámicas familiares y sociales complejas.

Este número de *Revista de Psicoterapia* no solo refleja el creciente interés en el Modelo Dinámico-Maduracional del Apego y la Adaptación (DMM), sino que también destaca la trayectoria de su desarrollo y su impacto en el campo de la psicoterapia. En este sentido, contar con la voz de Patricia Crittenden en esta edición es un privilegio y una oportunidad invaluable para profundizar en la evolución del modelo y sus aplicaciones más recientes.

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En el siguiente texto, Crittenden nos ofrece una mirada reflexiva sobre el recorrido del DMM, sus avances teóricos y su expansión a lo largo de los años. Con su característico rigor científico y compromiso con la práctica clínica, nos invita a comprender cómo este enfoque ha ido integrando distintos niveles de análisis para ofrecer una perspectiva más completa sobre la adaptación humana. Su testimonio no solo enriquece este número, sino que también nos recuerda la importancia de seguir construyendo puentes entre la investigación, la práctica y las necesidades de las personas con las que trabajamos.

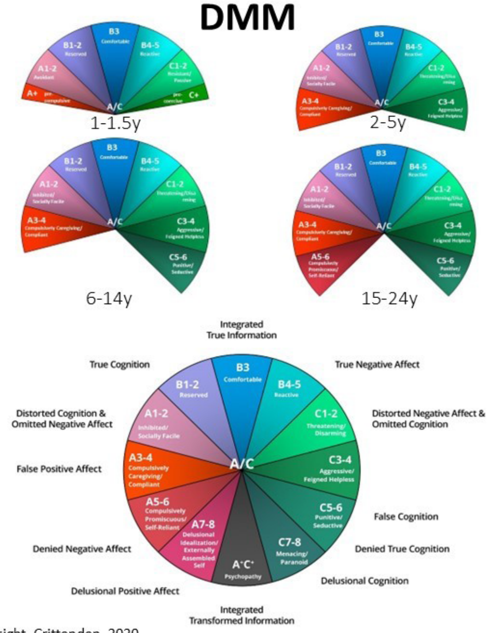
Con gran entusiasmo, damos paso a su contribución.

Forward by Patricia M. Crittenden, PhD

I am so pleased with this issue of REVISTA DE PSICOTERAPIA., edited by Silvana Milozzi, PhD, that focuses on the Dynamic-Maturational Model of Attachment and Adaptation (DMM). The issue is a great capstone to many years of DMM work in Spanish-speaking countries and three papers published earlier in REVISTA DE PSICOTERAPIA. The 2000 paper, *Moldear la arcilla. El proceso de construccción del self y su relación con la psicoterapia*, is one of my favorites.

The current issue of REVISTA DE PSYCHOTERAPIA reminds me of my first visit to Argentina and Chile in the late 1990's at the invitation of Prof. Vittorio Guidano. That trip occurred shortly after Pinochet left power in Chile; it was an experience that forever changed my outlook on Latin America and the international role of the United States. After that I came frequently for two decades of courses in attachment and psychotherapy for the Sociedad de Terapia Cognitiva Posracionalista. That broadened to teaching in Ecuador, Mexico, Panama, Palma, Spain, and Uruguay, including setting up courses with Spanish materials and Latin American trainers.

Figure 1
DMM Protective Strategies at Different Ages, with Information Processing



As frequently happens, the DMM focus on the reality of danger and the importance of having multiple strategies to protect oneself, one's partner, and one's children immediately made sense to psychotherapists who dealt directly with endangered people. At that time, an important change was occurring in the DMM, shifting the focus from *attachment* (with its implicit preference for security) to *adaptation* with its explicit focus on using attachment relationships to adapt to the dangers in one's context. Adaptation implies the use of many protective strategies when conditions are not safe (this highlights the difference between 'security' as felt safety and actual safety, as the absence of danger.) Figure 1 illustrates the classification of attachment strategies within DMM. In the DMM 'every strategy is the best strategy for some context and none is the best for all conditions.

The most current work in the DMM addresses the evolution of the brain specifically to cope with danger, demonstrating how exposure to danger, in the context of maturation and protective parents, promotes psychological development. A particular contribution of the DMM (see Figure 1) is describing the changes in information processing that occur as the brain matures and that permit the construction of increasingly precise protective strategies.

The DMM offers both a dynamic understanding of development and also a strengths approach to what other theories often consider a deficit or injury. A strengths approach can give respect and agency to people who have suffered, thus helping them to adapt more fully to their current conditions, even when these are unsafe (Crittenden, 1997; Crittenden et al., in preparation). The central idea is that danger itself does not lead to maladaptive behavior or psychological trauma; instead, erroneous information about danger creates these risks. This is an emerging, leading edge in DMM work.

Another leading edge is the understanding of sexuality, both its essential role in reproduction and its potential to foster attachment relationships, especially when enduring attachments are absent (Crittenden & Landini, 2023). That leads to one of the most important recent contributions of the DMM: a review of 242 studies of parent-child separation leading to the conclusion that separation of children from their parents always does harm and that the harm often extends across three and four generations (Crittenden & Spieker, 2023; Milozzi, 2025).

Finally, current DMM work is expanding work on somatic organs other than the brain, particularly around the concepts of "the dangerous '*un*'s'", that is, the impact of information that is *un*speakable, *un*thinkable, *un*controllable, and *un*knowable on adaptation.

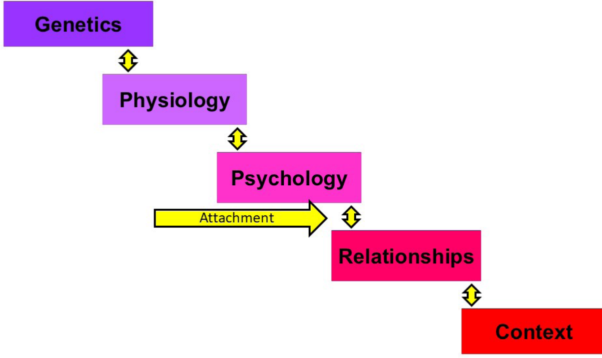
Some might say that the DMM has developed too slowly. I think the careful steps forward are an advantage, one that reduces the possible harm of insufficiently validated work. Requiring numerous, rigorous, and independent studies of new assessments is crucial to avoiding harm (first!) and guiding more attuned treatment (Crittenden, Claussen, & Kozlowska, 2007). Theory itself depends on a careful integration of basic empirical science, clinical case studies, and clinical experience, especially across several cultures (Crittenden & Spieker, 2019). Clinical problems *are* urgent, but rushing through fads of new ideas can be harmful to people who need help. The strong evidence of there being no reduction in mental illness, child protection, or criminality (Children's Bureau, 2018; Olfson et al., 2019; US Bureau of Labor Statistics, 2019) or improvement in treatment outcomes in the recent half century

(Brüne et al., 2012; British Psychological Society, 2013; Insel & Wang, 2010; Roth & Fonagy, 2006; Seligman, 2013) and the presence of largely unreported harm in more than 20% of treatment outcomes (Barlow, 2010; Leichsenring, et al. 2022; Lilienfeld, 2007; Lohr, et al. 2006; Rose et al., 2002; Wampold et al., 1997) suggests the wisdom of moving forward thoughtfully and carefully.

The DMM has grown slowly, building from simpler issues to more complex ones. Moreover, it has done so by integrating the best ideas from all the theories of treatment (Crittenden, Landini, & Spieker, 2021). *DMM Integrative Treatment* is not another, competing theory of treatment, but rather an integrated summation of what is known now and an organized framework for accepting new, not yet even imagined work. The framework accounts for genetic, organic (especially neurological), psychological, familial and cultural contributions to human adaptation, all concentrated in the function of attachment relationships to protect and support family members. See Figure 2.

Before closing, I want to thank Augusto (Tito) Zagmutt and Álvaro Quiñones, both of whom have opened doors to my work in Spanish-speaking countries. This issue of REVISTA DE PSICOTERAPIA both brings the newest work to Spanish-speaking countries and benefits from their experience. This is a great advantage to us all.

Figure 2
Dynamic Interplay of Influences on Adaptation



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Systematic review

Systematic Review of the Impact of Parent-Child Separation on Children's Mental Health and Development

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ABSTRACT

A large number of children around the world are separated from their parents either by social services or due to parental decisions. The causes are multiple and include child violence, parental abandonment, illegal immigration, parental imprisonment, etc. The purpose of the present study is to review scientific research on the effects on children of being separated from their parents. For this, a Systematic Review was carried out using the PRISMA statement on the scientific bases DOAJ, Scielo and Redalyc. Open access articles in English have been included. The filtering, screening and final selection are expressed in a flowchart and tables. According to the analysis it was identified that the effects are not specific to the type of separation and include a high incidence of neurological changes as a result of psychological trauma, early sexual development, physical and sexual abuse, school dropout, subpar academic performance, strained peer relationships, symptoms of psychosomatic and psychiatric disorders, as well as internalizing and externalizing behavior. It is also associated with anxiety, depression, delinquency, substance abuse, inappropriate sexual behavior and self-harm. Evidence suggests that separation can lead to ongoing cycles of family division. Research has shown that children are most at risk between the ages of 9 months and 9 years. Particularly high-risk conditions include separation during the preschool years, abrupt separation without prior notice to the child, being cared for by strangers and simultaneous change of residence.

Revisión Sistemática sobre el Impacto de la Separación de Padres e Hijos en la Salud Mental y el Desarrollo Infantil

RESUMEN

Un gran número de niños de todo el mundo son separados de sus padres por decisión de los servicios sociales o de los propios padres. Las causas son múltiples e incluyen la violencia infantil, el abandono parental, la inmigración ilegal, el encarcelamiento de los padres, etc. El objetivo del presente estudio es revisar la investigación científica sobre los efectos que la separación de los padres tiene en los niños. Para ello, se ha llevado a cabo una revisión sistemática utilizando la declaración PRISMA en las bases de datos científicas DOAJ, Scielo y Redalyc. Se han incluido artículos de acceso abierto en inglés. El filtrado, cribado y selección final se expresan en un diagrama de flujo y tablas. Según el análisis, se identificó que los efectos no son específicos del tipo de separación e incluyen una alta incidencia de cambios neurológicos como resultado de traumas psicológicos, desarrollo sexual temprano, abuso físico y sexual, deserción escolar, bajo rendimiento académico, relaciones conflictivas con los pares, síntomas de trastornos psicosomáticos y psiquiátricos, así como conductas de tipo internalizante y externalizante. También se asocia a ansiedad, depresión, delincuencia, abuso de sustancias, comportamiento sexual inadecuado y autolesiones. La evidencia sugiere que la separación puede dar lugar a ciclos continuos de separación familiar. Las investigaciones han demostrado que los niños corren mayor riesgo entre los 9 meses y los 9 años de edad. Entre las situaciones de especial riesgo se encuentran la separación durante los años preescolares, la separación brusca sin previo aviso al niño, el ser cuidado por extraños y el cambio simultáneo de residencia.

Palabras clave:
Toma de decisiones en los tribunales de familia
Apego
Adopción
Separación familiar
Trauma infantil

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The fundamental purpose of this systematic review is to carry out an objective and rigorous synthesis of academic literature and empirical studies that address the consequences of parental separation on children. Through an exhaustive search of the literature, we have identified and selected the most relevant studies that address this issue, with the aim of providing a complete and updated view on the various dimensions and consequences of this situation to facilitate the work of professionals in charge of children affected by this problem as well as those in charge of designing public policies related to this issue.

The separation of children from their parents is a complex and intricated phenomenon which can occur in a variety of contexts, such as migration, adoption, forced displacement, conflictual divorce and natural disasters. Over the years, this issue has attracted increasing interest from the scientific community, society in general and public policy makers, due to its profound implications for children's development and welfare (Crittenden & Spieker, 2023).

Despite increasing awareness and research efforts, many challenges persist in understanding the complexities of child-parent separation and its effects on children across different socio-cultural settings. Key questions remain unresolved, including the specific mechanisms through which separation impacts child development, the differential outcomes based on varying contexts of separation, and the effectiveness of interventions aimed at mitigating the negative consequences of separation. Moreover, the influence of factors such as socio-economic status, cultural background, and the quality of parent-child relationships further complicates the understanding of this phenomenon. Addressing these gaps in knowledge is crucial for informing evidence-based policies and interventions aimed at promoting the well-being and resilience of children experiencing parental separation. Therefore, this review seeks to explore the intricacies of child-parent separation, examine its diverse manifestations, and critically evaluate existing research to identify avenues for future inquiry and intervention.

A systematic review of the consequences of parental separation on children serves as a valuable tool for advancing knowledge, guiding practice, and improving outcomes for children and families experiencing this challenging circumstance since it provides a comprehensive overview of the existing literature, consolidating findings from multiple studies to offer a nuanced understanding of the topic. It also helps to identify patterns, trends, and gaps in research, facilitating evidence-based decision-making for professionals working with affected children and policymakers. I can also be useful to design relevant interventions, inform the outcomes of policies, and support services aimed at mitigating the negative effects of parental separation on children's well-being. In addition, by highlighting areas where evidence is lacking or conflicting, a systematic review can guide future research efforts, directing attention towards unanswered questions or emerging areas of interest.

The present study focused on three types of separations: First, separation with parents due to adverse family conditions, among which we can list conflictive parental separation, being placed in foster care, and being given up for adoption. Secondly, separation due to a parent's job, such as parents who are sent on a military mission or work far from where their family resides, and lastly, involuntary separation such as when parents are illegal immigrants who are deported or are incarcerated.

Separation Due to Adverse Family Conditions

Parental Abuse and Neglect

Child maltreatment and abuse involve several forms of physical, emotional, or sexual violence and is a significant concern for both society and the academic community due to its profound impact on the well-being and development of children. It creates a traumatic experience for young individuals, resulting in long-lasting and severe consequences, which vary based on the type and severity of the abuse, as well as the support provided by the environment (Crittenden & Spieker, 2023).

Children who have experienced maltreatment face a higher risk of developing psychological conditions such as anxiety, depression, eating disorders and post-traumatic stress disorder. The emotional impact of maltreatment may hinder their capacity to manage emotions and handle stress as adults (Crittenden, 2016; Milozzi & Marmo, 2022).

These children often have difficulties in interpersonal relationships. Child maltreatment can lead to trust and attachment problems in relationships with others. Survivors of maltreatment may have difficulty establishing healthy attachments and may experience communication problems and limited social skills.

Other related effects may include diminished self-esteem and a detrimental self-image. Children who have experienced abuse often internalize harmful messages, leading to a pessimistic self-view and a lack of confidence. Moreover, challenges in academics and employment are frequently evident.

As a coping mechanism, some maltreated individuals may resort to risky behaviors, such as substance abuse, excessive alcohol consumption or participation in dangerous activities, as a way of dealing with past trauma.

Child maltreatment is associated with a higher risk of long-term physical health problems, such as gastrointestinal and cardiovascular disorders, immune system problems, and obesity.

When children undergo severe abuse and neglect, it may result in them being placed in foster care or being adopted. Foster care is not only the outcome of detrimental living conditions but also a factor that heightens the chances of experiencing worsened physical, behavioral, and mental well-being. Moreover, when children are moved from one foster home to another, it intensifies the adverse effects they face (Rubin et al., 2007; Ryan & Testa, 2005).

In terms of Western countries, the United Kingdom stands out with the highest proportion of children residing outside their homes. This is due to four worrisome trends: the surge in investigations into families, the mounting number of children in alternative care, the decline in children being reunited with their parents, and the decrease in adoptions (UK Department for Education, 2017).

Conflicted Parental Separation

In cases of conflicted parental separation, problems between parents often affect children even before separation and have a negative impact on growth and brain structure. Children may experience intense feelings of anxiety, anger, confusion and sadness due to the breakup of their families and constant exposure to parental conflict. They may as well be caught in the middle of the parental dispute and experience loyalty to one of the parents. As a

consequence of that, they will experience great distress. When the exposure to parental conflict is constant, it might generate a state of chronic stress that negatively affects the development of key brain regions in emotional regulation such as the hippocampus and amygdala (Child Welfare Information Gateway, 2019).

Sometimes, in situations of conflictive parental separation, the child loses contact with one of the two parents, which further accentuates the above-mentioned consequences and has a harmful effect on the child's physical and psychological health.

Separation Due to the Work of One of the Parents

One of the biggest challenges that any family may face is when one parent has to live far away due to their job. This could be because they are seeking economic advancement or because of the nature of their work, such as military personnel being sent on missions. An example of this is seen in the United States, where between 2001 and now, around 1 to 2 million children have been separated from their parents due to military assignments (Lester et al., 2010; Nguyen et al., 2014; Siegel & Davis, 2013). Similar to any complex situation, it affects children and teenagers as they are at stages of development where the presence of a parent at home holds great importance, and the absence of a parent naturally leads to repercussions.

In disadvantages nations, with several economic problems (such as Latin American, African or Asian countries), a high number of children are separated from their parents since they have to travel to distant regions or countries in search of employment.

Involuntary Separation

In 2018, thousands of children were separated from their parents by American immigration authorities (Kopan, 2018). That same year, more than 200.000 U.S. children were separated from their parents and placed in foster care (U.S. Department of Health and Human Services & Administration for Children and Families, 2022), with similar placement statistics in 2019 and 2020.

Parent-child separation is widely acknowledged as a distressing situation, yet it has been reluctantly embraced as an indispensable measure for a significant proportion of children. On a global scale, the provision of institutional care for abandoned or orphaned children is prevalent. Through diverse approaches, Desmond et al. (2020) conducted a study and approximated that in 2015, a staggering number of children, ranging from 3.2 million to 9.4 million, experienced the unfortunate reality of being separated from their parents and subsequently placed in institutional settings.

Method

A systematic review is a research methodology that involves the comprehensive and structured synthesis of existing literature on a specific topic or research question. It follows a predefined protocol that includes systematic searching, screening, and selection of relevant studies, followed by the extraction, analysis, and synthesis of data from these studies.

The aim of a systematic review is to provide an unbiased and comprehensive summary of the current evidence on a particular topic, allowing for the identification of patterns, trends, and gaps in the literature.

The methodology for this study was selected to ensure a rigorous, comprehensive, and objective synthesis of the evidence on the consequences of parental separation on children, with the aim of informing practice, policy, and future research in this critical area.

The present review follows standards of the PRISMA statement (Urrútia & Bonfill, 2010; Munive-Rojas & Gutiérrez-Garibay, 2015), according to quality steps for systematic review except for items 5, 12, 13, 14, 15, 19, 22 and 27, which are specific for meta-analytic review studies.

The standards outlined in the PRISMA statement were followed to ensure a transparent and rigorous systematic review. The article selection process included four phases: identification, screening, eligibility, and inclusion. In the initial phase, 5,260 potentially relevant studies were identified through an exhaustive search in the DOAJ, Scielo, and Redalyc databases, using the keywords "Consequences" and "Parent-Child Separation." Boolean operators and synonyms were employed to maximize search coverage. Inclusion criteria were: articles published in English, studies with open access, and publications from the last ten years. Studies that were duplicated, irrelevant to the primary topic, or lacked a clearly defined methodological framework were excluded.

Each article was assessed for methodological quality and thematic relevance using a scoring system adapted from criteria commonly applied in systematic reviews. The selected articles (n=35) were analyzed to extract key information regarding design, studied population, and main findings. This approach enabled the identification of common patterns and significant differences in the effects of parent-child separation on children.

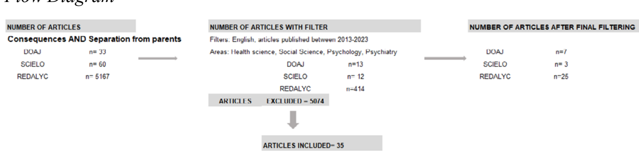
To ensure the traceability of the process, a PRISMA-style flowchart was created, highlighting exclusion stages and the corresponding justifications. Additionally, the quality of the included studies was evaluated using a checklist to ensure that all selected works met minimum standards of scientific rigor.

The Review has been registered in PROSPERO under the number 545462 for promoting transparency, preventing bias, and enhancing collaboration. This registration ensures methodological rigor, discourages outcome switching, and facilitates the dissemination of findings.

Procedure

This systematic review adhered to PRISMA standards, focusing on key elements such as title, abstract, eligibility criteria, sources of information, study selection, data extraction, and results synthesis. The review process is summarized below: (see figure 1)

Figure 1
Flow Diagram



Search Strategy

As shown in figure 1, flow diagram, an exhaustive search was conducted in the DOAJ, Scielo, and Redalyc databases on July 20, 2023, using the keywords "Consequences" AND "Parent-Child

Separation.” Boolean operators and synonyms were applied to broaden the search. Articles were included if they were published in English, open access, and within the last ten years. Initially, 5,260 articles were identified.

Screening and Selection Process

Articles were filtered based on the following criteria:

- Inclusion Criteria: (a) Published in English, (b) Published within the last ten years, and (c) Relevant to the topic.
- Exclusion Criteria: Duplicate studies, articles lacking a methodological framework, or studies irrelevant to the primary research question.

Following these steps, 439 articles were screened, and 35 met the inclusion criteria. Screening was conducted independently by two reviewers, with disagreements resolved through consensus.

Justification for Criteria

English was chosen due to its predominance in scientific communication and higher peer review standards. Research from the last decade was prioritized to reflect contemporary societal contexts and methodological advancements.

Quality Assessment

Studies were evaluated for methodological rigor using a standardized scoring system. Only studies meeting minimum quality thresholds were included.

This rigorous procedure ensures that the selected studies provide reliable and relevant evidence on the consequences of parent-child separation, enabling robust conclusions and recommendations.

Results

In the articles considered, we report: the author(s) and year of publication, instrument, sample and relevant results. The aforementioned information is reported in Table 1.

The data obtained are homogeneous, as reflected in the table of results. The different articles surveyed conclude that the separation of children from their parents has a negative impact on the child’s physical and mental health.

Table 1

Multidimensional Consequences of Paren-Child Separation. Analysis of Key Studies

	Autor/Year	Instrument	Sample	Results
1	Acion, L., Ramirez, M. R., Jorge, R. E., & Arndt, S. (2013).	Iowa Youth Survey 2010	78.240 secondrary school students	Adolescents who are children of military personnel recently sent away from home on assignment are at substantially increased risk of using alcohol, marijuana, and other illegal drugs. Changes in the place of residence accentuate the problems, and those most at risk are those who do not live with the other parent or a close relative.
2	Alfano, C. A. Lau, S., Balderas, J., Bunnell, B. E., & Beidel, D. C. (2016).	Systematic Review		How children adapt to separation is strongly influenced by their stage of development. The sudden absence of parents is very stressful and incomprehensible to young children. Children of military personnel who are on a mission have decreased academic performance. It has also been observed to be associated with increased maltreatment, sexual abuse, and physical and emotional neglect. There are additional associated stressors such as moving, moving away from family and friends, or financial hardship.
3	Amuedo-Durantes, C., & Arenas-Arroyo, E. (2019).			From 2005 to 2015, there was a notable rise of 19% in the probability of Hispanic children residing in the United States being separated from their parents and entrusted to the care of relatives or friends who were not at risk of deportation. Similarly, the likelihood of children living with an undocumented parent without the other parent’s presence has seen a 20% increase. The immediate consequences for children of detained immigrants encompass a range of physical, behavioral, and emotional issues. Additionally, developmental and speech delays have been observed. It is important to note that certain problems may persist even after the reunification of these children with their parents.
4	Auersperg, F., Vlasak, T., Ponocny, I., & Barth, A. (2019).	Meta-analysis	506.299 participants	It was found that there is a significant association between parental divorce and the following mental health aspects: depression, anxiety, suicide attempt and ideation, distress alcohol abuse, smoking and drugs use. A decrease in symptomatology is observed in the studies published between 1999 and 2017.
5	Bald, A., Chyn, E., Hastings, J. S., & Machelett, M. (2019).	Remove records of Rhode Island entre 2016-2018	13834 Children <6 años and 4821 niños >6 Children	The positive impact of removing neglectful and abusive homes on girls’ schooling is evident, with a decrease of 22.8% in the need for special education and the risk of repetition. However, no significant differences are observed in boys, indicating that they do not benefit as much from the removal of such homes.
6	Barajas-Gonzalez, R. G., Ayon, C., & Torres, F. (2018).	Literature Review Study		The article suggests that the continuous threat of parental deportation and the chronic uncertainty surrounding family security have detrimental effects on Latin American children and youth, particularly those living in mixed-status households. Many children perceive this situation as a form of psychological violence. Childhood adversity is identified as the most influential predictor of early-onset health conditions and mental illnesses, including anxiety, depression, and psychological stress. Recent advancements in behavioral neuroscience reveal that significant fear-inducing experiences during early life can disrupt the normal development of stress regulation, learning, memory, and social behavior.

	Autor/Year	Instrument	Sample	Results
7	Bell, T., & Romano, E. (2017).	Systematic Review		Various studies have shown that children placed in kinship care experience greater permanency, with lower rates of reentry, increased stability, and more placements with guardians compared to those living with foster families. However, children in kinship care have lower rates of adoption and reunification. Over time, the differences in these variables tend to diminish.
8	Bergström, M., Fransson, E., Modin, B., Berlin, M., Gustafsson, P. A., & Hjern, A. (2015).	National classroom Survey	147.839 students from 6th to 9th grade.	Children in shared custody tend to experience fewer psychosomatic problems compared to those primarily or solely living with one parent. However, they do report more symptoms than children in nuclear families. The satisfaction with material resources and parent-child relationships is associated with the psychosomatic health of children.
9	Bergström, M., Salari, R., Hjern, A., Hognas, R., Bergqvist, K., & Fransson, E. (2021).	Parental reports of the Strength and Difficulties Questionnaire and coparent-ting quality	12.845 3 yrs. Old children.	It was observed that there is an association between increased mental health problems and living mostly and only with one parent. This study suggests that the quality of shared parenting is a key determinant of mental health in preschool children and, therefore, should be the target of preventive interventions.
10	Biehal, N., Sinclair, I., & Wade, J. (2015).	Survey to Teachers and Social Workers	149 maltreated children	The study examined the progress of children six months after they returned home or, for those who did not reunite with their families, six months after the decision was made for them to remain in care. Four years later, the children were followed up again. The study found that the main factors influencing reunification were improvements in the parents' issues and the absence of unacceptably high risks to the child. Two-thirds of the children returned to improved family situations, sometimes due to changes in their home environment, while others were reunified despite lingering concerns. Remaining in care was strongly associated with positive outcomes across various aspects at the end of the follow-up period. Neglected children who were reunified, regardless of the stability of the reunification, had particularly poor outcomes. These findings highlight the potential of the care system to produce positive results for maltreated children.
11	Boyle, C. (2015).	Systematic Review		The study found that outcomes were more positive when there was collaboration between biological families and adoptive parents or foster caregivers. On the other hand, children who had ongoing contact with maltreating birth parents tended to have worse outcomes. These findings support current policies and previous research, emphasizing the need for a careful assessment and planning of contact.
12	Brown, A., Waters, C. S., & Shelton, K. H. (2017).	Systematic Review		This systematic review addresses a gap in knowledge regarding the behavioral and emotional outcomes, as well as academic achievement, of school-aged children who have been adopted from care. Adoption was associated with poorer academic achievement and higher levels of behavioral problems throughout childhood, adolescence, and emerging adulthood compared to non-adopted individuals..
13	Côté, S. M., Orri, M., Marttila, M., & Ristikari, T. (2018).		59476 individuals	Individuals who were removed from their homes as children were more likely to have substance-related disorders, psychotic or bipolar disorders, depression or anxiety, neurodevelopmental disorders, and other disorders compared to control subjects. Furthermore, these participants had a greater number of prescriptions for psychotropic medications and higher rates of criminal convictions.
14	Culpin, I., Heron, J., Araya, R., & Joinson, C. (2015).	Short Mood and Feelings Questionn-aire	7056 14 yrs. Old girls	In the case of girls from father-absent households, it was observed that they experienced earlier menarche and reported higher levels of depressive symptoms compared to girls from father-present households. Additionally, there was evidence suggesting that girls from families residing in rented housing and those facing financial problems had higher levels of depressive symptoms and earlier menarche. Moreover, girls whose mothers had prenatal depression reported higher levels of depressive symptoms and earlier menarche compared to girls whose mothers did not experience prenatal depression.
15	Doyle, J. J. (2013).			The results of the study indicate that being placed in foster care increases the likelihood of delinquency episodes and the need for emergency medical care. However, caution should be exercised when interpreting these estimates as they are based on "marginal cases" within a natural experiment, where researchers may have differing opinions on the placement recommendation.
16	Edyburn, K. L., & Meek, S. (2021).	Literature Review Study		A review of the literature reveals that even short experiences of detention, particularly when children are separated from their parents and caregivers, have severe and long-lasting negative effects across various domains of functioning. The practices of separation, detention, and transfer to temporary camps further compound the traumatic experiences that migrant families often flee from, subsequently placing already vulnerable children on a path of continued marginalization.
17	Fisher, P. A. (2015).	Literature Review Study		While a significant portion of these populations may lack mental health support and exhibit deficits in neurobiological or developmental aspects, there is also evidence of positive outcomes. A substantial proportion of these populations lack mental health support and experience deficits in neurobiological or developmental areas. Additionally, evidence from studies on the phenomenon of catch-up among adopted children after being in institutional foster care is included. Although complete recovery from early stressful experiences may not be achievable, research in this field suggests that adoption, particularly during the early years of life, maximizes the likelihood of a positive life trajectory. It is important to note that much of the systematic peer-reviewed longitudinal research on foster and adopted children does not extend beyond early adulthood. Therefore, it remains unclear whether the observed outcomes in the literature persist later in life. This is an area of great significance for future studies.

	Autor/Year	Instrument	Sample	Results
18	Friborg, O., Sørlie, T., Schei, B., Javø, C., Sørbye, Ø., & Hansen, K. L. (2020).	SAMINOR 1 y 2	24.459 adults.	In Norway, Indigenous Sámi and Kven minority children were placed in boarding schools with the aim of accelerating their adoption of the Norwegian majority language and culture. This study, which is based on a population sample, examines the rates of health, welfare, and disability pension among these children for the first time. Participants who attended boarding schools reported higher levels of discrimination, violence, engagement in unhealthy lifestyle behaviors such as smoking, lower levels of education, and family income compared to those who were not placed in boarding schools. The findings of this study align with the existing international literature on health disparities and emphasize the risk of poor health outcomes following the placement of indigenous or minority children in boarding schools.
19	Fujisawa, T. X., Shimada, K., Takiguchi, S., Mizushima, S., Kosaka, H., Teicher, M. H., & Tomoda, A. (2018).	3-Tesla scanner Statistical Parametric Scanner	21 children diagnosed with RAD	The objective of this research was to examine how the type and timing of childhood adversities impact the structural changes in regional gray matter volume in maltreated children with RAD. The results of the study revealed that there is a potential sensitive period between the ages of 5 and 7, during which there is a reduction in gray matter volume in the left primary visual cortex (BA17) as a result of maltreatment. Furthermore, the number of different types of maltreatment experienced by the child had the most significant impact on the reduction in gray matter volume, followed by exposure to neglect. These findings provide compelling evidence that the type and timing of maltreatment experienced by children and adolescents with RAD have a significant influence on the structural abnormalities observed in their brains. This research highlights the importance of early intervention and support for children who have experienced maltreatment, as it may help mitigate the long-term effects on their brain development and social functioning.
20	Goemans, A., van Geel, M., & Vedder, P. (2015).	Meta-analysis		No significant changes in internalizing, externalizing, or overall behavior problems were observed. These findings suggest that the developmental trajectories of foster children are not affected positively or negatively by foster care. This is concerning considering that many children enter foster care with pre-existing issues.
21	Khan, M. R., Scheidell, J. D., Rosen, D. L., Geller, A., & Brotman, L. M. (2018).	Waves I (adolescence), III (young adulthood), and IV (adulthood) de la National Longitudinal Study of Adolescent to Adult Health	11.884 young people	The association between parental incarceration and STI/HIV risk outcomes was found to be moderate to strong, regardless of the age at which the incarceration occurred. In multivariable models, parental incarceration before the age of 8 remained strongly linked to STI/HIV risk during both adolescence and adulthood, with stronger associations observed among nonwhites. Among participants of color, parental incarceration before the age of 8 was associated with more than twice the likelihood of using marijuana and cocaine in adulthood. The relationship between parental incarceration and delinquency, drug use, and mood disorders appeared to be partially mediated.
22	MacLean, S. A., Agyeman, P. O., Walther, J., Singer, E. K., Baranowski, K. A., & Katz, C. L. (2020).	Parent-Report version of the Strengths and Difficulties Questionnaire (SDQ)	73 mothers	Children who were forcibly separated from their parents as immigrants faced an increased risk of developing mental health disorders, including depression, post-traumatic stress disorder (PTSD), and anxiety disorders. Research showed that these children had elevated scores in emotional problems, peer problems, and total difficulties. Interestingly, male children had significantly higher rates of peer problems compared to females. Additionally, younger children between the ages of 5 and 11 demonstrated significantly higher rates of conduct problems, hyperactivity, and total difficulties. Surprisingly, the duration of separation did not significantly affect the scores. These results highlight that children who experience separation from their parents, regardless of the duration, undergo significant distress.
23	McIntosh, J., Smyth, B. M., & Kelaher, M. (2013).	Longitudinal Study of Australian Children (LSAC)	Children 0- 3 years.	In a time-sharing parenting arrangement after separation, children spend equal amounts of time with each parent during the day and night. However, there is limited data on the developmental consequences of such arrangements for infants. To address this gap, a study was conducted to investigate the association between the number of overnight stays away from the primary resident parent and infant soothing or emotional regulation with that parent. The study included three age groups and compared three levels of overnight care. After controlling for factors such as parenting style, parental conflict, and socioeconomic status, the findings revealed that more shared overnight stays for infants aged 0 to 1 and 2 to 3 predicted some unsettled and poorly regulated behaviors. However, this association was not observed for children in the 4 to 5-year-old group. These findings suggest that emotional regulation within the primary parent-child relationship serves as an important indicator of infant adjustment to parenting time arrangements.
24	Mok, P. L. H., Astrup, A., Carr, M. J., Antonsen, S., Webb, R. T., & Pedersen, C. B. (2018).	National Cohort Study	1.336.772 individuals born in Denmarc between 1971 and 1997	The study found that children who experienced separation from one parent during their childhood had a higher risk of engaging in violent offending later in life compared to those who lived continuously with both parents. The risk was even higher for paternal separation than for maternal separation, especially during mid-childhood, and increased with the number of separations. If the father was separated from the child at an earlier age, the risks were higher compared to when the separation occurred at an older age. However, the age at first maternal separation did not significantly affect the risk. The study also found that the risks increased as the age at first separation from both parents increased.

	Autor/Year	Instrument	Sample	Results
25	Paksarian, D., Eaton, W. W., Mortensen, P. B., Merikangas, K. R., & Pedersen, C. B. (2015).			The researchers measured three types of separation that were not due to death: maternal separation, paternal separation, and separation from both parents. They collected data from a cohort of 985,058 individuals born in Denmark between 1971 and 1991 and followed them until 2011. The study also assessed the occurrence of schizophrenia and bipolar disorder in relation to separation, age at separation, and the number of years of separation. They also examined the interactions with parental history of mental disorder. The results showed that each type of separation was associated with an increased risk of schizophrenia and bipolar disorder, even after adjusting for various factors such as age, sex, birth period, calendar year, family history of mental disorder, urbanicity at birth, and parental age. The longer the duration of parental separation, the higher the risk of both schizophrenia and bipolar disorder. The associations between separation from both parents and schizophrenia were stronger when the separation occurred at older ages, while the associations with bipolar disorder remained consistent throughout development. The first occurrence of parental separation seemed to have a greater impact on increasing the risk when it happened earlier in childhood. The associations also varied depending on the parental history of mental disorder, but in no situation was separation found to be protective.
26	Poitras, K., Tarabulsy, G. M., & Pulido, N. V. (2021).	Self Report, direct observation	50 pre-school age children	The aim of this research was to examine the correlation between face-to-face contact with birth parents and externalizing behaviors, while considering the instability of placement and the sensitivity of adoptive parents. The study involved fifty preschool children and their foster parents, who were visited in their homes. The foster parents provided self-reports on the child's externalizing behavior problems, and their sensitivity was assessed through play observations. Information on placement was gathered through interviews with birth parents and obtained from social services data. The findings indicate that more frequent contact with birth parents and lower levels of sensitivity in foster parents are independently associated with higher levels of externalizing behavior problems in children, even after accounting for placement instability.
27	Running Bear, U., Croy, C. D., Kaufman, C. E., Thayer, Z. M., Manson, S. M., & The, A. I. S. (2018).		771 Indian American .	The attendance to American Indian (AI) boarding schools has been linked to poor physical health; however, there is limited knowledge regarding the specific aspects of this experience that contribute to such health issues. Five experiences, including the age at first attendance, limited family visitation, forced church attendance, prohibition from practicing AI culture and traditions, and punishment for using AI language, may each have an independent association with physical health status in adulthood. It was hypothesized that the impact would be more pronounced for individuals who started boarding at later ages.Each of the aforementioned experiences was found to have an independent association with poorer physical health compared to those who did not undergo these experiences. Furthermore, an interaction effect was confirmed for individuals who were punished for using AI language and who were 8 years of age or older.
28	Sattler, K. M. P. & Font, S. A. (2021).			This research study examined the rates of guardianship and adoption dissolution by analyzing a complete cohort of children from a large foster care system in a specific state. The study also explored the relationship between child characteristics and risk factors with the occurrence of dissolution. The findings revealed that more than 2% of adoption placements and 7% of guardianship placements experienced dissolution. It was observed that Black children faced a higher risk of guardianship dissolution compared to White and Hispanic children, although this association was not found in adoption dissolution. Additionally, older age was linked to a greater risk of adoption dissolution, while females had a higher risk of guardianship dissolution compared to males. Furthermore, behavioral problems, cognitive disability status, and mental health issues were associated with an increased risk of dissolution.
29	Shi, H., Wang, Y., Li, M., Tan, C., Zhao, C., Huang, X., Dou, Y., Duan, X., Du, Y., Wu, T., Wang, X., & Zhang, J. (2021).	Cualitative Survey	811 children left by their parents.	Among the children who were evaluated, 287 (35.4%) were l taken care of by their mothers since their fathers have left them(FM-MC), while 524 (64.6%) were left by both parents and cared for by their grandparents (PM-GC). The rate of socioemotional problems among these children was 36.8%. When it came to paternal migration, the median age at which the child first experienced migration was 3 months, and the average duration per migration was also 3 months. On the other hand, for maternal migration, the corresponding values were 9 months. On average, these children had been separated from their fathers for 72% of their lifetime due to paternal migration, and from their mothers for 52% of their lifetime due to maternal migration. The study did not find any significant association between the detailed characteristics of paternal migration and the socioemotional development of young children. However, socioemotional problems were significantly associated with the proportion of cumulative duration of maternal migration in the child's lifetime. It was observed that children under the age of 3 in poor rural areas of China were at a high risk of experiencing socioemotional 30problems. The cumulative exposure to maternal migration was found to have a detrimental effect on early socioemotional development.
30	Siegel, B. S., & Davis, B. E. (2013).	Literature Review Study		The presence of war combat stress disorder, traumatic brain injury, psychiatric illness, and health risk behaviors can complicate the family life of a child. Research suggests that over 30% of soldiers returning from war have experienced post-traumatic stress disorder, depression, or traumatic brain injury. Additionally, comorbidities such as aggression and alcohol abuse are prevalent in nearly half of those with disabilities. Disturbingly, there has been a rise in suicide rates among military personnel. Children of returning soldiers who face these complications often exhibit both externalizing and internalizing behavioral changes, as well as changes in their school performance. They also report high levels of sadness and worry.

	Autor/Year	Instrument	Sample	Results
31	Smith, M., González-Pasarín, L., Salas, M. D., & Bernedo, I. M. (2020).	Systematic review		Out of the reviewed studies, 22 reported positive outcomes associated with contact between adoptees and their birth families, while 8 discussed potential risks. Generally, when the adoptive family is capable of maintaining open communication, contact with birth families is more likely to have positive effects on the adoptee. These findings support the current policy on open adoptions. However, it is important to note that contact arrangements should be determined on a case-by-case basis and closely monitored, as previous research has also highlighted the need for individualized approaches.
32	Turney, K., & Wildeman, C. (2016).	2011–2012 National Survey of Children's Health		Children in foster care experience poorer physical and mental health outcomes compared to children in the general population, children from specific family types, and children from economically disadvantaged families. Some of these differences can be attributed to the demographic characteristics of the children, but the majority of the disparities can be explained by the current family environment. Furthermore, children who are adopted from foster care are more likely to have health problems compared to children who remain in foster care.
33	Wall-Wieler, E., Roos, L. L., Nickel, N. C., Chateau, D., & Brownell, M. (2018).		3948 mothers whose oldest child was born in Manitoba, Canadá, between the 1st. of abril 1992 and 31st. March 2015	This particular study aims to investigate whether mothers who have had a child under the care of child protective services have higher mortality rates compared to their biological sisters who did not have a child in care. The researchers conducted a cohort study involving 1974 families, where one sister had a child in care and the other sister did not. The study analyzed rate differences and hazard ratios for all-cause mortality, as well as mortality from avoidable and unavoidable causes. The findings revealed that mothers who had a child in care experienced 24 additional deaths per 10,000 person-years compared to their sisters who did not have a child in care. These mothers also had higher rates of mortality from preventable causes and unavoidable causes. The hazard ratios indicated that the risk of mortality from preventable causes was 3.46 times higher for mothers with a child in care, while the risk of mortality from unavoidable causes was 2.92 times higher. Interestingly, the number of dependent children did not have an impact on the mortality rates among mothers with at least one dependent child. The higher mortality rates, particularly in relation to avoidable mortality, among mothers with a child in care highlight the necessity for targeted interventions to support these mothers. It is crucial to provide appropriate support and resources to help improve the health outcomes and overall well-being of mothers who have children under the care of child protective services.
34	Whittle, S., Dennison, M., Vijayakumar, N., Simmons, J. G., Yücel, M., Lubman, D. I., Pantelis, C., & Allen, N. B. (2013).	MRI and DMS IV complete self-report measures of child maltreatment and diagnostic interviews.	117 adolescents.	Childhood maltreatment has been found to have a significant impact on brain development, specifically in the left hippocampal volume and amygdala growth. Additionally, the analysis of the cortex revealed that maltreatment influenced the thickening of the superior parietal region, which was associated with the experience of psychopathology. This suggests that childhood maltreatment can lead to both immediate and long-term effects on brain development. Furthermore, it has been observed that childhood maltreatment can impair brain development during adolescence. One possible mechanism for this is the experience of Axis I psychopathology during adolescence. This indicates that the effects of childhood maltreatment on brain development can persist into the adolescent years.
35	Wildeman, C., Goldman, A. W., & Turney, K. (2018).	Literature Review		Paternal incarceration has been found to have a negative association with various indicators of child health and well-being. This association may be causal in nature. On the other hand, the evidence regarding the association between maternal incarceration and child health is mixed. While some research suggests a negative association, further studies are needed to fully understand this relationship. It is important to note that the average effects of paternal incarceration on child health and well-being are well-established. However, research has also indicated that certain factors can moderate this association. Therefore, it is crucial to consider these moderating factors when examining the impact of paternal incarceration on child health and well-being.

Separation Due to Adverse Family Conditions

Parental Abuse and Neglect

It is important to keep in mind that caregiving neglect as well as numerous caregiver transitions produce lasting imprints on the child's behavioral and biological development, Fujisawa et al. (2018) observed that there is a sensitive period between 5 and 7 years of age for reduction in primary visual cortex gray matter volume due to maltreatment. The number of maltreatment types had significant effect on gray matter volume reduction and the second most significant variable was exposure to neglect. Whittle et al. (2013) concluded that childhood maltreatment is associated with impaired brain development during adolescence. The authors conclude that psychopathology during adolescence may be one mechanism by which childhood maltreatment has ongoing effects on brain development during the adolescent years.

When home situations are very adverse removal from the family home could be the least harmful situation. Bald et al. (2019) studied a sample of 13834 children <6 years and 4821 children >6 years, finding that removal from neglectful and abusive homes has positive effects on schooling in girls by 22.8%, decreasing the need for special education and the risk of repetition. No significant differences were observed in boys, who would not benefit to the same extent from home removal.

Fisher (2015) found that a considerable proportion of children removed from their homes have mental health difficulties and neurobiological or developmental deficits. The author also argues that while it may not be possible to fully recover from early stressful experiences; adoption, especially in the early years of life, maximizes the chances of a positive life course trajectory. This study does not extend beyond early adulthood, so it is unclear whether changes continue later in life. In contrast to these data, Goemans et al. (2015) conclude that foster care does not negatively or positively

affect the developmental trajectories of foster children. Given that many children enter foster care with problems, this is a concerning situation. Brown et al. (2017) found that adopted children exhibit lower academic levels and elevated levels of behavioral problems during childhood, adolescence, and emerging adulthood compared with nonadopted children. This is consistent with the findings of Côté et al. (2018), who found that those individuals who had been removed from their home as children were more likely than controls to have substance-related disorders, psychotic or bipolar disorders, depression or anxiety, neurodevelopmental disorders, and other disorders.

Study participants had more prescriptions for psychotropic medications and higher rates of criminal convictions. Paksarian et al. (2015) found a strong association between individuals who had been separated from both parents and schizophrenia, especially when the separation took place at older ages. Likewise, they found a correlation with bipolar disorder, but in this case no differences were found according to the age of separation. Associations differed according to parental history of mental disorder, although in no situation was separation protective.

The evidence found in this review, shows that the consequences of separation are not as severe when children are removed from their homes, but remain in the care of other relatives or friends (Bell & Romano 2017). Likewise, Boyle (2015), noted that outcomes were particularly positive when there was a collaborative approach between biological families and adoptive parents or foster caregivers. Outcomes tended to be worse for children who had ongoing contact with maltreating biological parents. The findings of the review support current policy and previous research in recommending a more reflective approach to assessing and planning contact. This is in line with Smith et al. (2020), who argue that in general, contact with the birth family is associated with positive outcomes for the adoptee, especially when the adoptive family is capable of communicative openness, although they emphasize the need for each case to be analyzed separately and for contact to be monitored.

In a study conducted with preschool children, Poitras et al. (2021) found that adopted children tend to present externalizing problems, and that the low sensitivity of adoptive parents is associated with a higher level of externalization. On the other hand, Turney and Wilderman (2016) found that those children in foster care have poor physical and mental health compared to children in the general population, children from specific family types, and children from economically disadvantaged families. This is a worrisome situation considering that adopted children who are older or who have behavioral problems, cognitive difficulties, and mental health difficulties have a higher likelihood of adoption or guardianship dissolution (Sattler & Font, 2021). Child-parent separation appears to affect not only the young children, but also the parents. In a study by Wall-Wieler et al. (2018), those mothers who had a child in child protective services care were found to have higher mortality rates compared with their biological sisters who did not have that experience. Higher mortality rates, particularly avoidable mortality, among mothers who had a child in care indicate the need for more targeted interventions for these mothers.

Overall, the synthesis of evidence underscores the complex and multifaceted nature of the consequences of parental separation on children and parents. While some studies suggest potential benefits of removal from adverse home environments, others emphasize the long-term challenges faced by children in foster care or adoptive families. Additionally, the mental health and neurobiological implications of child-parent separation are significant, highlighting the importance of comprehensive support and intervention strategies for affected individuals and families.

Conflicted Parental Separation

Auersperg et al. (2019) concluded in their meta-analysis study that there is a significant association between parental divorce and the following aspects of mental health: depression, anxiety, suicide attempt, suicidal ideation, distress, alcohol and drug use and smoking. When the separation is on bad terms, the problems are accentuated. Bergström et al. (2021) observed an association between increased mental health problems and living mostly and only with one parent. This study suggests that the quality of shared parenting is a key determinant of mental health in preschool children and should therefore be targeted for preventive interventions. In another study of 147,839 Swedish students, Bergström et al. (2015) found that children in shared custody suffer fewer psychosomatic problems than those living mostly or only with one parent but report more symptoms than those in nuclear families. Satisfaction with material resources and parent-child relationships was associated with the psychosomatic health of the children in that study. Consistent with these data, Culpin et al. (2015) found that girls from absent father households had higher levels of depressive symptoms and earlier menarche. These problems increased when girls resided in rented housing and financial problems were experienced.

In regard to the shared parenting regime with equal number of overnight stays in both parents' homes, it was found that a higher number of shared overnight stays for the 0 to 1 year and 2 to 3 year groups predicted some less settled and poorly regulated behaviors, but none for children in the 4 to 5 year group. The findings suggest that emotional regulation within the primary parent-child relationship is a useful index of infant adjustment to parenting time arrangements (McIntosh et al., 2013).

When studying the relationship between separation from a parent and delinquent behavior, Mok et al. (2018) observed that separation from a parent during childhood is associated with an elevated risk of later violent offending compared to those living continuously with both parents. The associations are stronger for paternal separation than for maternal separation at least until mid-childhood and increase with the number of separations. Separation from the father for the first time at an earlier age is associated with higher risks than if paternal separation first occurs at an older age, but there is little variation in risk associated with age at first maternal separation. Increasing risks are associated with increasing age at first separation from both parents.

Overall, these findings highlight the complex interplay between parental separation and children's well-being, underscoring the importance of considering factors such as the quality of parental relationships, the nature of separation, and the timing of events in understanding the diverse impacts on children's mental health and behavior. Effective interventions and support strategies should be tailored to address the specific needs and circumstances of children and families experiencing parental separation.

Separation Due to the Work of One of the Parents

All the articles surveyed present concordant results. Acion et al. (2013) found that adolescents who are children of military personnel recently sent away from home on assignment have a substantially increased risk of using alcohol, marijuana, and other illegal drugs. Changes in the place of residence accentuate the problems, and those most at risk are those who do not live with the other parent or a close relative. Alfano et al. (2016) concluded that sudden parental absence is very stressful and incomprehensible to young children. Military children on assignment decrease their academic performance. It has also been observed to be associated with increased maltreatment, sexual abuse, and physical and emotional neglect. There are additional associated stressors such as moving, moving away from family and friends, or financial hardship.

Shi et al. (2021) conducted a study on Chinese children whose parents had to leave home in poor rural areas to work in other areas. They found that the children tested had high rates of socio-emotional problems, especially when the separations were repeated and before the age of three years. Many of these children had been separated from their mother or father for more than half of their lives.

These findings underscore the pervasive and detrimental effects of parental absence on children's well-being, including increased risk behaviors, academic difficulties, and socio-emotional problems. These challenges are particularly pronounced among children of military personnel and those affected by parental migration for work, highlighting the need for targeted interventions and support to mitigate the adverse impacts of parental absence on children's development and mental health.

Forced Separation

Barajas-Gonzalez et al. (2018) argue that the persistent threat of parental deportation and chronic uncertainty regarding family safety is detrimental to Latino children and youth, especially those living in mixed-status households, and many children experience it as a form of psychological violence. They concur with MacLean at al. (2020) who found that immigrant children who faced forced separation from their parents are at increased risk of developing. Finally, studies of children whose fathers were incarcerated were surveyed. Wildeman et al. (2018) found that parental incarceration is negatively associated with a variety of indicators of child health and well-being. Although the evidence for the average effects of parental incarceration on child health and well-being is strong, research has also suggested that some key factors moderate these consequences. Khan et al. (2018) found that parental incarceration at any age was moderately to strongly associated with STI/HIV risk. In multivariable models, parental incarceration at age <8 years remained strongly associated with STI/HIV risk in both adolescence and adulthood, with stronger associations among nonwhites. Among black participants, parental incarceration before age 8 was associated with more than twice the odds of marijuana and cocaine use. Delinquency, drug use, and mood disorders appeared to partially mediate the relationship. mental health disorders, such as depression, post-traumatic stress disorder (PTSD), and anxiety disorders. Younger children (ages 5 to 11) also demonstrated significantly higher rates of conduct problems, hyperactivity, and overall difficulties. Scores did not differ significantly by duration of separation. The results reveal that children who are separated from their parents experience high levels of distress regardless of the duration of separation. Similar results were found for children who were separated from their parents and sent to boarding schools or language acquisition camps for members of different native tribes.

In summary, the synthesized findings underscore the pervasive and deep impact of parental separation on children's mental health, emotional well-being, and behavioral development across diverse circumstances. These findings highlight the urgent need for comprehensive support and intervention strategies to mitigate the adverse effects of parental separation and promote resilience among affected children and families.

Discussion

An exhaustive analysis was carried out in the Scielo, Redalyc and DOAJ networks of publications on the effects on children of separation from their parents. The search terms used were Consequences AND parent child separation. Originally 5260 articles were found. English language articles published in the last ten years were used as a search filter. A final screening was carried out in which duplicate articles and those that did not fall within the selected topic were excluded. A total of 35 articles were finally surveyed.

After an in-depth and critical analysis of the articles, the results were grouped into three categories: separations caused by adverse family situations, separations due to the work of one of the parents, and forced separations.

The evidence found consistently highlights the detrimental effects of these experiences on children's mental health, emotional stability, and behavioral development. According to the results of this study, the effects are not specific to the type of separation and include high rates of neurological changes due to psychological trauma, early sexual maturation, physical and sexual abuse, school dropout, poor academic performance, poor peer relations, psychosomatic symptoms, psychiatric disorders and internalizing and externalizing behavior.

Parent-child separation is also associated with problems such as depression, anxiety, delinquency, self-harm, substance abuse and inappropriate sexual behavior. Evidence was found that separation within one generation leads to intergenerational cycles of family separation. According to the data collected, children are most vulnerable between the ages of 9 months and 9 years. Particularly risky conditions included separation during the preschool years, separation without notice to the child, simultaneous change of residence, and care by strangers.

In all cases, the authors agree that being separated from parents in childhood is a powerful predictor of physical and mental health complications, being found to be associated with early-onset mental illness. Advances in behavioral neuroscience indicate that this early separation experience provokes fear early in life and has the potential to disrupt the typical development of stress regulation, learning, memory and social behavior. An association was observed between separation from parents and substance and alcohol use, decreased academic performance, and the presence of psychopathology in adolescence. Some factors appear to buffer the impact of separations, such as being left in the care of relatives or friends when children have been removed from the home by child protective services or deported. Likewise, when children are adopted by sensitive families,

and especially when there is good communication between birth and adoptive families, there is room for resilient outcomes. It is suggested that when parents separate, shared parenting, cooperative care and affectionate access to both parents appears to be a very important factor in lessening the impact of separation on children.

The findings underscore the urgent need for targeted interventions and support services to address the complex challenges faced by children and families experiencing parental separation. These interventions should prioritize early identification of at-risk children, access to mental health resources, and comprehensive support for families navigating the complexities of separation.

The data obtained are intended as a contribution to the development of child protection policies and decision making, which should be adapted to each particular case and whose results should be carefully monitored and evaluated.

This systematic review is subject to several limitations that must be acknowledged. First, the inclusion criteria were restricted to articles published in English, which may have excluded high-quality research published in other languages. This language bias could limit the comprehensiveness of the review, particularly in regions where non-English publications predominate.

Second, the review only considered open-access articles available in DOAJ, Scielo, and Redalyc databases. While this approach ensured accessibility and transparency, it may have excluded relevant studies indexed in other databases or those published in subscription-based journals.

Third, the reliance on studies published within the last ten years was intended to capture contemporary research and insights. However, this temporal constraint may have excluded seminal studies or historical data that could provide a more nuanced understanding of parent-child separation.

Additionally, variations in the methodological rigor of the included studies could introduce bias. While efforts were made to evaluate the quality of each study, differences in sample sizes, measurement tools, and contextual factors across studies may affect the comparability and generalizability of the synthesized findings.

Finally, potential biases related to the selection and interpretation of data cannot be entirely ruled out. The researchers' own perspectives and the scope of the search strategy may have influenced the results and conclusions of this review.

To address these limitations, future studies should aim to include publications in multiple languages and expand the database sources to enhance the diversity and comprehensiveness of the review. Longitudinal research designs and cross-cultural studies are also recommended to provide deeper insights into parent-child separation's long-term and context-specific impacts.

Conflict of Interest

The author declare that there are no conflicts of interest related to this manuscript.

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Artículo

Una Aproximación Metacognitiva Relacional al Apego en Psicoterapia

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RESUMEN

Abordo en este artículo la necesidad de una metaobservación para reconocer los aspectos relevantes de quiénes somos, de nuestras relaciones, de su historia y de su futuro. Un planteamiento fundado en los primeros compases del desarrollo a través del apego con las figuras significativas, que requiere para su trabajo clínico una vinculación entre el mindfulness, la función reflexiva y de un adecuado mapeado de los patrones de relación interpersonal. La optimización de las habilidades metacognitivas, la utilización del mindfulness y las intervenciones dirigidas al incremento de la función reflexiva son el andamiaje teórico del modelo que planteo. La brújula para la navegación mental y contextual, la denomino: proceso de auto y hetero observación relacional y contextual (PAHORC). La identificación de los estilos de apego abre la puerta a la descripción de las diadas relacionales recíprocas, que permiten comprender la variabilidad de los modelos relacionales con diferentes personas y en diferentes contextos. La perspectiva de la multiplicidad del Self y un abordaje dialógico, facilita un trabajo con estos patrones relacionales. Esto permitirá restaurar aquellos daños sufridos en las primeras etapas del desarrollo y reconstruir modelos relacionales más satisfactorios y adaptativos. Por lo tanto, es un artículo metateórico, teórico y técnico, sustentado en una perspectiva integradora inspirada por el modelo cognitivo analítico ampliado que he ido desarrollando a lo largo de los últimos años. Mencionare desarrollos innovadores que se están produciendo recientemente e integrare de forma asimilativa las aportaciones de otros modelos.

A Relational Metacognitive Approach to Attachment in Psychotherapy

ABSTRACT

In this article I address the need for meta-observation to recognize the relevant aspects of who we are, our relationships, their history and their future. An approach based on the early stages of development through attachment with significant figures, which requires for its clinical work a link between mindfulness, reflective function and an adequate mapping of interpersonal relationship patterns. The optimization of metacognitive skills, the use of mindfulness and interventions aimed at increasing reflective function are the theoretical scaffolding of the model I propose. The compass for mental and contextual navigation, I call it: process of relational and contextual self- and hetero-observation (PAHORC). The identification of attachment styles opens the door to the description of reciprocal relational dyads, which allow us to understand the variability of relational models with different people and in different contexts. The perspective of the multiplicity of the Self and a dialogic approach facilitates working with these relational patterns. This will allow to restore those damages suffered in the early stages of development and to reconstruct more satisfactory and adaptive relational models. Therefore, this is a metatheoretical, theoretical and technical article, based on an integrative perspective inspired by the extended cognitive analytical model that I have been developing over the last few years. I will mention innovative developments that are taking place recently and integrate in an assimilative way the contributions of other models.

Keywords:
Attachment
Metacognition
Cognitive-analytic psychotherapy
Reflective function
Mindfulness
Mentalization

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Hablar de apego y de patrones de relación interpersonal exige poder observarlos, y esto está directamente relacionado con la función reflexiva y con la capacidad del sujeto de descentrarse y metaobservar, de ahí que desde el inicio en el título se incluya el eje fundamental del artículo que es una aproximación metacognitiva al apego.

La riqueza del modelo y su extensión exige que, en un artículo como este limitado a algunos aspectos de la psicoterapia, tenga que focalizar en aquellos aspectos teóricos relevantes para el objetivo de lo que quiero transmitir.

Este artículo está inspirado en la teoría del apego de Bowlby (1989) y en desarrollos posteriores que matizan y profundizan en diferentes aspectos del modelo (Cassidy y Sharver, 2016; Steele y Steele, 2017). Incorpora los diferentes estilos de apego con las figuras parentales y con otras que van siendo significativas a lo largo del proceso evolutivo, ampliando pues la visión a un modelo de múltiples apegos que sirven de sustento a una conceptualización del self que incorpora una perspectiva desarrollada por Anthony Ryle: los roles recíprocos, la concepción teórica de la disociación parcial del trastorno límite de la personalidad en la que el modelo de los múltiples estados del self se convierte en un eje teórico articulador a nivel teórico y técnico.

Somos únicos y tenemos idealmente un self coherente e integrado (Ramachandran y Blakeslee, 1999), pero a su vez tenemos múltiples posibilidades de manifestarnos con diferentes personas y en diferentes contextos (Hermans y Dimaggio, 2004; Mirapeix, 2008; Ryle y Fawkes, 2007; Ryle et al., 1997). La integración psicológica no nos lleva a un self único real y verdadero, es la habilidad de ser capaz de ocupar los espacios entre las realidades sin perder ninguna de ellas. Es la capacidad de sentirse uno mismo de manera simultánea al hecho de ser muchos. Lo que se requiere es que las múltiples realidades que forman parte de los diferentes estados del self encuentren la oportunidad de vincularse a través de la narrativa (Bromberg, 1996).

La multiplicidad del self y su disposición a experiencias disociativa es entendida desde una perspectiva de un continuum que va desde experiencias disociativas cotidianas al trastorno disociativo de la identidad (Mirapeix, 2008; Ryle et al., 2007). Dentro de las aportaciones vinculadas a la teoría del apego y a la multiplicidad del self, conllevan una categorización de diferentes niveles disociativos y de multiplicidad que podemos encontrar la siguiente clasificación en cuatro prototipos que son: la multiplicidad asociativa, la multiplicidad reprimida, la multiplicidad disociativa y la persona con una tendencia a la de disociación múltiple psicótica (Southgate, 2010).

Hare un recorrido por algunos principios teóricos nucleares, centrándome especialmente en los desarrollos del apego con diferentes figuras a lo largo del proceso evolutivo y que en psicoterapia cognitivo analítica denominamos roles recíprocos. Esto viene acompañado del desarrollo de diferentes narrativas y patrones relacionales, vinculadas a distintos estilos de apego que permiten una aproximación al análisis lingüístico de las vinculaciones interpersonales, culminando todo ello con la aplicación del análisis de las secuencias dialógicas desarrolladas por un querido compañero y amigo, terapeuta cognitivo analítico finlandés, Mikael Leiman (2012).

Como tendremos ocasión de ver a lo largo del artículo, planteo la teoría del apego como un vértice teórico técnico que supone un andamiaje con características transteóricas y transdiagnósticas que van más allá de la utilización exclusivista en modelos teóricos específicos, pudiendo ser aplicada por diferentes escuelas psicoterapéuticas adaptándolo a las peculiaridades de cada modelo (Herstell et al., 2021; Southward et al., 2024).

Por último, me permitiré reflexionar de forma especulativa sobre la incorporación de nuevos marcos conceptuales en la comprensión de la teoría del apego y su aplicación a la psicoterapia, abordando someramente la teoría de redes (McWilliams y Fried, 2019; Roefs et al., 2022), el principio de energía libre y la inferencia activa de Friston (2010), junto a una concepción del apego desde la perspectiva de los sistemas dinámicos complejos (Hayes y Andrews, 2020). Todos ellos desarrollos complejos e innovadores, que aportan una nueva luz que enriquece el marco teórico del apego desde modelos muy actuales.

Algunos Principios Teóricos Nucleares

En mi exposición abordaré algunos aspectos nucleares vinculados al temperamento, los tipos de apego, los patrones relacionales, a la influencia que el apego tiene en el desarrollo del self, a los modelos de trabajo interno sustentados en aquel momento en una teoría limitada del procesamiento de la información y a la importancia de la relación del apego y la metacognición, al apego y la personalidad.

También abordaré una temática que ha tenido una especial significación en él maridaje entre la teoría del apego y el modelo cognitivo analítico, la integración necesaria entre los planteamientos de Bowlby y Vygotsky. Profundizaré en algo que publiqué hace tiempo (Mirapeix, 2015), una guía que sirve como referente para la navegación mental y contextual (el PAHORC). Terminando con un planteamiento que defiende el apego, el self y la multiplicidad como vértices transteóricos y transdiagnósticos que pueden guiar la intervención psicoterapéutica.

Por lo tanto, voy a ir abordando estos diferentes aspectos, aunque sea de forma breve a continuación. Desarrollar en profundidad cada uno de los componentes de este apartado da para un artículo sobre cada uno de los componentes de este epígrafe, por lo tanto no me queda más remedio que ser lo más sintético y claro que me sea posible.

Temperamento y Apego

La relación entre el apego y el temperamento ha sido una temática de interés desde el inicio del desarrollo del modelo teórico. Hay una intersección inevitable entre el patrón de relación que se establece entre el bebé y la madre y el temperamento con una clara base genética y la influencia que tiene en ambas figuras y el desarrollo del vínculo de apego y posteriores patrones de relación. Este en sí mismo es un tema monográfico que intentaré abordarle de forma sucinta (Vaughn y Bost, 2016).

Tanto el apego como el temperamento son dos niveles de explicación sobre las diferencias individuales en el proceso de adaptación socioemocional y en la construcción de la personalidad que han sido comúnmente aceptadas como explicaciones nucleares

en psicología evolutiva. A pesar del interés que despierta esta temática queda por delante mucha investigación para aclarar las muchas preguntas que suscita (Vaughn et al., 2008).

Hay diferencias fundamentales entre los dos enfoques. La teoría del apego se construye en los primeros años de la vida, fruto de las formas de relación con las figuras parentales. Es un modelo como hemos dicho de clara raíz biológico etológica, qué parte de la base de que la construcción de los estilos de apego influyen directamente en la evolución de la conducta, el afecto, la cognición y la formación de las relaciones interpersonales (Milozzi y Marmo, 2022).

Por otro lado, la actual teoría sobre el temperamento (Rothbart, 2011) intenta describir y explicar la organización individual y las diferencias en los estilos de acción, reactividad y regulación, en función de toda una serie de disposiciones endógenas.

Como podemos ver, los dos planteamientos pareciese que tienen una incompatibilidad ontológica. A mi juicio, y de nuevo sustentado en esa epistemología basada en la complementariedad (Opazo, 2022), creo que habrá que comprender y desarrollar cuál es la interacción entre un contexto relacional con las figuras parentales y las disposiciones biológicas que condicionan determinado tipo de comportamientos que vienen automatizados y genéticamente determinados. Ese es el reto.

El que los rasgos temperamentales vengan genéticamente determinados no están exentos de que haya algunos rasgos que pueden ser modificados como resultado de las transacciones con el entorno ambiental (Braungart-Rieker et al., 2010)

Pero tal y como plantea el autor (Rothbart, 2011) la teoría del apego y el modelo psico biológico del temperamento, tienen ciertas similitudes que es necesario resaltar. Ambas teorías y a través de aspectos muy relevantes que están enraizados en estructuras neuroanatómicas y fisiológicas, ambas tienen la función de promover la supervivencia del individuo y ambas estructuras están orientadas a facilitar el crecimiento del individuo de tal manera que favorezca una mayor adaptación al contexto en que vive. Por lo tanto, si bien ontológicamente son de niveles explicativos muy diferentes, hay grandes coincidencias en el objetivo que persiguen.

Teoría y Tipos de Apego

La teoría del apego, es básicamente una teoría sobre la supervivencia, sobre cómo nos mantenemos a salvo de los riesgos a los que estamos expuestos como individuos (Milozzi, 2022); pero también de cómo formamos lazos afectivos con otras personas y nos reproducimos, es decir, cómo sobrevivimos como especie. Es a partir de las relaciones tempranas con los cuidadores primarios que emerge la mente y es a través de la interacción con ellos que se activarán los diversos centros funcionales innatos en el bebé que irán configurando los distintos sistemas motivacionales, es decir, las estructuras que gobernarán la afectividad, la cognición y la acción (Milozzi, 2022).

Los niños no son capaces de protegerse a sí mismos cuando vienen al mundo, pero nacen con la habilidad de mostrar su malestar y de organizar la forma en que lo despliegan de una manera crecientemente adaptada a las respuestas de sus cuidadores. La manera en que la figura de apego responde al malestar del niño contribuye a moldear la forma de vincularse con otras personas y de regular las emociones (Milozzi y Marmo, 2022)

Sin entrar a profundizar en los diferentes tipos de apego conocidos de sobra por los lectores, simplemente quiero hacer hincapié en dos cosas. En primer lugar han habido diversas variaciones a lo largo de la historia en los diferentes tipos de apego que se han identificado, quedando finalmente limitados a cuatro tipos como son: el seguro, el ansioso, el evitativo y el desorganizado.

Estos vínculos de apego que se forman en los primeros compases de la relación con las figuras parentales de referencia, tienden a mantenerse a lo largo del tiempo, pero hay otros muchos contextos y otras muchas figuras significativas en el desarrollo evolutivo del bebé, del infante y del adolescente. Los diferentes contextos como la fratría, el colegio, los compañeros, los grupos de pertenencia van generando diferente tipo de figuras de referencia con las que establecemos vínculos de mayor o menor intensidad, de mayor o menor bondad y de diferentes cualidades. Tendremos ocasión de verlo de manera más específica en un apartado más adelante en el artículo.

Todo ello podemos resumirlo en que lo que comienza con un vínculo emocional intenso biológicamente determinado y sustentado en un planteamiento etológico, como es la necesidad del otro que nos dé seguridad ante la desprotección, enfermedad o situaciones de amenaza, no es otra cosa que la evidencia de que no somos nada si no es a través del vínculo con el otro. Es este vínculo con el otro, en el sentido más Vygotskyano del término, el que nos hace ser lo que somos.

Los Modelos Internos de Trabajo

No se entiende la teoría del apego sin el desarrollo teórico de Bowlby influenciado por la teoría del procesamiento de información y vinculado al desarrollo de lo que él denominó los modelos internos de trabajo (Bretherton y Munholland, 2016).

Bowlby propuso que la cualidad de las relaciones en la infancia con sus cuidadores da como resultado la creación de modelos de trabajo, que son representaciones internas del self y de los otros que permiten proveer de prototipos mentales que contribuyen a la configuración de futuras relaciones en el contexto social. Estos modelos internos de trabajo no son otra cosa que esquemas mentales donde las expectativas sobre la conducta de un individuo en particular hacia el self, es agregada y construida. Son reglas conscientes y o inconscientes de organización de la información con respecto a las experiencias de vinculación emocional así como de los contenidos emocionales y representaciones mentales. No reflejan una imagen objetiva del cuidador, sino que incorporan las respuestas del cuidador como patrones de relación, componente este muy compartido con la internalización de las relaciones objetales del modelo cognitivo analítico inspirado en las teorías psicoanalítica de Ronald Fairbairn (1963). Este planteamiento está en la base y es compartido por el modelo cognitivo analítico en el que lo que se construye en el modelo interno de trabajo es cómo me veo yo a mí y qué es lo que espero de los demás.

Una vez que los modelos internos de trabajo están constituidos, existen más allá de la conciencia que el individuo pueda tener de ellos y tienden a estabilizarse, aunque sin lugar a dudas, van a evolucionar ante los sucesivos cambios relacionales que se van produciendo en la vida del sujeto. Tan es así, que si cambian las circunstancias de la forma de relación con la figura del cuidador, esto conllevará cambios en el patrón relacional de apego con dicha figura.

Los patrones de apego y los modelos internos de trabajo se crean en los primeros meses de vida irán enriqueciéndose por las nuevas experiencias del bebé, cuyo objetivo era obtener proximidad y cuidado de la figura del cuidador. Estos modelos de funcionamiento interno tienen primero una estructura sustentada en patrones de relación corporal y posteriormente en la representación de imágenes, esbozos de palabras que construyen el significado y posteriormente el lenguaje. Esto dota de sentido a que la evaluación e investigación sobre el apego no solo pueda ser realizada a través de las reacciones corporales que se observan en el bebé en la situación extraña, sino que posteriormente en niños más mayores y adultos la evaluación del lenguaje y las estructuras narrativas contribuyen a poder conocer el patrón de apego implícito.

De tal forma que, modelos internos de trabajo le permiten al bebé predecir la conducta del otro o comportarse de tal forma, que pueda inducir un comportamiento específico que desea sea desarrollado por parte de la figura de apego. La configuración circular y bidireccional de los patrones relacionales se construyen desde los primeros compases de la relación entre el bebé y la figura de apego; Bowlby y Ryle coinciden en esto.

Los Patrones de Relaciones Interpersonales y Roles Recíprocos

Los terapeutas cognitivos analíticos, tenemos una clara influencia por parte de Vygotsky. Eso nos hace tener una concepción algo más extensa que la aplicación exclusiva de la teoría del apego al desarrollo del self y de la influencia de la capacidad mentalizadora de las figuras parentales primarias (Ryle y Kerr, 2020).

Sin el otro no soy, por lo que la relación con el otro me configura. Desde nuestra perspectiva y sustentados en los planteamientos de la teoría del apego y en los propios y específicos del modelo cognitivo analítico no podemos entender al self si no es desde una perspectiva relacional. Nos construimos como personas a través de las relaciones que mantenemos con los demás.

Desde el modelo cognitivo analítico, los patrones de relación los entendemos desde una perspectiva y terminología que denominamos roles recíprocos. Para una mejor comprensión voy a describir brevemente algunas características de estos y una breve categorización de algunos de los roles recíprocos que se observan frecuentemente en la clínica.

Estos roles reflejan dinámicas de "acción y reacción", donde las conductas, expectativas y emociones de una persona hacia otra se ven inducidas, reflejadas o complementadas en la otra persona.

Los roles recíprocos permiten identificar los patrones de relación interpersonal que son prototípicos de una persona y que se repiten en diferentes contextos. Generados a través de la relación emocional intensa con las figuras de apego, contribuyen a comprender el desarrollo del self relacional y el trabajo con estos patrones es uno de los focos fundamentales de la terapia y es a través de las intervenciones relacionales que se facilita el cambio de estos patrones disfuncionales.

Trabajar de forma activa con los patrones de relación interpersonal disfuncional exige una función reflexiva conservada, que permita metaobservar y tomar conciencia de los patrones de relación disfuncional. Siendo este un paso absolutamente necesario para poder utilizarlos en el trabajo clínico en el aquí y en el ahora de la relación terapéutica y en las relaciones interpersonales de la vida cotidiana del paciente.

Los siguientes son algunos de los roles recíprocos más comunes (ver Tabla 1).

Un enfoque sustentado en los patrones de relación conlleva su identificación y trabajo sistemático con la reiteración desadaptativa de los mismos.

El Desarrollo del Self

Desde nuestra perspectiva (Kerr et al., 2015), el desarrollo del self está también vinculado a la capacidad de reflexión del individuo y a la íntima relación a través de juego, la interacción corporal y a través de signos con las figuras parentales (Trevarthen y Aitken, 2001). Pero además de eso, el contexto social y cultural configuran de manera definitiva la construcción social de la mente del bebé

Tabla 1
Diferentes Posibilidades de Roles Recíprocos

FIGURA PARENTAL	NIÑO	FIGURA PARENTAL	NIÑO
Cuidador	Cuidado	Critico	Devaluado
Protector	Protegido	Incompetente	Necesitado
Contenedor	Contenido	Dependiente	Maduro forzado
Reforzador	Autonomo y seguro	Explotador	Sumiso/cabreado
Sobreprotector	Dependencia	Exigente	Exigido
Sobreimplicado	Angustiado	Abandonico	Abandonado
Maltratador	Maltratado	Manipulador	Manipulado
Despectivo	Rechazado	Sadico	Masoquista
Abusador	Abusado	Dominante	Dominado
Destructivo	Aplastado	Venenoso	Envenenado
Controlador	Controlado	Adorable/idealizado	Adorador
Despectivo	Despreciado	Intrusivo	Invadido
Activo	Pasivo	Conflictivo	Complicado
Elogioso	Sobrevalorado	Distante	Desprotegido

(Vygotsky, 2014). No somos nadie sin el otro, y no solo por el vínculo de apego que todos establecemos como garantía de seguridad y supervivencia, sino porque llegar a ser humanos implica absorber la cultura en la que crecemos y eso no es posible sin entender los fenómenos sociales implicados en la construcción social de la mente (Wertsch, 1985).

A su vez, las expectativas que se construyen en la mente del bebé son en sí mismas abstracciones basadas en interacciones repetidas con estructuras prototípicas dentro del propio individuo (Fonagy, 2010). El sentido de un self autónomo surge de forma completa sustentado en las relaciones seguras entre el bebé y la figura de apego (Emde, 1990; Steele et al., 1996)

El control progresivo que va desarrollando el niño seguro, le permite moverse en la dirección de sentirse propietario de su propia experiencia interna y terminar por reconocer su propio self como competente en activar los mecanismos regulatorios y en desarrollar un control metacognitivo. Esto le permite poder conseguir una comprensión de sí mismo y de los otros como agentes intencionales, en los que su conducta es organizada a través de estados mentales pensamientos sentimientos creencias y deseos (Fonagy et al.,1995 y Sroufe, 1997). El proceso es pues intersubjetivo: el niño consigue conocer la mente del cuidador a la vez que el cuidador es capaz de comprender y contener el estado mental del niño (Fonagy 2016).

La Metacognición

Desde mi punto de vista y con la intención de sustentar mi concepción de la multiplicidad, creo que no resulta beneficioso hablar en términos de conocimiento metacognitivo de la mente del otro, de forma global, en términos de un otro absoluto. Desde mi perspectiva, tanto el niño, como el cuidador, aprenden a identificar diferentes estados mentales tanto en sí mismo, como en el otro.

Es precisamente la toma de conciencia de que una misma persona es capaz de tener diferentes estados mentales, la que facilita comprender que pueda comportarse de manera diferentes en distintas situaciones contextuales y que, además, esto venga acompañado de construcciones narrativas diferenciales en función del estado mental en que se encuentre.

Esta pluralidad del comportamiento, esta polifonía narrativa, está directamente relacionada con una concepción de una multiplicidad normal, que puede ser perfectamente algo que se encuentre armónicamente integrado de una forma coherente, que permita tener simultáneamente la sensación subjetiva de un self global que abarca diferentes formas de manifestarse.

Las aportaciones de Fonagy y Target (1997) han resultado fundamentales para establecer un vínculo directo y estrecho entre la metacognición y el desarrollo de los vínculos de apego. La capacidad parental para leer la mente del bebé y responder de forma satisfactoria (sensible y contingente) a las necesidades que el bebé expresa y que son identificadas (en el mejor de los casos) por los padres, es un componente nuclear para el desarrollo de la mente y el self y para la construcción de un vínculo de apego seguro o en su defecto con sus diferentes dificultades. Solo dándose las circunstancias anteriores, el bebé es capaz de desarrollar una representación mental de sí mismo y de los demás como sujetos intencionales.

Apego y Personalidad

Si en los trastornos de personalidad o las personalidades disfuncionales, su núcleo fundamental está vinculado a la arquitectura identitaria y a los patrones de relación interpersonal (Clarkin et al., 2007). El desarrollo de los patrones de relación tempranos, las relaciones de apego, y la construcción de los modelos internos de trabajo, van a dar lugar a la configuración de cómo la persona construye las relaciones con los demás. Estamos pues ante una teoría con unas implicaciones teóricas y técnicas mayúsculas.

Tan es así, que esta concepción circular de los patrones de relación, que tiene una clara vinculación con los modelos de trabajo descritos por Bowlby y que han sido adoptados por otros muchos modelos, resulta especialmente significativo encontrarse investigaciones que utilizan modelos cognitivos sociales como el CAPS (Mischel y Shoda, 2013) que han permitido demostrar que la descripción de la circularidad relacional, es más eficaz y fiable que la descripción de criterios diagnósticos a la hora de diagnosticar los diferentes subtipos de personalidad (Rhadigan y Huprich 2012).

Todo lo anterior, que la mayor parte de los profesionales vamos a estar de acuerdo con ello en mayor o en menor medida, tiene una trascendencia muy relevante con respecto a que no se trata de que seamos nosotros los que veamos la importancia de las relaciones interpersonales en la construcción de lo que somos. Lo relevante, es que seamos capaces de transmitir al paciente y ayudarle a que él sea capaz de ver cómo ha sido el proceso a través del cual se ha construido como persona. Esto, inevitablemente conlleva un desarrollo tiene una función reflexiva, de una metacognición o de una capacidad de mentalización, con un funcionamiento óptimo. Solo así le permitira observarse con un mínimo de descentramiento, consiguiendo convertir el hecho de observar su pensamiento en objeto de su metaobservación.

Bowlby y Vygotsky: Una Integración Necesaria

En la década de los 90 hubo un debate entre el creador del modelo cognitivo analítico y otros dos autores con respecto a algunas diferencias entre la teoría del apego y el modelo cognitivo analítico. No voy a hacer aquí una exégesis de los intercambios y desacuerdos entre Jeremy Holmes y Anthony Ryle, ni el debate que se estableció entre Anna Jellema y el propio Ryle. Originariamente se entendieron los planteamientos de Bowlby como excesivamente biológicistas y con una fundamentación metodológica más dirigida a la investigación y con pocas repercusiones clínicas en el momento en el que fueron desarrolladas. Entraré a describir la necesaria integración de estos 2 planteamientos, que a mi juicio son más que compatibles.

En un articulo reciente, se explora precisamente la presunta incompatibilidad epistemológica y diferencias difícilmente integrables a nivel teórico entre los planteamientos etológicos con una base biológica de la teoría del apego de Bowlby y los planteamientos socio génicos de Vygotsky con respecto a la construcción social de la mente. Vamos a ver esto con un poco más de detalle, pues me parece una temática relevante dentro del contexto del artículo.

Hay una serie de diferencias muy relevantes con respecto a la orientación sustentada en un enfoque evolutivo y etológico

de la teoría del apego de John Bowlby y una orientación socio cultural e histórica en la adquisición de valores y en el lenguaje propuesta por Lev Vygotsky. Estos dos planteamientos que tienen una fundamentación teórica sustentada en dos modelos teóricos claramente diferentes.

Desde el punto de vista del origen del desarrollo del bebé, John Bowlby plantea que las predisposiciones biológicas y los mecanismos evolutivos son los que promueven la búsqueda de una figura de apego a través de la cual se consolidan vínculos afectivos de gran intensidad, necesarios para la supervivencia; mientras que el planteamiento sustentado en un modelo socio cultural y de interacción social de Vygotsky, este explica la formación social de las funciones psicológicas superiores, el aprendizaje del lenguaje y los procesos de regulación del comportamiento.

En el enfoque de Bowlby, como enfoque de base biológica y etológica, viene sustentado más en los comportamientos innatos del bebé como las señales que emite y que son reconocidas adecuada o inadecuadamente por parte de la figura parental encargada del cuidado, dando como resultado un tipo u otro de apego. Sin embargo, desde el planteamiento Vygotskiano, la mediación cultural y la adquisición del lenguaje, como hemos dicho anteriormente, son fundamentales para el desarrollo cognitivo, la construcción del self, el aprendizaje del lenguaje, la regulación emocional y en definitiva la construcción social de la mente.

Amén de otros comentarios que pueden derivarse de un análisis detallado de este artículo, quiero plantear que desde la perspectiva de una epistemología basada en la complementariedad y sustentada en el enfoque integrativo supra paradigmático (Opazo, 2022), que el problema fundamental de la dicotomízacción de las aportaciones sociogénicas y de la teoría del apego, están mal planteadas, precisamente porque está mal formulada la pregunta, como si la partícula "y", que es la que genera la disyuntiva entre tener que elegir entre Bowlby "y" Vygotsky, fuerza a tener que hacer una elección que no es necesaria. Desde el punto de vista de una epistemología basada en la complementariedad, la pregunta incluye el "y/o". Con esto resulta que la integración entre los postulados de Bowlby y Vygotsky, permiten crear un marco donde la seguridad emocional y el aprendizaje cultural se entrelazan, para promover el desarrollo psicológico del bebé. Las dos perspectivas no son antagónicas sino complementarias.

Navegación Mental y Contextual: El Proceso de Auto y Hetero Observación Relacional y Contextual, el PAHORC

Esperar que el paciente sea capaz de auto observar sus diferentes estados mentales, personajes interiores, transiciones, modelos de relación con el otro y variabilidad contextual de todo lo anterior, exige la presencia de una función reflexiva conservada y un entrenamiento específico en favorecer un estado de serenidad mental que permita un descentramiento que facilite la metaobservación de los procesos señalados. Tuve ocasión de plantear inicialmente esta guía para la navegación mental relacional y contextual, que denominé el proceso de auto y hetero observación relacional y contextual (PAHORC) en un artículo de hace ya unos años (Mirapeix, 2015).

Los beneficios de entenderme a mí mismo, a través de la auto observación y de entender al otro a través de la capacidad de leer sus mensajes verbales, no verbales, prosódicos, corporales…etc. Sin lugar a duda, conocerme facilita el conocerte y contribuye a mejorar el bienestar relacional.

La identificación de la mente del otro, ser capaces de superar la opacidad que siempre existe en la mente del otro, a la cual, no podemos acceder nada más que a través de intuiciones, deducciones de su contenido verbal. Son mensajes que vienen acompañados de un componente no verbal de la comunicación, tanto a nivel prosódico, como corporal. En definitiva, se trata de ser capaz de percibir e intuir la mente del otro para poder establecer un dialogo mentalizador.

Una comprensión relacional de la psicoterapia conlleva ser consciente de que el terapeuta está implicado en el proceso terapéutico. La diada relacional terapeuta-paciente, tiene una dinámica implícita que debe de ser detectada, descrita y utilizada por parte del terapeuta en el desempeño de su actividad profesional.

Desde esta visión del self y de la multiplicidad de sus manifestaciones, desde esta comprensión del self dialógico, desde dónde surge una comunicación polifónica, nos permite también comprender la presencia de voces qué son prestadas el contexto sociocultural donde fueron generadas.

Apego, Mindfulness, Compasión y Mentalización

Las aportaciones de David Wallin en su texto de apego y psicoterapia (Wallin, 2012), que dan una importancia considerable al entrenamiento y utilización del mindfulness en el abordaje terapéutico, marcan un hito en la implementación de intervenciones en un contexto relacional.

Quiero hacer hincapié aquí en las aportaciones de algunos autores conocidos y algunos amigos y otros de prestigio internacional, sobre la importancia del entrenamiento específico de los terapeutas en mindfulness y en un proceso terapéutico breve de autoobservación que facilite un profundo conocimiento de uno mismo como persona y profesional y que contribuya a que desarrolle lo que denominamos una presencia terapéutica que contribuye a una optimización de su rendimiento profesional y protección del sufrimiento personal (Rodriguez et al., 2014).

En un artículo anterior, concretamente el de "La conciencia reflexiva del Self relacional" (Mirapeix, 2015), hablaba de la necesidad de formar a los terapeutas en Mindfulness y en la realización de un trabajo breve de psicoterapia personal en vista de poder facilitar lo que denominamos la presencia terapéutica. Esta va a ser necesaria para que el terapeuta sea capaz de poder dar un paso atrás, observarse a sí mismo, observar al paciente y observar la circularidad relacional y la influencia mutua del paciente en él y de él en el paciente. Entendemos que esta actitud de presencia terapéutica y de circularidad en un proceso de observación del propio terapeuta, del paciente y de la interacción, forma parte de la manera de realizar una psicoterapia altamente eficaz, que permita no estar preso de influencias personales que puedan ser negativas y que sesguen nuestra intervención, así como poder observar con mayor nitidez y detalle los movimientos emocionales que percibimos en el paciente (Mirapeix, 2017).

Si queremos invitar al paciente a que realice algo similar, a que sea capaz de distanciarse de sus problemas, dar un paso atrás, incrementar su capacidad de auto observación, la del otro, de los procesos relacionales que se pone en funcionamiento y del contexto en el que todo sucede, es absolutamente recomendable que si

nosotros nos hemos entrenado para saber hacerlo, va a resultar más fácil poder ayudar al paciente a que haga lo mismo.

Recientemente (Kabrel et al., 2024) planteaba ciertas similitudes entre la navegación externa que requiere de nuestra orientación y de mapas de referencia para posicionarnos en el mundo que nos rodea, con la navegación a través de los procesos mentales, pues hay un soporte neurobiológico similar que sustenta ambas capacidades de exploración, la externa y la interna. Observar los diferentes estados mentales y personajes interiores y sus modos de relación exigen una finura en la percepción de estados somato sensoriales que subyacen a las emociones y cambios de estado.

Entender el mindfulness como una actividad metacognitiva elevada (Jankowski y Holas, 2014), es pertinente para poder abordar la complejidad de la autoobservación e integrar diferentes perspectivas de la observación de sí mismo, de la representación mental del contenido de la mente del otro, así como imaginar como el otro puede estar visualizándonos a nosotros.

Por último, señalar que disponemos de un programa de intervención que sintetiza elementos del mindfulness, la compasión y el apego constituyendo una intervención estructurada desarrollada en España en la Universidad de Zaragoza y que se denomina terapia de compasión basada en los estilos de apego (Garcia et al., 2016).

El Apego, el Self y las Relaciones Interpersonales, como Vértices de una Intervención Transdiagnóstica y Transteórica

Como vengo defendiendo a lo largo de este artículo, no se puede comprender ni la personalidad de un individuo ni su concepto subjetivo de self, ni la multiplicidad de sus manifestaciones, sin hacer referencia a los patrones de relación de apego que configuraron su forma de relacionarse desde la cuna. Da igual el tipo de trastorno psicopatológico que vayamos a tratar, el apego y los otros componentes mencionados en este párrafo están siempre presentes en el tratamiento y son componentes transteóricos y transdiagnósticos que de una u otra forma están implicados en el diseño estratégico y en la implementación técnica (Mirapeix, 2018).

Los resultados de la investigación desde varias perspectivas teóricas, han demostrado que los factores individuales relacionados con las cogniciones, esquemas tempranos y el Self, tienen un impacto en el resultado de la psicoterapia en diferentes trastornos (Kyrios et al., 2016). Una mejor comprensión del self y los constructos relacionados con el, cómo son los esquemas tempranos y los estilos de apego en los diferentes trastornos psicológicos, va a ofrecer nuevas vías para comprender y avanzar en el entendimiento de los diferentes trastornos psicológicos y su tratamiento.

El interés en ganar en eficacia terapéutica y en demostración científica de la misma ha permitido llevar los tratamientos, preferentemente cognitivo conductuales, a un nivel de reconocimiento científico que ha conseguido que sean avalados por agencias de prestación de servicios clínicos y por instituciones dedicadas a la financiación de proyectos de investigación. Sin embargo, esta focalización en la eficacia en resolver trastornos psicopatológicos específicos ha olvidado de alguna manera prestar atención a la naturaleza del individuo que presenta una psicopatología concreta. La práctica clínica ha ido dejando de lado algunos aspectos muy importantes de la rica historia personal de cada individuo que impacta e influye en el desarrollo del trastorno y en su trayectoria a lo largo de la vida del sujeto o del propio tratamiento que se esté implementando (Kyrios et al., 2016)

El planteamiento transdiagnóstico necesita de una visión ideográfica que permita identificar los predictores, mediadores y moderadores de la respuesta terapéutica con la intención de incrementar el conocimiento de cómo personalizar las intervenciones para cada cliente (McMain et al., 2015). Pero aún y con todo, sabemos que el self es un concepto extenso, confuso y enredado, sin referentes empíricos (Westen y Heim, 2003).

Diferentes Apegos con Diferentes Figuras en el Proceso Evolutivo

Una posición básica que defiendo en este artículo es aquella que plantea que no hay un solo estilo de apego que se desarrolle de manera preferente y exclusiva con uno de los progenitores responsables del cuidado del bebé (Howes y Spieker, 2016). Los patrones de apego originarios que se configuran como vínculos primarios con las figuras parentales son el soporte de posteriores vínculos relacionales que se producen con figuras significativas en diferentes contextos. Contextos familiares, los primeros con hermanos y abuelos, durante el proceso de socialización en la guardería y colegio con los compañeros y amigos, con los maestros, distintos profesores y mentores y posteriormente a partir de la adolescencia con amigos y especialmente amigas y parejas románticas, ya en el mundo laboral con compañeros de trabajo y jefes e incluso en el contexto restringido de la vida en familia con figuras en ocasiones significativas como las mascotas. En definitiva, con la presencia de múltiples bailes relacionales.

En su proceso evolutivo, puede desarrollar diferentes estilos de apego con una misma figura a lo largo del eje tiempo, así como diferentes estilos de apego con diferentes personas en la secuencia espacio temporal por la que todos transitamos. Este planteamiento sustenta una concepción del apego entendida desde una perspectiva en la que se entiende al bebé como un individuo en proceso de desarrollo inscrito en un contexto relacional múltiple, lo que inevitablemente da lugar a la configuración de diferentes patrones de relación con diferentes personas y en diferentes momentos. Podemos incluso sintetizarlo diciendo: somos el sumatorio de los patrones de relación interpersonal significativos que han ido configurando nuestra personalidad.

Del Polimorfismo de los Patrones de Relación a la Multiplicidad del Self

Sustentado en esta concepción del desarrollo de diferentes patrones de apego en función de las diferentes figuras de referencia con la que los vínculos de relación se construyen, resulta un marco fundamental para comprender que esa multiplicidad enriquecedora de apegos múltiples, está en la base del desarrollo de una concepción de un self integrado y único, a su vez compuesto de múltiples posibilidades de expresarse, en diferentes relaciones y contextos sociales (Mirapeix, 2023a).

Estamos pues ante el modelo teórico de los múltiples estados del self desarrollado específicamente por el creador del modelo cognitivo analítico en el análisis de la fenomenología que se presenta en la clínica de los pacientes con trastorno límite de personalidad (Ryle et al., 1997). Pero también, como tuve ocasión de plantear en una publicación hace ya unos años (Mirapeix, 2008), el modelo de los múltiples estados del self, que sustenta esta concepción de

un self polifónico y múltiple, puede ser considerado en términos dimensionales, que van desde una multiplicidad normal coherente con transiciones suaves y contextuales entre diferentes estados mentales, a un self múltiple y disociado con cambios bruscos como en el caso del trastorno límite de personalidad, que en ocasiones puede resultar en auténticas desconexiones con lagunas de memoria en el hilo conductor que permite unificar la transición entre un estado y otro y que formaría parte de lo que conocemos como trastorno disociativo de la identidad. Un planteamiento de la multiplicidad y la complejidad disociativa siguiendo un continuum similar al planteado por Pérez Rodriguez y Galdón (2003).

La deprivación y en particular el trauma temprano, tiene como resultado el afectar a la propensión individual a manifestar múltiples selves, y hablar con múltiples voces en la terapia (Fonagy, 2010). La asunción fundamental que asume Fonagy, es invocar la teoría del apego como marco teórico que permite comprender la conducta social individual en términos de modelos mentales genéricos de las relaciones sociales que ha ido construyendo el individuo. Estos modelos, aunque en evolución constante, y sujetos a modificaciones existen lado a lado y de forma muy cercana que permiten que constituyan las estructuras que subyacen a las múltiples voces en terapia.

Las múltiples voces que un sujeto va albergando en su interior, están directamente relacionadas con la adquisición del lenguaje, con la cultura familiar y con los patrones de relación que implícitamente son expresados a través del lenguaje del individuo. La multiplicidad de voces es un fenómeno normal (Fernyhough, 2017). Entendido desde una perspectiva dimensional, puede tener diferentes grados en función de su integración, coherencia y articulación del discurso interno de las diversas voces que pueden tomar el protagonismo del discurso en un momento u otro.

Del grado de coherencia e integración de las diferentes partes de uno mismo, se deriva una personalidad armónica, integrada y con un funcionamiento flexible y adaptado; o todo lo contrario, una personalidad falta de coherencia e integración, con tendencia a la rigidez y un funcionamiento desadaptado a nivel relacional, tanto íntimo como social. Los patrones de apego, las matrices relacionales construidas por la aposición a lo largo de la evolución del sujeto y la coherencia identitaria y del self van a condicionar el resultado adaptativo de todas estas configuraciones (Hermans y Gieser, 2011).

Es necesaria la presencia de una función reflexiva conservada, o una adecuada capacidad de mentalización, para poder percibir los diferentes estados y personajes y sus respectivas transiciones en la configuración de lo que somos como sujetos y la identidad atribuida. Cuando la función reflexiva está bien desarrollada las personas pueden comprender que sus diferentes personajes interiores, partes del Self o posiciones del yo (Hermans y Gieser, 2011) pueden ser integrados en una visión unitaria de sí mismos y urdir una narrativa que una las diferentes manifestaciones polimorfas de una multiplicidad del self relacional.

Esta visión sustentada en la multiplicidad y en la riqueza relacional, introduce una comprensión mucho más flexible y compleja de nosotros mismos y de los demás que cuando a ello sumamos una actitud más amable y compasiva, las relaciones que establecemos son mucho más armónicas y basadas en la tolerancia. Los conflictos o desacuerdos no son con la totalidad del otro con quien nos relacionamos, como luego veremos desde la perspectiva dialógica, los conflictos son entre partes de mí mismo y partes del otro.

En las personas con personalidades disfuncionales, esta integración de las perspectivas complejas sobre la multiplicidad del self relacional no es lo flexible que se requiere para un proceso adaptativo exitoso, y la rigidez y falta de adaptación están en la base de la disfunción de diferentes tipos de personalidad.

Estilos de Apego, Narrativas y Análisis de Secuencias Dialógicas

Las narrativas surgen del proceso de interacción con el otro y de la incorporación de la cultura y las habilidades lingüísticas en el bebé, el niño, el adolescente y el adulto. Los diferentes estilos de apego contribuyen a configurar estilos narrativos diferenciados, en consonancia con los modelos internos de trabajo descritos por Bowlby.

Si bien la investigación sobre la situación extraña, sirvió para realizar las primeras evaluaciones científicas de la teoría del apego (Ainsworth et al., 2015), estuvieron sustentadas en la reacción corporal del bebé ante la ausencia y retorno de la figura de apego. Según fuese la respuesta en la globalidad de la escena se establecían unos tipos u otros de apego.

En la investigación del apego adulto, a través de la entrevista del apego adulto (George et al., 1985), la evaluación de la narrativa constituye un aspecto fundamental a la hora de la codificación del estilo de apego y requiere un entrenamiento específico en el sistema de codificación de la entrevista.

Veremos a continuación cómo la comprensión relacional y circular de los procesos de comunicación entre 2 individuos, tiene una clara manifestación en la teoría del apego y están perfectamente integradas en el concepto de roles recíprocos específico de la terapia cognitivo analítica. Hay un gran solapamiento de esta circularidad en la que el patrón de relación queda claramente reflejado en la estructura narrativa.

La Visión Clásica del Análisis Narrativo y los Estilos de Apego

El desarrollo narrativo y la teoría del apego están íntimamente relacionados. Las experiencias de apego temprano influyen en cómo construimos nuestras historias personales y, estas historias, a su vez, dan forma a nuestra identidad y nuestras relaciones futuras. Comprender esta conexión puede ayudarnos a desarrollar estrategias para promover el bienestar emocional y las relaciones saludables.

La evaluación del apego adulto evalúa los modelos de trabajo interno que un adulto posee y cómo hace referencia a las interacciones con las personas que estuvieron a su cuidado durante su infancia, esto lo hace construyendo un relato con mayor o menor coherencia fluidez y claridad. La cualidad de la narrativa construida por el sujeto está relacionada con el grado de seguridad o inseguridad de las relaciones de apego. En definitiva, la narrativa que el sujeto construye está sustentada en la representación que el niño tiene de sí mismo de los demás y de la relación que mantuvo con ellos La forma en que el sujeto cuenta Sus experiencias relacionales con los demás nos sirve para describir y clasificar los tipos de apego que pueden inferirse de la narrativa construida. Un discurso coherente viene a sugerir que el sujeto posee un modelo de funcionamiento interno coherente con respecto a las experiencias de apego.

La entrevista del apego adulto es una herramienta única de investigación con el poder de evaluar múltiples aspectos de

dominios psicológicos y sociales, como ha venido demostrándose en una investigación masiva con la utilización de la AAI desde 2008.

Dentro del AAl, la organización del lenguaje relacionado con el apego parece ser una manifestación de la "dinámica" de la cognición y la emoción mediada por la atención. Por lo tanto, las diferencias individuales en la flexibilidad de la atención pueden influir en los patrones de cuidado, que en su caso pueden dar forma a las respuestas en la descendencia que influyen en la organización de sus propias propensiones en desarrollo. Sin duda, esto a alterado permanentemente la forma en que se considerará el lenguaje dentro del contexto de la investigación clínica y del desarrollo. Una de las críticas en relación con la entrevista del apego adulto, es que resulta demasiado engorrosa su aplicación y extremadamente costosa la capacitación del entrevistador para conseguir la acreditación. El autor citado, Erik Hesse, tiene un capítulo excelente de revisión sobre esta entrevista en el texto de Cassidy (Hesse, 2016).

Sin embargo, en investigaciones recientes ha habido una evolución con respecto a la metodología que se utiliza para llevar la evaluación de los patrones de apego (Daniel 2009; Talia et al., 2017). La gran innovación que introdujo Daniel fue incluir la investigación acerca del contenido de la narrativa durante las sesiones de psicoterapia. Por lo tanto, se empezó a focalizar no tanto en cómo decían lo que decían, sino realmente en un análisis de lo que decían.

Recientemente Talia et al. (2017), han informado de desarrollos de gran calado en el estudio del apego en psicoterapia. En su investigación las verbalizaciones del paciente durante la sesión son clasificadas como seguras, evitativas o rechazantes y preocupadas. Estas fueron analizadas a la luz de los criterios de codificación de la AAI, intentando aclarar las formas en que el discurso favorecía o mantenía la proximidad emocional con el terapeuta.

Las transcripciones de la interacción entre el terapeuta y el paciente y el discurso se evaluaban a través de un nuevo sistema de codificación del apego (Patient Attachment Coding System (PACS) Talia et al., 2017). Este sistema de codificación se centraba en 3 escalas fundamentales que se derivaban de los principios nucleares de la teoría del apego. La escala de búsqueda de contacto que puntuaba conductas que tendían a incrementar la proximidad emocional y la posibilidad de recibir apoyo por parte del terapeuta, la escala de evitativa evaluaba las conductas que disminuían la cercanía emocional entre el paciente y el terapeuta, y por último la escala de resistencia que evaluaba las conductas que tenían la tendencia a frustrar los intentos del terapeuta de apoyar al paciente o de dotar de sentido a su experiencia.

El Análisis de Secuencias Dialógicas

Recientemente he tenido ocasión de publicar aspectos relacionados con lo que hoy en día se denomina psicoterapia dialógica (Hermans y Gieser, 2011; Leiman, 2012; Dimaggio et al., 2006). Presente un abordaje dialógico del paciente con ideación suicida (Mirapeix 2023a) y en otro momento la aplicación de esta concepción dialógica a la supervisión en psicoterapia (Mirapeix 2023b).

Un análisis dialógico de la comunicación entre dos individuos, entiende el acto comunicativo como intencional y que sistemáticamente posiciona al otro en un lugar, habitualmente recíproco, que viene a satisfacer las motivaciones y/o expectativas del hablante. La dialéctica relacional y los efectos circulares del efecto del hablante y el destinatario, tienen a su vez una influencia basada en el feedback obtenido fruto de la respuesta del destinatario y el efecto que pueda tener en el hablante. La comunicación es de ida y vuelta, cualquier expresión va dirigida a un otro y espera una respuesta (Bakhtin, 1984/2012).

La utilidad y potencia de esta visión dialógica del Self, estriba en que permite abordar con una mayor complejidad el dialogo interior. Esto es así porque lo que subyace es un planteamiento en el que utilizándolo de forma metafórica, se entiende al Self como compuesto al igual que un coro, con distintos personajes que expresan la complejidad de la vivencia subjetiva. De tal forma, que se orquesta un diálogo entre distintos puntos de vista. Este planteamiento del Self dialógico en el que habitan distintas posiciones del yo ha sido detalladamente desarrollado por Hubert Hermans y Dimaggio (2004).

Este, Hermans, teorizó el yo como una constelación de posiciones estructuradas dialógicamente. Cada una con su propia visión del mundo y su propia voz, en relaciones de intercambio intersubjetivo y dominación. El yo se mueve entre posiciones en un paisaje imaginario, dependiendo del tiempo, el lugar y la situación, lo que da lugar a un yo multivocal. Desde este planteamiento, la multivocalidad se ve como algo positivo. La patología que pueda derivarse de esta multivocalidad, no depende del grado de multiplicidad, sino más bien del grado de rigidez de las posiciones y del dominio de una posición sobre las demás.

Cuando alguien cuenta lo que le sucede, construye una narrativa que da cuenta de su experiencia. Tenemos dos formas fundamentales de poder escucharla: una centrada en la narrativa convencional y otra sustentada en una comprensión dialógica de la narrativa (Leiman, 2012). Estos dos modelos de comprensión tienen implicaciones teóricas y técnicas sintetizadas en la breve descripción que presento a continuación.

En la visión narrativa clásica, la forma habitual que tenemos de comprender el cómo una persona cuenta las historias, es pensar que quien cuenta algo quiere que nosotros sepamos su contenido. La narrativa, los sucesos que son descritos y las personas que están incluidas en la historia, se convierten en el foco principal de nuestra atención como oyentes. Esta visión basada en el sentido común reconoce al hablante y al contenido como las características fundamentales de la expresión.

En la visión dialógica, una comprensión dialógica de la narrativa conlleva que haya tantas variedades de contar lo que a la persona le ha sucedido, como personas intentan contarlo. Hay una unidad del Self que es polifónica. Cada expresión puede ser dicha por un protagonista. Puede ser una voz que exprese la identidad de uno de los personajes interiores con una voz característica (o posiciones del yo en términos de Hermans). Puede ir dirigida a otro personaje interno o a alguien externo. Unas voces se diferencian de otras por el contenido, por la prosodia, por el lenguaje corporal, por el contenido emocional que acompaña, los patrones relacionales implícitos, la disposición a actuar y por tener motivaciones y expectativas diferentes.

Las posiciones del yo no están aisladas unas de otras, sino que pueden entablar diálogos; quien habla, se coloca en una posición y su mensaje se dirige a alguien a quien le coloca en una contraposición. Si yo digo por ejemplo: necesito sentirme cuidado, me estoy posicionando en un rol de necesidad de protección y situando al otro en el rol de protector. Desde el punto de vista dialógico, entender una

expresión conlleva captar la dinámica relacional implícita en dicha expresión. Esto pone en evidencia el patrón de relación interpersonal y en última instancia el vínculo de apego implícito.

Como luego veremos con más detalle, toda expresión de un sujeto va dirigida a un destinatario. Este, el destinatario, habita en la mente del emisor antes de que verbalice su expresión. El otro, pues, está presente en nuestra mente, en nuestro diálogo interno durante el proceso de la construcción de aquello que le queremos decir. Como decía, mi expresión va siempre dirigida a alguien y antes de ser dicha ese alguien ya habitaba en mí (estaba introyectado), habitaba él y la relación que manteníamos o la que deseaba mantener o la que temía que mantuviésemos.

Por otro lado, el receptor tiene su propio diálogo interno y escuchar el mensaje recibido implica que será el destinatario quien valore de qué forma lo acopla a los que anticipadamente esperaba escuchar. De la misma forma, verá qué encaje tiene y de qué forma se articula el mensaje recibido con las motivaciones y expectativas del receptor.

Este diálogo complejo, se convierte en aún más complejo cuando lo entendemos desde la perspectiva de la multiplicidad del Self. Aquí, surge con todo su sentido y profundidad el aforismo de Leiman que me permití modificar de la siguiente forma: ¿quién de ti está hablando a quién de mí?; ¿de qué, por qué y para qué?

La gran aportación del análisis de las secuencias dialógicas, es que a través de un microanálisis de la estructura de la comunicación y de las expresiones entre el sujeto hablante y el destinatario del mensaje (sea éste otra persona, institución u objeto) puede inferirse un patrón relacional en el cual, quien habla se coloca en una posición y a quién va dirigido el mensaje es colocado en otra contraposición. El baile relacional y los vínculos de apego están implícitos en la estructura narrativa.

Esta comprensión amplía la visión narrativa vinculada a la teoría del apego, inspirándose en esta concepción de un self dialógico que permite abordar la comunicación entre las diferentes partes del hablante y las diferentes partes del destinatario. Lo puedo describir como la articulación de los múltiples discursos de diferentes personajes en un coro polifónico que, inicialmente se presenta como una cacofonía sin sentido y que el proceso terapéutico pretende convertirla en un canto coral empastado, con un director de orquesta que contribuya a dar sentido a la multiplicidad del self.

No solo es importante detectar los diferentes personajes con sus diferentes voces. En psicoterapia, es muy necesario saber identificar las transiciones entre unas voces y otras, cuándo hablan unas y cuando otras, Cuál es el contenido del que habla cada una de las voces, de cada personaje, desde qué perspectiva histórica se comprende, a quién va dirigida, cuál es el motivo que está detrás de su expresión y qué pretende conseguir del otro que le escucha.

Por lo tanto, el trabajo clínico desde la multiplicidad interna, se entiende mejor desde una perspectiva dinámica del trabajo momento a momento con el paciente y con cada uno de sus personajes internos y sus voces, más que con una comprensión basada en arquetipos estáticos, que de alguna forma solo tiene una utilidad descriptiva y clasificatoria pero lo esencial en el trabajo psicoterapéutico es esa concepción dinámica, dialógica y en permanente evolución y cambio.

No resulta extraño pues plantear, que una persona puede tener diferentes tipos de apego, diferentes formas de relacionarse y especialmente desde esta perspectiva de la multiplicidad del self. Una buena base segura que permite construir una alianza terapéutica razonablemente sólida para trabajar con la complejidad de las diferentes partes que configuran el self de un individuo, es un proceso necesario para poder dar cabida a los diferentes cambios en los patrones de relación y lo que todo ello implica en función de qué personaje y qué voz esté activa en qué momento y qué finalidad sea la que cumple en ese acto del teatro vital del individuo.

Aportaciones Innovadoras en Relación con el Apego, la Multiplicidad y la Psicoterapia: Nuevos Marcos Conceptuales

Este artículo metateórico, teórico y técnico que como señale desde el inicio, está escrito desde una perspectiva integradora inspirada en la teoría del apego y por el modelo cognitivo analítico ampliado que he ido desarrollando a lo largo de los últimos años.

Pero hay aportaciones recientes que están en fase de desarrollo, que permiten continuar con la maduración y consistencia mejorada de la teoría y la practica psicoterapeutica. Es por esto que, por terminar, mencionaré algunos desarrollos innovadores que se están produciendo recientemente.

El Apego y la Teoría de Redes

Como he señalado a lo largo del artículo, el apego puede ser considerado como una variable transdiagnóstica y operar como un vértice dentro de una red de componentes que forma parte del análisis de redes (McWilliams y Fried, 2019).

El enfoque de la teoría de redes es un marco teórico para explicar la existencia, el desarrollo y el mantenimiento de los trastornos mentales y está integrado en un marco más amplio de la ciencia de sistemas y la ciencia de redes. La suposición central del enfoque de red es que el complejo sistema de síntomas que interactúan dinámicamente constituye el trastorno. Esto contrasta con el punto de vista de la causa común, en el que una entidad subyacente, latente, categórica o dimensional causa una serie de síntomas (Roefs et al., 2022).

En general, el enfoque de red asume que la propagación de la activación es el motor que impulsa el trastorno mental: los elementos conectados se sincronizan, se mantienen mutuamente activamente en círculos viciosos y se convierten en una entidad autosuficiente (Roefs et al., 2022). El apego entendido como una variable tras diagnóstica puede ser incorporada como uno de los nodos de las diferentes variables que componen una red y en función de su peso específico, de su conectividad y de su papel dentro de la red, nos va a aportar datos relevantes para la comprensión del caso.

Comprensión del Apego Desde la Teoría de los Sistemas Dinámicos Complejos

En línea con uno de los desarrollos teóricos actuales, Nos podemos preguntar: ¿como seres humanos, podemos ser vistos como sistemas dinámicos complejos? Desde este punto de vista, ¿cómo se puede analizar el apego como dos sistemas dinámicos complejos en relación?

Este modelo, pone de relieve la naturaleza dinámica, no lineal y recíproca de los procesos de apego. Desde esta perspectiva de análisis, se considera a ambos individuos en una relación como sistemas complejos que interactúan y se influyen mutuamente a lo largo del tiempo.

Este proceso de interacción dinámico, no tiene un patrón de interacción lineal, de tal forma que un cambio leve en uno de los componentes pueden provocar efectos de gran magnitud en el resto del sistema. Esta ausencia de linealidad viene caracterizada por la presencia de bucles de retroalimentación, donde el resultado de una interacción del sistema influye de manera retroactiva en su consiguiente entrada de manera cíclica. Son bucles de retroalimentación cíclicos auto reforzantes, sirve el apego un ejemplo claro de esto (Bringmann et al., 2023).

Por último, estos sistemas están adaptados al ambiente y son altamente resilientes, de tal forma que su propia estructura dinámica compleja le permite adaptarse a entornos cambiantes ajustando su dinámica interna frente a perturbaciones o factores estresantes (Hayes y Andrews, 2020).

Todo lo anterior nos ayuda a comprender la complejidad inherente a los seres humanos. Somos entes biopsicosociales y espirituales con una relación dinámica y compleja entre las partes y subsistemas que nos dan sentido a nuestra existencia y que traen como resultado una adaptabilidad que resulta crucial para la supervivencia y el crecimiento en diferentes contextos. A los bucles de retroacción a los que me refería antes suponen una interacción entre pensamientos, emociones, sensaciones corporales, conductas en un proceso de interacción cíclica continúa en la relación con el otro. La comprensión del individuo no puede basarse en un análisis meramente individual sino que tiene que estar sustentada en esta dinámica relacional compleja entre los dos contendientes en el proceso relacional, en este caso el apego como foco de análisis.

Desde esta perspectiva de la complejidad, el sistema de apego del bebé, está impulsado por fuerzas biológicamente determinadas que buscan la proximidad a los cuidadores para la seguridad, la comodidad y la supervivencia. El sistema de apego del bebé se caracteriza por emitir conductas del estilo: llorar, aferrarse y sonreír para mantener la atención y el apoyo del cuidador. De esta manera, las conductas de apego del bebé se regulan dinámicamente en respuesta a las señales ambientales y a las interacciones con el cuidador. La relación dinámica compleja entre los dos contendientes en la relación de apego implica que, los cambios en la capacidad de respuesta o disponibilidad emocional del cuidador van a influir en las conductas de apego y los estados emocionales del bebé. Y de manera circular, las respuestas y comportamientos del cuidador a aplacarán o mantendrán las conductas expresadas por el bebé.

Esto implica un baile incierto en el que puede producirse un acoplamiento y sincronía, o no. De la gratificación o frustración de las necesidades del bebé y la respuesta del cuidador se deriva la construcción de un patrón de apego u otro. Una responsabilidad que satisfaga las necesidades del bebé es la que termina por constituir un apego seguro y apoyar un desarrollo sano y satisfactorio del bebé. Hablamos pues de la relación dinámica entre 2 sistemas complejos.

Por lo tanto, podemos concluir que la interacción es bidireccional. Hay una influencia recíproca, en la que la relación de apego entre el bebé y su cuidador se caracteriza por la reciprocidad entre ambos contendientes. Cada componente del sistema influye y es influenciado por el otro. Los comportamientos del bebé afectan las respuestas del cuidador, y viceversa, creando un ciclo de retroalimentación dinámica. Esta relación circular, bidireccional y de refuerzo supone un proceso de corregulación, en el que tanto el bebé como el cuidador contribuyen a la regulación de los estados emocionales y fisiológicos del otro. Esta corregulación es esencial para mantener la estabilidad relacional y promover el desarrollo adaptativo.

El resultado de esta correlación entre dos sistemas complejos supone como resultante, la emergencia y un apego seguro sustentado en que la calidad del vínculo surgido de las interacciones dinámicas entre el bebé y el cuidador, están sustentadas en un cuidado constante, sintonizado y receptivo, que conduce a una relación estable y de confianza. Es por esto por lo que resulta coherente comprender la relación que construye el apego desde una perspectiva de una dinámica compleja, donde los patrones de interacción evolucionan con el tiempo en función de la historia de interacciones y cambios en el entorno interno y externo.

El Principio de Energía Libre de Friston como Marco General

Analizado todo lo anterior desde la perspectiva del principio de energía libre de y la inferencia activa (Friston, 2010), nos permitiría afirmar que el equilibrio dinámico entre los PRIORS y el ajuste en la predicción de la respuesta y la minimización de los errores en dicha predicción, son los que contribuyen a comprender la relación dinámica bidireccional con una finalidad adaptativa en la que termina por surgir un apego seguro cuando se dan las condiciones óptimas para el proceso de adaptación al contexto.

Según este modelo, todo sistema biológico, incluido el cerebro, y por extensión la mente, tiende a minimizar el nivel de energía libre como medida de la sorpresa o incertidumbre que la mente y el cerebro calculan con respecto a las predicciones de lo que puede suceder en el mundo que les rodea. Hay pues un equilibrio circular claro entre los modelos internos del mundo que tiene la persona y los efectos derivados de las entradas sensoriales que va recibiendo. El principio de energía libre está directamente relacionado con la inferencia activa, donde está es un mecanismo que permite actualizar el modelo del mundo que tiene la persona para reducir la sorpresa y además actúa sobre el mundo para hacer realidad sus predicciones minimizando así la energía libre.

Desde la perspectiva del principio de energía libre, PEL, los estilos de apego pueden ser vistos como modelos predictivos internos que los individuos tienen sobre las relaciones interpersonales. Un apego seguro implica un modelo donde se espera que los cuidadores sean consistentemente disponibles y sensibles, minimizando la energía libre asociada a la incertidumbre en las interacciones sociales.

En definitiva, el modelo de Friston permite comprender la teoría del apego desde una perspectiva predictiva en la que el objetivo fundamental es la minimización de la sorpresa. Esto está directamente vinculado a los procesos internos de regulación emocional. De alguna forma y desde este modelo, los eventos de separación, pérdida o trauma se pueden analizar cómo perturbaciones que aumentan la energía libre. El sistema interno, los modelos internos de trabajo descritos inicialmente por Bowlby, pueden ser entendidos desde la PEL, como intentos de realinear el modelo interno que no resulta adaptativo fruto de la ausencia de seguridad, y la terapia va dirigida a la promoción de un apego seguro que permita un adecuado funcionamiento de la capacidad predictiva del individuo.

Conclusiones

Como hemos podido ver a lo largo del artículo, el trabajo psicoterapéutico influenciado desde la teoría del apego y desde una práctica sustentada en lo relacional, implica al paciente y al terapeuta. Cuando hablamos de descentramiento, metaobservación, mindfulness, detección de sensaciones somato sensoriales, identificación de los patrones relacionales, conciencia del contexto sociocultural; no solo estamos refiriéndonos a habilidades que debe desarrollar el paciente.

El entrenamiento de los terapeutas, debe de conllevar una práctica cotidiana de la autoobservación y de las relaciones contextuales. Eso exige el desarrollo de una presencia terapéutica que venga marcada por una capacidad de regular las propias emociones del terapeuta, que le permitan situarse en la posición de una base segura en la que el paciente pueda reposar su dolor. Es fundamental que a su vez, al terapeuta sepa regular sus propias emociones sin caer en el agotamiento que puede provocar una psicoterapia sin el cuidado adecuado del terapeuta.

Si hemos de ser la base segura para el paciente y favorecer que reconstruya con nosotros patrones de relación que le permitan dar una nueva forma a su vida relacional y a su adaptación social; también hemos de ser una base segura para nosotros mismos. Eso exige un entrenamiento y un autocuidado diario y compartido con compañeros y supervisores que nos acompañen en nuestra tarea de cuidar a otros y de cuidarnos a nosotros mismos.

Declaración

Los autores no recibieron apoyo económico o financiación para apoyar la investigación ni la autoría y/o publicación de este artículo. No hay interés económico o beneficio de la aplicación directa de esta investigación.

Conflicto de Intereses

El autor de este manuscrito declara que no existe ningún conflicto de interés financiero, personal, académico o institucional que pudiera haber influido en la realización de este estudio, el análisis de los datos o la interpretación de los resultados.

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Article

Rethinking Developmental Trauma Using the Child Attachment and Play Assessment

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ABSTRACT

Child abuse and neglect has a major impact on children's development and is a significant factor in a range of adult psychiatric disorders as wells as problems in relationships and social functioning. In the last two decades the effects of child maltreatment have been given a specific nosology in terms of a complex form of PTSD (CPTSD). Considerable progress has been made in validating questionnaires that screen for CPTSD and meet the criteria proposed by ICD11. Despite the basis of CPTSD in childhood, assessments have been biased towards adults and little use has been made of play based procedures for use with maltreated children. This paper argues for the use of the Child Attachment and Play Assessment (CAPA) as an additional assessment procedure. The CAPA uses the established narrative story stem procedure (NSSP) and codes for child attachment, unresolved loss and/or trauma, and observed somatic signs of trauma. Because it gives a direct window into the perception of the child it gives the therapist child specific information to help formulate an intervention plan most likely to help a particular child. The aim is not to supplant current assessments but enrich them. The term developmental trauma (DT) is preferred because the CAPA uses a psycho-social rather than medical model.

Reformulando el Trauma en el Desarrollo a Través del Child Attachment Play Assessment

RESUMEN

El maltrato y la negligencia infantiles tienen un gran impacto en el desarrollo de los niños y son un factor significativo en una serie de trastornos psiquiátricos en la edad adulta, así como en problemas de relación y funcionamiento social. En las dos últimas décadas, los efectos del maltrato infantil han recibido una nosología específica en términos de una forma compleja de TEPT (TEPT Infantil). Se ha avanzado considerablemente en la validación de cuestionarios que detectan el TEPT y cumplen los criterios propuestos por la CIE11. A pesar de la base del TEPT en la infancia, las evaluaciones han estado sesgadas hacia los adultos y se ha hecho poco uso de procedimientos basados en el juego para su uso con niños maltratados. Este artículo propone el uso de la Evaluación del Apego y el Juego en el Niño (CAPA) como un procedimiento de evaluación adicional. La CAPA utiliza el procedimiento establecido de la narrativa de la historia (NSSP) y codifica el apego infantil, la pérdida no resuelta y/o el trauma, y los signos somáticos observados del trauma. Dado que ofrece una ventana directa a la percepción del niño, proporciona al terapeuta información específica sobre el niño para ayudar a formular un plan de intervención con más probabilidades de ayudar a un niño en particular. El objetivo no es suplantar las evaluaciones actuales, sino enriquecerlas. Se prefiere el término trauma del desarrollo (DT) porque el CAPA utiliza un modelo psicosocial en lugar de médico.

Palabras clave:
Evaluación del apego y el juego infantil
Trauma del desarrollo
PTSD complejo
Apego
Modelo dinámico maduracional del apego

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The focus of this paper is the assessment and treatment of developmental trauma (DT) in children and adolescents. The main contributors to DT are child abuse and/or neglect and war; only the former is discussed here. Following a selective review of current diagnostic procedures, an alternative approach to assessment is offered in the form of the Child Attachment and Play Assessment (CAPA) using the established narrative stem story stems procedure (NSSP) (Emde et al., 2003). The aim is not to supplant current assessments but to show how the CAPA can enhance the understanding of a particular child's attachment and trauma and, crucially, help select the therapeutic intervention most likely to succeed. The final section has pointers for intervention and treatment together with a brief case study.

Child maltreatment has been typically categorised in terms of physical, sexual, emotional abuse and neglect. More recently, work on Adverse Childhood Experiences (ACEs) has widened the definition to include domestic violence, parental drug and alcohol abuse, parent separation and imprisonment (Maneiro et al., 2023). The global prevalence of maltreatment is high, for example the United Nations Children's Fund estimate 60% of children under 5 endure physical or psychological punishment at home (UNICEF, 2024). All forms of abuse can have an adverse impact on neurological development (Teicher & Samson, 2013); the effects persist into adulthood and are significant factor in the cause of many psychiatric diagnoses (Marques-Feixa et al., 2023). The consequences of childhood trauma are not restricted to individuals. When large populations of children are traumatised, there is an epigentic effect; for example environmental security allows more time for reproduction, girls reach the menarche later and the birth rate declines. Environmental dangers such as extreme poverty, child abuse and war activate the opposite (Belsky et al., 1991; Belsky, 2008).

Although the protection of children from abuse has long red in the social policy agendas of the USA, Antipodean and European countries, this has only recently been reflected in diagnostic criteria used by child welfare practitioners. In 1991 Terr's pioneering work on traumatised children made the useful distinction between the differences in "one off blows" and "long-standing or repeated ordeals" (Terr, 1991). This was followed by a concerted effort by van der Kolk arguing a new diagnosis was needed which he termed developmental trauma disorder (DTD) (van der Kolk, 2005). DTD was rejected by American Psychatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) but included in World Health Organization's (2019) International Statistical Classification of Diseases and Related Health Problems (11th ed., ICD-11) under the rubric of complex PTSD (CPTSD). In the process the focus on children was to some extent lost in attempts to formulate diagnostic criteria for CPTSD in adults (see Maercker, 2021, for review).

While there is a consensus that DTD/CPTSD originates in attachment relationships, the concept of a 'disorder' puts the focus of the problem onto the child; i.e. a disorder is something the child has. To emphasis the social origins of the problem, in this paper the term developmental trauma (DT) is preferred with reference to DTD or CPTSD when used by other writers.

Developmental Trauma

There are two main differences between DT and other forms of trauma. First, it entails abuse or neglect perpetrated by attachment figures. This can produce 'fear without solution,' inducing an approach-avoidance dilemma in that the very people who are supposed to protect the child (Parents) are also the source of harm. Second, it is multiple and chronic. Various types of abuse frequently occur together over long periods of development (Terr's "long-standing or repeated ordeals") and unlike PTSD it is usually difficult to identify a specific traumatic event that has caused the child's problems. To be classed as traumatic, threats or actual acts of harm to the self or self-substitutes, such as siblings, must be severe enough for the child to doubt their safety, psychological integrity and even physical survival.

ICD-11 Complex PTSD

For a diagnosis of Complex PTSD in adults the three core elements of PTSD have to be met. 1) Re-experiencing the traumatic event (e.g., flashbacks, intrusive memories or images, nightmares). This is more than a matter of reflecting on traumatic episodes but involves acute mental and physical sensations such as fear or horror. 2). Deliberate avoidance of reminders likely to produce re-experiencing of the traumatic event(s). 3) Hypervigilance (although unlike PTSD, in CPTSD the startle response may be muted). In addition, for CPTSD: 1) Problems in affect regulation; 2) Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) Difficulties in sustaining relationships and in feeling close to others. Symptoms of CPTSD may vary according to culture and females are at greater risk than males.

Although complex trauma is often rooted in childhood maltreatment, ICD-11 does not have separate criteria for CPTSD in children. It does note children and adolescents are more vulnerable than adults to developing CPTSD and, where attachment figures are the source of trauma, children and adolescents often develop disorganised attachment.

The American Psychiatric Association (2013) added a sub type of PTSD for children under 6 years that is more developmentally sensitive and includes manifestation of trauma symptoms in play. Cruz et al. (2022) note this revision suggests PTSD in children may differ from that in adults and traumatised children are discernibly different to non-traumatised peers.

One problem with the CPTSD diagnosis is co-morbidity. Children under five may also be diagnosed with Reactive Attachment Disorder or Disinhibited Social Engagement Disorder, and children and adolescents with Depressive Disorders, Eating Disorders, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct-Dissocial Disorder, and Separation Anxiety Disorder (World Health Organization, 2019).

Assessment of CPTSD and DTD in Children

An impressive amount of research went into validating the CPTSD diagnosis producing a number of clinically useful scales. For example, the self-report Trauma Symptom Inventory (Briere et al., 1995). There is also a scale for DTD (Spinazzola et al., 2021). See also the International Trauma Consortium[1].

The assessment of CPTSD and DTD in children and adolescents is dominated by questionnaires with little use made of structured interviews (e.g., The National Child Traumatic Stress Network,

2025). There are also a number of comprehensive trauma-focused clinical assessments such as the Chadwick Centre (2025).

An exception is the narrative story stem procedure (NSSP). This is a doll play technique in which an interviewer, not known to the child, presents the child with the start of a story (the stem) and, using a few simple props, asks the child to "tell me and show me what happens next". Kelly and Bailey (2012) estimate at least three dozen methodologies use this approach in hundreds of published studies. Various batteries of stories are available and there are around half a dozen systems of analysis, some coding for attachment (see Farnfield, 2014a on NSSPs and attachment). With a few exceptions quantitative analysis predominates over qualitative (see Kelly & Bailey, 2012 for review).

A major advantage of the NSSP is that, unlike questionnaires, it offers a direct window into the experience of an individual child (Emde et al., 2003) and so has been effective in the understanding and treatment of traumatised children (e.g., Hodges et al., 2003). A number of investigators have used the NSSP to screen for post traumatic play (e.g., D'Elia et al 2022, Farnfield & Onions, 2022; Løkkegaard et al., 2021). Given the objection that children's 'stories' and 'play' do not necessarily reflect the reality of their lived experience, construct validity of the NSSP (Kelly & Bailey, 2012) convergent validity across cultures (Wan et al., 2024) is encouraging.

Attachment

There is a consensus that DT has an adverse impact on child attachment. The two competing theories of attachment are the prototype ABC+D model and the Dynamic Maturational Model of Attachment and Adaptation (DMM). The former is grounded in the Ainsworth infant ABC patterns (Ainsworth et al., 1978) with the addition of disorganisation (D) (Main & Solomon, 1986), and is the one more widely used in research. The DMM is also based on Ainsworth's model but diverges from the ABC+D in that it does not use D but identifies expansions of A and C according to context and maturation (Crittenden, 2006).

The DMM is the model used here and significant differences and unresolved problems are as follows (for a full explanation of the DMM see Crittenden, 2016):

- Whereas ABC+D is largely rooted in infant behaviour, the DMM expansions offer a further twelve sub-patterns, A3-8 and C3-8 together with combinations of A and C.
- Using the Adult Attachment Interview (AAI) (Main & Goldwyn, 1984-1998) ABC+D codes for unresolved loss and trauma, mainly in a preoccupied form. Conversely, the DMM-AAI (Crittenden & Landini, 2011) has fourteen types of unresolved loss and trauma, rooted in dismissed and preoccupied with a similar range identifiable in DMM child and adolescent assessments (Crittenden et al., 2021).
- The ABC+D model sometimes assesses children from at risk populations as securely attached. A meta-analysis of the attachment patterns of institutionalised children found rates of security as high as 74% (Lionetti et al., 2015). This is a bizarre situation with no theoretical or empirical explanation. Likely these cases would be rated in the A3-8 sub-patterns using the DMM (see Farnfield, 2014b).
- The DMM codes for what are termed modifiers (see below). These refer to chronic disruptions of affect regulation and are the closest the DMM gets to D.

The Child Attachment and Play Assessment (CAPA)

Underpinning Ideas

The gold standard for attachment assessments is Ainsworth's strange situation procedure (SSP) (Ainsworth et al., 1978). Like the SSP, the CAPA assesses both attachment and play/exploration. The theoretical and empirical back ground is as follows:

- Winnicott's potential space (1971) and the development of mentalising in children (Fonagy et al., 2004)
- Constructs used in the MacArthur & Story Stem Assessment Profile (Hodges et al., 2003) and other Coding Systems (Emde et al., 2003)
- Play therapy with traumatised children
- Crittenden's DMM of attachment and adaptation
- The Infant CARE Index – assesses parent-child play (Crittenden & DiLalla, 1988).
- The SSP and Preschool Assessment of Attachment (PAA) (Crittenden, 2004) for observation of child behaviour when under stress
- Social engagement signals
- The AAI – how different patterns of speech can be used as an indicator of defensive exclusion (Bowlby, 1998/1980).
- Porges polyvagal theory (Porges, 2011).
- Sensory Attachment Intervention (SAI) (Bhreathnach, 2025a)

Procedure

Use of the NSSP is developmentally possible from 36 months; the age that approximates to the 'move to representation' (Main et al., 1985), when children are able to re-present to the self and an attentive adult internal representational models of attachment. Most systems do not employ the procedure beyond 7-8 years, but the CAPA has routinely been used with children up to the age of 12 and we are now developing a system for adolescents.

All attachment assessments need to generate moderate anxiety in subjects for attachment behaviour to be activated. In the NSSP the child's attachment system is activated by completing stories about attachment with a strange adult. Other than a warm up story, all the stories pull for attachment: for example a child/little animal gets lost or the child burns his/her hand. The CAPA uses a combination of the MacArthur (Bretherton & Oppenheim, 2003) and Anna Freud stories (Hodges et al., 2003) for pre-school children and has separate sets for school age children and adolescents.

Although the Anna Freud procedure has twelve stories, we have found they take too long and children get tired or bored. A CAPA procedure uses about seven stories and takes about twenty minutes for pre-schoolers and 30 – 40 minutes for older children. The CAPA is video recorded and coding by a reliable coder takes about two to three hours, depending on the complexity of the child's situation. Training and reliability take about 150 hours spread over six months (see Farnfield, 2025).

Coding Constructs

Coding is organised around the following seven constructs.

1. The child's relationship with the interviewer
2. The child's observed level of physiological arousal

3. Social engagement signals (body language)
4. Discourse, either verbal or in the play (telling or showing)
5. Mentalising
6. Markers & patterns for unresolved trauma and loss
7. Chronic problems with affect regulation – the DMM modifiers (see below).

Rather than counting the number of times a significant marker appears, in accordance with other DMM procedures, coding is a pattern recognition exercise. This means the coder is looking simultaneously for similar patterns across all seven constructs.

Validity

At the time of writing there are four peer reviewed published CAPA studies with an aggregate data base of 300 children (Farnfield, 2015; Farnfield & Onions, 2022; Wauthier et al., 2022, 2023). Data from a further 380 in four separate samples are currently under analysis. The CAPA has convergent validity with the CARE-Index (Crittenden & DiLalla,1988), an observational procedure for pre-schoolers, and an attachment interview for school age children (Farnfield, 2014b). Also construct validity regarding attachment insecurity and known risks in the environment such as parent mental health (Farnfield & Onions, 2022). It distinguishes between endangered (largely children in foster care) and safe community children (Farnfield, 2015), and community endangered children from severely maltreated children in residential care (Farnfield & Onions, 2022). Stability of attachment using the CAPA over a two-year period with a group of highly traumatised institutional children (here referred to as the MB study) was 70% (Farnfield & Onions, 2025). Finally, there is good correspondence between unresolved trauma on the CAPA and validated trauma scales (Wauthier et al., 2023).

The CAPA and Developmental Trauma

The CAPA is designed to inform treatment, not a forensic assessment to prove a child has been abused by a particular person. A CAPA coding is composed of three parts: the child's attachment strategy; unresolved loss and/or trauma and, third, chronic problems in affect regulation (the DMM modifiers). Attachment is determined by patterns across the first four constructs. Mentalising is a separate category useful for treatability but not discussed here. The last two constructs provide an estimation of the degree of traumatisation. Loss/trauma is determined by discourse and specific markers (construct 6) and affect regulation by construct 7. In terms of the ICD11 PTSD criteria for adults, the CAPA codes for pre-occupied trauma and hypervigilance. Deliberate avoidance (dismissed trauma) is, by definition, harder to detect; in particular the A+ attachment strategy is organised around psychological avoidance. With regard to ICD11 adult CPTSD, the CAPA screens for problems in affect regulation and the relationship with the interviewer. Shame and guilt typically form part of the mindset in A+ attachment.

Taken together the constructs form the basis for formulating a hypothesis concerning the impact of developmental trauma on a particular child. The three components are now explained in more detail.

Attachment

The DMM attachment patterns are given in figure 1.

Figure 1
DMM A+ and C+ Patterns

Type A+	Type C+
Idealise attachment figures	**Fight**
A3 role reversal	C3 aggressive
A5 indiscriminate attachment	C5 Punitive
A7 idealisation of dangerously abusive carers (Stockholm syndrome)	C7 menacing.
Negate the self	**Flight or cling**
A4 compulsive compliance with adult demands	C4 feigned helplessness
A6 compulsive self-reliance	C6 obsessed with rescue
A8 externally assembled self.	C8 paranoid.

The notation A+ or C+ refers to the DMM A3-8 and C3-8 sub-patterns to distinguish them from the normative insecure Ainsworth A1-2 and C1-2 patterns. At the risk of over simplification, the DMM strategies are organised in terms of how they deploy flight fight or freeze.

A+ is a self-defensive strategy that takes the perspective of abusive adults; hence the self is 'bad', the child blames the self for their predicament and tries to please or placate attachment figures and other powerful adults (Crittenden, 1992). Because Type A+ inhibits feelings of vulnerability it is a form of freezing peculiar to humans (see Porges, 2011). The odd A+ subscripts idealise attachment figures and the even numbers negate the self. Taken together they represent gradations of a false self.

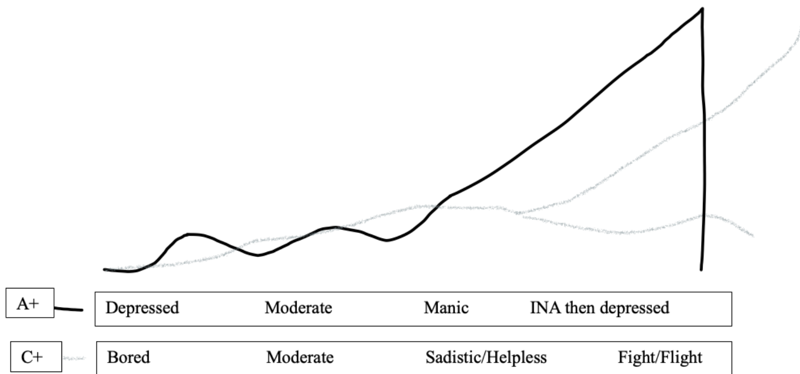
Type C+ uses combinations of fight alternated with flight or cling. In C3, aggression masks vulnerability and the desire for comfort. In C5, vulnerability of the self and others is dismissed meaning children using this pattern are capable of calculated acts of aggression or violence. On the even numbered side, C4 and C6 are forms of passive aggression in which anger is sugar coated with helplessness and obsession with rescue.

The strategic range of attachment behaviour increases with development. C3-4 and A3-4 are pre-school patterns and may be expand, with maturation, to C5-6 in the school years and A5-6 in adolescence. Types C7-8 and A7-8 develop in adulthood (Crittenden, 2006). CAPA coding follows the orthodox DMM model with the exception of A8. Imitation forms a key part in the development of pre-school children and the CAPA has coded for A8 in the schools years since its conception. A8 is predicted to develop from multiple home placements (Crittenden & Landini, 2011) and the MB study (Farnfield & Onion, 2025) is the first to provide empirical evidence.

In all cases it is the child's perception of safety and danger that motivates behaviour. For children who have never been safe, it is the deployment of their strategy that increases feelings of security rather than safety per se; one of the reasons DT is so hard to alleviate.

Following other DMM studies (Crittenden et al., 2021), the CAPA MB study assessed a miniscule percentage of abused children as B secure and all of these were reorganising to B from an A+ or C+ or A/C pattern. Likewise a tiny number of children were assessed in normative insecure A1-2 or C1-2 patterns.

Figure 2
The Arousal Cycle in A+ and C+



Comfort 'Disorders'

In A+ and C+ comfort (love, tenderness, safe caresses) has been denied or is otherwise unobtainable. Children in both patterns find it extremely hard to use even caring adults to help them coregulate their arousal but their reaction differs. Children using A+ feel they are responsible for managing their own affective states and so tolerate a world where they do not receive comfort. This inevitably leads to breakdowns of strategy – what the DMM calls intrusions of forbidden negative affect (inas). Adults have decided anger and desire for comfort are forbidden so when desire for comfort breaks through the child has an ina. These occur only in A+ and frequently take the form of rages, where, unlike C+, the child is out of their own control. They may also result in unregulated comfort seeking approaches that are seen by adults as 'inappropriate sexual behaviour'.

In C4, and particularly C6, elicitation of comfort is now used to the point the child may make her or himself vulnerable to further abuse. In C5 the primary source of comfort – mother – is trashed. This is particularly an issue for boys aged around 10 – 12 years. CAPAs of boys using C5 show alarming examples of misogyny, sexual sadism and denigration of motherhood

In Bion's terms, one of the functions of an attachment figure is to act as a container for their infants physiological and later affective arousal (Bion, 1962/1991). An important finding from CAPA studies is the arousal cycle in A+ differs significantly from that in C+ (see figure 2). In A+ the child feels responsible for managing their arousal and cannot use the interviewer or therapist for co-regulation. Watching the CAPA video we see the child's arousal run in a wave of troughs and peaks: often pulling themselves up to complete the story and slumping back down between stories. This can be quite stark: the child gets up and walks round the room, sits down again, cheerfully completes the story then lies on the table with their head on the hands or even kneels on the floor. When highly aroused the child appears manic or has an ina, for example sticking their tongue out at the camera. Inas and manic states of arousal frequently end with a slump back into depression.

In C+ the child does make use of the interviewer, however this is not the co-regulation seen in B secure, but forcing the interviewer to respond to intense displays of controlled aggression (C5) or self harm (C6). Interviewers often experiences a disturbing emotional counter transference including shock and revulsion (response to C5-7) or a desire to rescue (C6).

In both A+ and C+ the inter personal process by which this happens is best captured by Klein and Bion's description of projective identification (Klein, 1975; Bion 1962/1991). In A+ the interviewer/therapist may be listening or observing stories that clearly stem from maltreatment but s/he feels tired or bored as if the child is signalling, "there is nothing to see here, don't worry about me." In C+ the interviewer is forced to feel some of the split off feelings the child cannot contain her/himself.

Unresolved Loss and Trauma – Affect Regulation

While some children exposed to DT are able to organise around trauma using their attachment strategy, others show lapses in strategic functioning (DMM unresolved loss or trauma) and/or more chronic somatic problems (the DMM modifiers). In effect we are looking at a continuum, given in Figure 3.

Figure 3
Developmental Trauma – Mental and Somatic Representation R, DO, Dip, INAs and ESS are DMM Modifiers (XX).

Mental representation - Unresolved loss or trauma in the discourse – shown or told
Reorganisation [R]
Dynamic post traumatic play
Stuck or toxic play
Disorientation (DO) Confusion regarding whether the self or others are the source of memories.
Somatic representation – Written in the body
Depression (Dp) denotes futility regarding the effectiveness of attachment behaviour.
Intrusions of forbidden negative affect (INAs) (anger, desire for comfort) in a compulsive A+ pattern.
Expressed somatic signs (ESS) somatic signs, such as repeated scratching, coughing, of experiences that cannot, for whatever reason, be brought to conscious expression.

Mental representations of DT are, at least in part, conscious and can be communicated in spoken discourse or in play. The CAPA criteria for unresolved loss or trauma are given in Figure 4.

Following the AAI, transforming dysfluency in the story telling refers to points where the child is transforming or excluding information that, if brought to consciousness, would entail them to suffer; Bowlby's concept of defensive exclusion (Bowlby, 1998). Dissociation, hypervigilance and loss of sensory regulation clearly have somatic components.

Figure 4
Capa Criteria for Unresolved Trauma

Transforming dysfluency in the discourse (spoken or play)
Concerning themes across stories e.g. wet beds, people looking down at dead people
Preoccupied stories in Type A+ which are told with flat affect. In effect the stories are preoccupied with regard to content but dismissing regarding affect
Hypervigilance e.g. suddenly looking at the door, asking the interviewer if someone is coming in, starting at noises the interviewer cannot hear
Weird or bizarre content
Content that feels chillingly real (often told with flat affect)
Somatic expression of bodily pain, e.g. showing the site of previous injury
Sudden loss of sensory regulation, e.g. tripping due to loss of muscle tone
Dissociation e.g. zoning out; temporary loss of connection with the interviewer and/or the task.
Inability to use the relationship with the interviewer for relief – stuck or toxic play compared to dynamic
post traumatic play (Gil, 2017)

Using Figure 3, reorganisation is the closest modifier to strategic functioning with little or no DT. Reorganising stories show traces of an insecure pattern with passages that also rate B secure. Reorganisation is a modifier because it not only denotes a change in strategy but also entails disruptions to old ways of thinking, feeling and behaviour, rather like the experiences people may go through in therapy.

The difference between toxic and dynamic post traumatic play was described by Gil (2017). In the latter the child plays out parts of traumatic scenes and is able to use the mind and presence of the interviewer (in the CAPA) or therapist to find meaning in the experience. In toxic play the child repeats traumatic experience without new meaning or relief and so effectively re-traumatising the self. Disorientation refers to confusion about the source of memories and information so the child flips from an A to C pattern and back again without either functioning strategically. DO is very rarely coded in the CAPA.

The ability to turn trauma into a narrative is a sign of healing the wound whereas, in somatic representation, trauma ceases to be a story one can tell and is written in the body (van der Kolk, 2015). Somatic, bodily trauma, veers from very low to manically high states of arousal. In the DMM depression is not a quasi-psychiatric diagnoses, although there are some overlaps: flat affect, sadness and futility regarding the effectiveness of attachment strategies. The discourse often has a striking clarity that invites a B secure coding but on inspection what the child sees so clearly is the impossibility of any change. Intrusions of forbidden anger or desire for comfort are described above. Expressed somatic signs are the physical manifestations of episodes that cannot be talked or even thought about (Bowlby, 1979). For example, at first it appears the child has a cold. She sniffs and scratches her lip; but as the stems progress her sniffing and scratching gets more and more pronounced, particularly at points she is anxious. The interviewer points this out to carers and other professionals who know the child well and they say, "Oh, she always does that."

Rethinking Psychiatric Diagnoses

Many children are referred to professional services for problems with affect regulation: Johnny cannot control himself; Johnny is defiant; Johnny is given a diagnosis such as ADHD, PDA, CD. There has been an explosion in such diagnoses and many children are put on medication. Far fewer children are referred because they are sad, depressed or so anxious to please they negate their own needs; in other words the children successfully using an A+ strategy.

From a DMM perspective a significant number of these diagnoses could be explained in terms of both strategic behaviour and breakdown in attachment strategy. DMM studies have found that psychiatric diagnoses rarely correlate with DMM attachment patterns (Crittenden et al., 2021). However, in the CAPA-MB study, at entry to residential care 81% of children with anxiety disorders were in the A+ group (p = <. 046, Ø.358) and 75% two years later (T2) (p = <. 044, Ø.395). The A+ strategy is poorly equipped to contain arousal when compared with Type C+. In A+ the self is responsible for affect regulation whereas Type C+ is intensely interpersonal with a focus on the self and its problems.

At T2, children assessed as unresolved regarding loss were significantly more likely to be diagnosed with depression, anxiety or attachment disorders and, crucially, to play out scenes depicting loss of family. This supports the reframing of attachment disorder using an attachment rather than medical model. For these children, 'attachment disorder' was their response to loss of family, whether birth or previous foster carers was not clear.

Of great significance for the validity of the model was the bi-directional relationship between the depression modifier and inas. Depression at entry correlated with inas two years later, and vice versa. This gives empirical evidence for the DMM seesaw of arousal in A+ described above. The display of one or other state (dp or ina) may change frequently and clinical diagnosis may be influenced by not just the day but the hour an assessment takes place.

Intervention and Therapy

The first requirement when trying to help DT children is to remove the source of danger. There is likely a consensus that before any therapeutic work can begin the child must be in a stable and safe environment. This is the responsibility of child protection agencies for whom the most radical intervention is removing the child to foster care. The problem is that separating children from their parents is in itself uniformly damaging (Crittenden & Spieker, 2023) and greater use needs to be made of schemes that try to ensure children are safe while simultaneously keeping them with parents or relatives (Crittenden et al., 2024). When children are still unsettled, for example in a short term foster placement, use can be made of 'bridging therapies' otherwise traumatised children can go for years with no therapeutic help. The usefulness of contact with an adult mind that tells them: "you are not made, it is the world that is mad and what you feel and do is normal behaviour under abnormal circumstances", should not be underestimated.

The clinical utility of the PTSD and CPTSD diagnoses "has yet to be investigated" and, because of its complexity, CPTSD may require a greater number of interventions and longer courses of treatment (Cloitre, 2020). Best practice guidelines for the treatment of CPTSD in adults are built around a three phase approach. Phase 1: ensure the person is safe; reduce symptoms and increase psycho-social competencies. Phase 2 Focus on unresolved aspects of traumatic memories and Phase 3 consolidation and facilitate transition to greater engagement with relationships and social life (Cloitre et al. 2011). A meta-analysis of treatment for adult CPTSD gave some support for Cognitive behavioural therapy (CBT), exposure alone

(EA) and eye movement desensitisation and reprocessing (EMDR) but noted few RCTs reported affect dysregulation data and outcomes were poorer for subjects traumatised as children (Karatzias et al., 2019).

Likewise, validated treatments for children and adolescents with DTD are limited. In his seminal work on DTD, van der Kolk notes, "Treatment must focus on three primary areas: establishing safety and competence, dealing with traumatic reenactments, and integration and master of the body and mind ... Unfortunately, all too often, medications take the place of helping children acquire the skills necessary to deal with and master their uncomfortable physical sensations." To "process" their traumatic experiences, these children first need to develop a safe space where they can "look at" their traumas without repeating them and making them real once again" (van der Kolk, 2005).

Integrative and relational treatments may be effective (Cruz et al., 2022) but evidence for efficacy varies. For example, the Attachment, Regulation and Competency (ARC) model has a number of peer reviewed papers (see ARC[2]) whereas empirical support for Hughes' Dyadic Developmental Psychotherapy, widely used with families with fostered and adopted children in the USA and UK, appears to be thin (Hughes, 2017). Sachser et al. (2017) used 12 sessions of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) with children and adolescents diagnosed with either PTSD or CPTSD. The programme included psycho-education, relaxation and affect regulation. Both groups responded to TF-CBT but the CPTSD group ended treatment with clinically and statistically greater symptoms than those with PTSD.

DMM Functional Formulation

There is no DMM therapy. Crittenden has long taken the view that we have enough therapeutic modalities to be going on with and the purpose of an attachment assessment, like the CAPA, is to assist in the selection of the therapy most likely to succeed with a particular child. To this end, DMM practitioners and therapists have focussed on formulation, with particular attention to the whole family system (Dallos et al., 2019), to arrive at a DMM informed integrative treatment (Crittenden et al., 2021). Unlike a diagnosis, a family functional formulation (FFF) is a hypothesis open to review and change during treatment (Landini, 2014).

Rather than looking at symptoms or behaviour, DMM assessments focus on information processing (in mind and body). Using a CAPA assessment, intervention could be planned using the following steps These are no more than suggestions until empirical evidence for their effectiveness becomes available:

Affect regulation Where trauma is written in the body (any one of Dp, INAs, ESS or hypervigilance) this should be treated first using a somatic intervention aimed at helping the child co-regulate their arousal, ideally with attachment figures. With are currently co-evaluating Breathnach's Just Right State Programme (Bhreathnach, 2025b). Clinical experience indicates dance and music therapy may prove effective.

Unresolved loss and trauma Where trauma is at a representational level a wide range of psychotherapies that use spoken language and/or symbolic communication should be useful. Gil gives useful pointers to changes in therapeutic technique for dynamic post traumatic play and for toxic play (Gil, 2017). DT does not get better on its own and what seems essential is that the therapy makes explicit reference to the child's lived experience. Children's CAPA stories frequently contain episodes and fragments of episodes based on reality together with themes across stories and these can be very useful in treatment. Occasionally children will make a disclosure of abuse, during or after the CAPA, that necessitates a child protection enquiry.

Attachment strategy Attachment strategies are just that – strategic. Attempting to change a child's self-protective strategy without first eliminating the dangers it is responding to can cause actual harm. Changing attachment is anyway hard, and likely hardest during developmental 'latency' in the school years. In the MB study the main change over two years was from A+ to A/C as children adapted to a mode complex environment; they were in residential care but still had contact with foster or birth families. If the CAPA and clinical history indicate the child is suffers no major traumatic disturbance then attempting to treat their attachment strategy alone may be unnecessary. That said the following observations may prove helpful.

Type C+ is much more resistant to change than A+ (Farnfield & Onions, 2025) and there are many pitfalls awaiting the therapist working with children and young people who use this pattern. First there is a risk of collusion. The C+ patterns split cognitive and affective information, and people, into positive and negative. When the therapist challenges the negative the child will react, and the therapist may be tempted to back down and conform with the child's world view. Children, and adults, using C+ have endless episodes to delight their therapists, many depicting the self as victim. While some of it is true, the C+ mindset is to use victim hood to justify attacks on, or elicit rescue from, other people. Children using C5/7 mistrust adults and see danger in genuine overtures of comfort. As with adult Borderline Personality Disorder patients, a secure base approach, common to most therapies, may actually make the child more anxious and suspicious (Bateman & Fonagy, 2006). Somehow the therapist has to gain the trust of the child and then try and help the child achieve empathy with others. This is no mean task. The good news is that people using a C strategy are intensely interested in relationships.

The A+ pattern is cognitive so CBT is likely the wrong therapy for this pattern; certainly attending to cause and effect (something the child using A+ is good at) may only increase their already strong sense of self blame. Any therapeutic modality that enables the child to find a true self is recommended for trial. The trap for the therapist is that the child is eager to please and may borrow the therapist's perspective to wear as another layer of a false self. Experience indicates the A8 pattern is responsive to non-directive play therapy.

The following brief case study illustrates how the CAPA can be used in formulation. An extensive child abuse case study is by Crittenden and Poggioli (2011).

We will call this boy Harry. He is 10 years old. Because any history or background information can bias coding, all the coder knew was Harry's age and that he was male; for DMM Good Practice see Crittenden et al. (2013).

Here is an abbreviated summary of Harry's CAPA coding.

Relationship with Interviewer

Harry finds the procedure hard. He is genuinely struggling (A+) not refusing, as in C+. He doesn't want to do the stories but he does the best he can; a sign of compliant A+. In repose he is sad.

Arousal

His arousal drops steadily as the exercise goes on. He does not show the up and down wave of a regulated A+ strategy so this suggests depression.

Social Engagement Signals

A lovely smile to his brother who is in the waiting room and a few laughs with the interviewer, but at crucial points Harry makes no eye contact and is emotionally flat when talking about positive things – e.g. the reunion with parents. At one point he smiles when describing how the father doll hits the child – false positive affect (A+).

Discourse

A4 with one example of A5.

Mentalising

The accuracy of depression – Harry can name intense feeling states like "scared" but can produce nothing in his stories to alleviate them.

Trauma

A running theme of loss of family. Is Harry in foster care? At this point we do not know. There is one scene where the father repeatedly hits the child. This has elements of stuck play.

Modifiers – Affect Regulation

Depression; flat affect, and his stories end in futility. At the start Harry makes a two fingered V sign at the camera when the interviewer is not looking – an ina.

ESS – sniffing that gets more pronounced as the procedure unfolds.

Coding: Depression, Unresolved loss of his family, possibly Unresolved trauma physical abuse, A4 INA (anger) ESS sniffing

Note that the possibility of physical abuse does not mean the CAPA can be used in evidence against Harry's father. As noted above, this is not a forensic assessment procedure.

The coder then had a meeting with the referrer's: Harry's social worker and psychologist. Harry is the youngest of five children. His parents were together but have now separated. There is a long history of alcohol abuse and domestic violence. Harry recently went to school with bruises on his back and pinch marks on his arms but would not say who did this to him. The child protection authority have referred the family to a specialist Family Drug and Alcohol Court. Harry is in foster care with one of his brothers.

Ideally Harry and his family might benefit from:

- Direct therapy to try and help him shift the trauma (INA ESS) from his body to a more conscious position where by he can share it with the therapist. Trauma needs to be dealt with directly and explicitly.
- In parallel, work with his parents on their relationship, parenting and needs of their children followed by parent-child intervention such as filial therapy (van Fleet, 2005) Theraplay (Booth & Jernberg, 2010).

Unfortunately the prognosis for rehabilitation is not good. Harry's mother has been diagnosed with depression and is living with her mother. A DMM-AAI with his father indicates his mentalising is low and his pattern is C7. Father has a history of 'false imprisonment' (locking previous female partners in his cellar) and Harry's mother says he strangled her to point she wet herself.

Harry has "a long history of challenging behaviour" and is now excluded from school. The psychologist assessed him for ADHD but did not think Harry met the criteria. Looking at his CAPA and the family history, Harry is suffering from DT locked in his body with somatic expression and outbursts of rage he cannot control. Harry really would like to be liked and to conform to the rules (he uses A+) but his body won't let him and his mind is so full of horrible things he can't think straight.

The professional team discussed setting up a compensatory relationships for Harry starting with play therapy; this was not the first therapy of choice in an ideal world but the easiest to access. They then put together the following programme:

- Psycho education – a short course teaching Harry how fear without relief produces sensations in his body and sometimes his mind.
- SAI informed intervention with Harry and his foster father (Bhreathnach, 2025a), with whom he was developing a positive relationship, to help Harry manage states of unbearably high or low arousal.
- Psycho-therapy aimed at his specific experience of trauma.

After eight months work Harry was better able to regulate his feelings and to talk about physical abuse from his father whom he still idealised. Neither of his parents would engage with therapeutic work and his social worker was working towards Harry living with his maternal grandmother and mother. There are tens of thousands of children like Harry in every country.

Conclusion

The CAPA can be used where clinical history and screening, using a questionnaires, indicate a more in depth assessment of developmental trauma may be useful. Of the available systems for analysing the NSSP, it, arguably, provides the most comprehensive portrait of an individual child in terms of attachment, representational and somatic forms of trauma. In all cases a full clinical assessment including then history of care and parent-child observation is essential.

Although it has been used in clinical practice for several decades the empirical base for the CAPA is still modest. Research by practitioners to evaluate the effectiveness of different therapies is crucial. An important next step is the see if observed states of physiologically arousal are accurate. For that we need studies using bio-physiological measures such as skin conductance and heart rate variability.

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Conflict of Interest

The author of this manuscript declares that there are no financial, personal, academic, or institutional conflicts of interest that could have influenced the conduct of this study, the data analysis, or the interpretation of the results.

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Revisión sistemática

Vínculos De Apego En Familias Homoparentales. Una Revisión Sistemática

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RESUMEN

La presente investigación tiene por objetivo realizar una revisión sistemática de la literatura sobre los vínculos de apego en familias homoparentales. Para ello, se aplicó la declaración PRISMA para la revisión sistemática en las bases de datos Redalyc, Scielo, DOAJ, Portal Regional en Salud de la Organización Panamericana de la Salud (OPS), Dialnet, Sciencedirect, PubMed y EBSCO relevando artículos científicos en español, inglés y portugués. También, se utilizó el método PICOS para la realización del cribado. Al encontrarse 7 investigaciones sobre la temática, se utilizaron todos los artículos hallados sin distinción del año de su publicación. Se excluyeron textos en francés, capítulos de libros y revisiones sistemáticas. Los resultados exhiben la necesidad de realizar investigaciones sobre el vínculo de apego en estas familias, ya que todos los artículos relevados, se centran en el estudio de los primeros cuidados, la seguridad emocional y la protección. Esto se debe a que la gran mayoría de las investigaciones sobre la temática son de tipo cualitativas, lo cual demuestra la importancia de realizar más investigaciones cuantitativas y poder medir la variable apego a través de instrumentos específicos que midan dicha variable.

Attachment Bonds in Homoparental Families. A Systematic Review

ABSTRACT

The objective of this research is to carry out a systematic review of the literature on attachment bonds in homoparental families. To this end, the PRISMA statement was applied for the systematic review in the databases Redalyc, Scielo, DOAJ, Regional Health Portal of the Pan American Health Organization (PAHO), Dialnet, Sciencedirect, PubMed and EBSCO, surveying scientific articles in Spanish. , English and Portuguese. Also, the PICOS method was used to perform screening. When 7 investigations were found on the topic, all the articles found were used without distinction of the year of their publication. Texts in French, book chapters and systematic reviews were excluded. The results show the need to carry out research on the attachment bond in these families, since all the articles surveyed focus on the study of first care, emotional security and protection. This is because the vast majority of research on the subject is qualitative, which demonstrates the importance of conducting more quantitative research and being able to measure the attachment variable through specific instruments that measure said variable.

Keywords:
Attachment
Homoparental families
Systematic review

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A lo largo de la historia, tanto hombres gays como mujeres lesbianas han venido criando y educando a sus hijos e hijas, aunque estas familias han permanecido ocultas durante siglos por los grandes prejuicios que hay en torno a la homosexualidad (Montes et al., 2016).

Las familias llamadas homoparentales son aquellas formadas por dos progenitores del mismo sexo, gays o lesbianas y sus hijos o hijas. Este tipo de familias constituidas por padres gays y madres lesbianas con sus criaturas, a diferencia de otras, son las menos conocidas y aceptadas socialmente. La gran mayoría de estas familias está formada por parejas homosexuales con hijos o hijas nacidos dentro de una unión matrimonial heterosexual anterior. Esto se da mayormente en familias de lesbianas ya que las mujeres, suelen quedarse con la tenencia de sus hijos o hijas al separarse de sus parejas heterosexuales anteriores (González et al., 2004).

Camacho y Gagliesi (2013) sostienen que siempre existieron parejas de gays y lesbianas que tuvieron hijos, pero las formas de hacerlo eran diferentes a las actuales. Además, había menos visibilización de las mismas. Esto se debe, a la mayor aceptación de la comunidad LGBTIQA+ y a la militancia de estos grupos que han ido ganando derechos, lo que ha generado una disminución en el nivel de discriminación.

Actualmente, muchas de estas familias están teniendo a sus hijos/as por subrogación de vientres en el caso de padres gays, y en el caso de parejas de lesbianas se puede observar el nacimiento de sus hijos o hijas a través de técnicas de reproducción humana asistida. También, muchos gays y lesbianas eligen ser padres o madres por el proceso de adopción de menores (González et al., 2004).

Estas familias ponen en jaque los vínculos de parentesco tal como son definidos por Schneider (1968) donde un hombre y una mujer a través de relaciones sexuales dan origen a su descendencia generándose de este modo, vínculos de consanguineidad. Por lo cual, resulta pertinente observar cómo es el funcionamiento de estos primeros vínculos parento filiales dentro de estas familias.

Esta investigación tiene por finalidad indagar sobre los vínculos de apego en las constituciones familiares homoparentales. El primero en hablar del vínculo de apego fue Bowlby (2009) quien definió a la conducta de apego como cualquier forma de conducta que tiene como resultado lograr o conservar la cercanía con otro individuo manifiestamente identificado al que se considera mejor capacitado para enfrentarse al mundo. Este vínculo, comienza a consolidarse alrededor de los 6 meses a través de interacciones entre las figuras de apego y el bebé, así como también la protección y el confort que los cuidadores les proporcionan y la felicidad por parte de ellos para responder a sus demandas (Bowlby, 2012).

Milozzi (2018) sostiene que a partir de las relaciones tempranas con los cuidadores primarios emerge la mente del bebé y es a través de la interacción con ellos que se activarán los diversos centros funcionales innatos en el niño que irán configurando los distintos sistemas motivacionales, como afectividad, la cognición y la acción. La calidad de este primer vínculo, más las actitudes del cuidador y la consistencia en los cuidados, determinarán la salud mental o la psicopatología del niño que está todavía en desarrollo.

Investigaciones como la de Silverstein y Auerbach (1999) quienes han investigado con parejas de gays han llegado a la conclusión que ni las madres ni los padres son esenciales para el desarrollo infantil y que la paternidad responsable puede ocurrir dentro de una variedad de estructuras familiares. Refieren que lo único que necesitan los niños es al menos una persona responsable, una cuidadora o cuidador adulto que tenga un vínculo emocional positivo con ellos y con quien tengan una relación consistente. Han encontrado que la estabilidad del vínculo emocional y la predictibilidad de las relaciones de cuidado son variables significativas que predicen el ajuste infantil positivo.

En esta misma línea, Castaño et al. (2018) sostienen que la maternidad y paternidad en parejas del mismo sexo son similares a las maternidades y paternidades de parejas heterosexuales, su elección sexual no es determinante para la crianza de sus hijos. Incluso, pueden promover patrones saludables en la crianza del niño o niña.

Lebrón (2020) quien se preguntó si el hecho de tener una familia no tradicional afecta la capacidad de desarrollar un apego saludable, lo que puede ser un factor de riesgo para el surgimiento de psicopatologías, sostiene que la capacidad de desarrollar vínculos afectivos saludables no está condicionada por la composición familiar u orientación sexual de los padres, madres o cuidadores. Pero también, menciona que la personalidad o el estilo de apego de los cuidadores pueden tener un impacto significativo en el estilo de apego y personalidad de los niños y niñas.

En la Investigación realizada por Balma et al. (2023) sobre roles parentales y figuras de apego en niños y niñas criados por familias homoparentales se observa que hay diferencias significativas respecto a la constitución de la figura de apego en familias de varones y mujeres. En las familias formadas por dos varones se observa que el vínculo de apego del niño se consolida con el papá que desde un primer momento deja su vida laboral para ocuparse de la crianza en los primeros tiempos del niño. Esto genera que el niño recurra a él ante necesidades básicas. En cuanto al vínculo de apego cuando se trata de dos mujeres, se observa que el primer vínculo de apego se da con la mamá gestante ya que suele ser la encargada de la lactancia. Sin embargo, ambas intentan entablar un vínculo de lactancia sin lograrlo.

Dada la escasez de estudios sobre el apego en familias homoparentales es que surge el interés en realizar esta investigación.

Método

El presente estudio se realizó de acuerdo con los estándares de la declaración PRISMA, *Preferred Reporting Itemsfor Systematic reviews and Meta-Analyses* (Marmo et al., 2022; Hutton et al., 2016; Munive-Rojas y Gutiérrez-Garibay, 2015), siguiendo rigurosamente los protocolos de calidad para revisiones sistemáticas. Se cumplió con los ítems del método PRISMA, excluyendo aquellos relacionados con metaanálisis (ítems 5, 12-16, 19 y 22). Se garantizó la adherencia a los ítems 1-4, 6-11, 17-18, 20-21, 23, lo que aseguró una revisión sistemática exhaustiva y transparente.

Procedimiento

El objetivo de esta investigación fue realizar una revisión sistemática de la literatura sobre la constitución del vínculo de apego en niños criados por familias homoparentales. Para ello se utilizó el Método PRISMA. Los criterios de elegibilidad fueron que todas las investigaciones cumplieran con los criterios de PICOS es decir, debían tener población, intervenciones, comparaciones, resultados y diseño del estudio. Además, se seleccionaron todos

los textos sin restricción de años, en idioma: inglés, portugués y español. Quedaron por fuera textos en otros idiomas como el francés, capítulos de libros y revisiones sistemáticas. Las bases de datos utilizadas fueron: Scielo, Redalyc, DOAJ, Dialnet, El Portal Regional en Salud Organización Panamericana de la Salud (OPS), ScienceDirect, Pubmed y EBSCO.

Con el objetivo de reclutar aquellas publicaciones que fueran pertinentes para la búsqueda, los términos considerados inicialmente para la misma fueron: *"Apego"* AND *"homoparentalidad"* (ver figura 1). Estos términos y marcadores booleanos han permitido un mejor cribaje y afinamiento de la búsqueda y que aparecieran textos en inglés, español y portugués sobre la temática.

En todas las bases de datos se utilizaron los mismos descriptores de búsqueda, estos fueron: "*Apego"* AND *"homoparentalidad*". El primer buscador en el cual se realizó el cribaje fue Redalyc, donde se encontraron 85 artículos, de los cuales solo se seleccionaron 7 ya que 3 estaban repetidos dentro de esta misma base de datos, dos eran revisiones sistemáticas y el resto fue descartado por no tener relación con la temática o no cumplir con PICOS.

El segundo buscador fue Scielo donde no se encontraron artículos con los mismos descriptores de búsqueda. Lo mismo sucedió con los buscadores Dialnet, ScienceDirect, Pubmed y EBSCO.

En las bases de datos DOAJ y Portal Regional en salud de la Organización Panamericana de la salud (OPS), con los descriptores de búsqueda: "*apego*" AND "*homoparentalidad*" se encontró un artículo en cada una de estas bases de datos. Los dos artículos fueron utilizados en la siguiente revisión por cumplir con los criterios de inclusión. El proceso de búsqueda y selección se artículos se encuentra reflejado en la figura 1.

Resultados

Se desprende de esta investigación la escasez de artículos que mencionan específicamente la variable apego en sus objetivos generales (Tabla 1). De las investigaciones relevadas, el total de ellas muestra la predominancia de investigaciones cualitativas, de esto se puede inferir porque la variable apego no estaría desarrollada como tal. Generalmente no se explicita el término apego, no obstante, se lo menciona haciendo referencia a términos como cuidado, protección, seguridad emocional, vínculo familiar.

Discusión y Conclusiones

Se encontró que las investigaciones de Giraldo Aguirre (2015) así como también la realizada por Rodrigo y Rodrigo (2016) arriban a la conclusión que independientemente de cómo sea la estructura familiar y la orientación sexual de los padres, el papel principal de la familia sigue siendo el cuidado, la educación y la protección de los niños. Esto coincide con los aportes realizados por Castaño et al. (2018) y Lebron (2020).

Las investigaciones de Santos y Alves de Toledo Bruns (2006) sostienen que las personas homosexuales que forman una familia, viven diversas experiencias que a su vez son complejas ya que deben enfrentar discriminación y prejuicios, sin embrago, construyen relaciones solidas y amorosas con sus hijos. Estos últimos, forman vínculos afectivos con los miembros de la familia y otras personas de su círculo social. Por otro lado, Malagón y Salinas-Quiroz (2021) quienes trabajaron con un papá soltero gay, encontraron que el cuidador tuvo que adaptar su vida a las necesidades de la menor y se trabajó con la red social de apoyo percibida para que esté padre pueda seguir cumpliendo las funciones de proveedor y cuidado.

Figura 1
Diagrama de Flujo

Nota: El siguiente flujograma representa los textos que han quedado seleccionados dentro de la revisión sistemática

Tabla 1
Artículos Revisados

Título/ base de datos	Muestra	Instrumento	Resultados Relevantes
Homoparentalidad en cuestión: la voz de hombres gay y mujeres lesbianas con hijos. (Redalyc) Santos y Alves de Toledo Bruns Año: 2006	Este estudio se centra en las experiencias de nueve mujeres y cinco hombres homosexuales que han formado familias.	Entrevistas con el objetivo de comprender cómo viven la paternidad y maternidad, y los desafíos que enfrentan.	Los niños establecen lazos emocionales con los miembros de su familia y otras personas de su círculo social. La orientación sexual es un factor complejo influenciado por diversos factores biológicos, psicológicos y sociales. El prejuicio y la discriminación son obstáculos comunes para las familias homoparentales. A pesar de los desafíos, las familias homoparentales pueden ser igual de sólidas y amorosas que las familias heterosexuales. La falta de reconocimiento legal y social dificulta la vida de muchas parejas homosexuales y sus hijos. Los resultados muestran que las personas homosexuales enfrentan desafíos como el prejuicio, la discriminación y la falta de reconocimiento legal. Sin embargo, también construyen relaciones sólidas y amorosas, basadas en la igualdad y el respeto mutuo.
La experiencia de maternidad en una familia homoafetiva femenina. (Redalyc) Moraes Martínez y Barbieri Año: 2011	Una familia homoparental formada por dos mujeres y su hijo de 9 años.	Se realiza estudio de caso.	Se llega a la conclusión que la mujer que gesta y pare es la que se ocupa menos de los cuidados de crianza del niño. El cuidado del menor lo ejerce la no gestante ya que la madre biológica es la primera que sale a trabajar. Consideran este reparto de tareas natural porque además la madre gestante es la que tiene menos paciencia según ambas madres.
La adopción de niños por gays. (Redalyc) Lopes de Almeida Amazonas et al. Año: 2013	El estudio analiza la experiencia de tres hombres gays que adoptaron hijos. A pesar de las dificultades de acceso y el miedo a la estigmatización, los participantes comparten sus historias de adopción.	El estudio es cualitativo y utiliza entrevistas semi estructuradas.	El deseo de ser padre no está ligado exclusivamente a características masculinas o femeninas. La adopción por hombres homosexuales es una realidad y estos padres enfrentan desafíos y prejuicios, pero también encuentran gran satisfacción en sus familias. La paternidad se construye de forma individual y social, y no se limita a lazos biológicos. La sociedad y sus normas influyen significativamente en la experiencia de ser padre gay, tanto en relación a la aceptación como a la discriminación. El afecto es fundamental en la construcción de vínculos familiares. La conexión entre la identidad sexual del padre y su relación con el hijo: La aceptación de sí mismo es esencial para crear un ambiente seguro y abierto. Revelar la adopción a los hijos fortalece el vínculo de confianza. El amor y el cuidado son los pilares de las familias homoparentales.
La sexuación en hijos de hombres homoeróticos: análisis de un caso. (Portal Regional OPS) Bernal et al. Año: 2015	Se evalúa a una hija que es criada por dos padres homoeróticos. Se divide la sexualidad en cuatro momentos y se analizan en profundidad los dos primeros que tienen que ver con los primeros vínculos y el límite al goce incestuoso.	Análisis de un caso. Metodología cualitativa.	Los 4 momentos que analizan las autoras son: El primero de los padres sin Magalí desplegando sus individualidades y su sexualidad. Segundo momento cuando llega la niña y se marca esta diferencia entre ambos padres y entre niña y adultos. Se asigna sexo y genero por parte de los padres hacia Magalí. Tercer momento: socialización de la menor fuera de la familia. Aparece en ella la diferencia sexual. El cuarto y último momento es el de Magalí adolescente construyendo su propia sexualidad. Magalí ve a su padre Raúl como el que juega con ella, el que mira novelas y habla con la empleada domestica. Es decir lo instala más como la figura femenina, el que se ocupa de su crianza. Mientras que Eduardo era el proveedor económico. Magalí lleva dos apellidos: el primero es el de Eduardo, quien cumple una función paterna y el segundo el de Raúl quien cumple función de crianza o materna.
Prácticas de paternidad de algunos varones gais de Ciudad de México. Entre tabúes y nuevas apuestas para su ejercicio. (Redalyc) Giraldo Aguirre Año: 2015	Cuatro padres residentes en Ciudad de México. Orientación sexual: Todos se reconocen públicamente como gais y son activistas por la diversidad sexual. Situación familiar: Viven con sus hijos y algunos tienen pareja. Nivel socioeconómico: Pertenecen a sectores medios y tienen altos niveles de escolaridad. Forma de ser padres: Todos son padres adoptivos, excepto Lorenzo que tiene una hija biológica.	Entrevistas	Los padres homosexuales comparten muchas similitudes con otros padres en cuanto a cuidado, socialización y formación moral de sus hijos. Sin embargo, cuando se enfrentan al mundo exterior, surgen particularidades debido a su orientación sexual.

Título/ base de datos	Muestra	Instrumento	Resultados Relevantes
Publicidad, chicos, Familia, Educación. La publicidad como un homogeneizador cultural (Redalyc) Rodrigo y Rodrigo Año:2016	Aunque el artículo no menciona explícitamente las fuentes específicas de datos empíricos, es probable que hayan utilizado: Estadísticas sobre estructuras familiares, tendencias publicitarias y resultados educativos. Observaciones de familias y niños interactuando con la publicidad. En el hogar y en el contexto educativo.	Investigación secuencial que consta de seis fases. En la primera etapa, delimitación teórica. Identificación y descripción de las conexiones existentes entre las diferentes variables. Se examinó en profundidad los anuncios publicitarios que utilizan escenas familiares para promocionar productos o servicios. Se buscó identificar las estrategias comunicativas empleadas y su posible influencia en los niños y sus familias. En la siguiente fase se lleva a cabo una experiencia educativa utilizando la publicidad como herramienta didáctica. Entrevistas, grupos focales u observaciones de familias y niños interactuando con la publicidad.	El papel principal de la familia sigue siendo el cuidado, la protección y la educación de los niños. Esta función es inherente a todos los tipos de familia y a lo largo de la historia. Las necesidades básicas de los niños permanecen inalterables a lo largo del tiempo, ya que están arraigadas en la naturaleza humana. Estas necesidades son universales y trascienden los cambios sociales. Las relaciones interpersonales y la comunicación genuina siguen siendo fundamentales para el bienestar humano. La publicidad refleja la diversidad de modelos familiares existentes en la sociedad contemporánea y, al mismo tiempo, influye en la percepción de estos modelos. La publicidad puede ser utilizada como un recurso educativo, como se demostró en el estudio, donde se empleó una campaña publicitaria para analizar diferentes modelos familiares y valores. Los niños, la familia, la publicidad y la educación están estrechamente relacionados. La familia inicia el proceso de socialización, la educación formal continúa esta tarea y la publicidad ejerce una influencia informal.
Organización de la calidad del cuidado en una familia con un padre soltero y gay. (Portal DOAJ) Malagón y Salinas Quiroz. Año: 2021	Participó un padre, soltero por elección y gay, con un hijo de un año y nueve meses de edad	Entrevista semi estructurada. Se realiza análisis de discurso a través de categorías y sub categorías.	La investigación evaluó como se adaptó el adulto y modifico su vida social a las necesidades del menor. También, se trabajo con la red de apoyo social percibida, la cual era fundamental para que este padre pudiera salir a trabajar. Evaluó la capacidad de poner límites que tiene este padre. Se indagó sobre la significación de paternidad. La cual es definida por el entrevistado como soñada y feliz. Se evaluaron las necesidades y satisfacción del niño, las rutinas y estrategias, la emotividad, la iniciativa del niño y las respuestas del adulto. Se concluye que no hay diferencias entre la crianza entre un papá heterosexual y uno homosexual.

Nota: El siguiente cuadro esta ordenado por año en el cual fueron publicados los artículos

Estas dos investigaciones concuerdan con lo hallado por Silverstein y Auerbach (1999), quienes sostienen que no es necesaria la figura de un padre o una madre para el desarrollo del menor y que la paternidad responsable puede ocurrir dentro de una variedad de estructuras familiares. Solo se necesita que el menor tenga un vínculo afectivo positivo con un adulto responsable de su crianza y cuidado.

Bernal et al. (2015) realizan un estudio de caso en el cual se observa a una hija criada por dos padres varones. En la cual, uno de ellos toma un rol femenino de cuidado y crianza, mientras que el otro padre, toma el rol de proveedor del hogar. Esto se corrobora con la Investigación realizada por Balma et al. (2023) sobre roles parentales y figuras de apego en niños y niñas criados por familias homoparentales donde se evidencia que hay diferencias significativas respecto a la constitución de la figura de apego en familias de varones y mujeres. En las familias formadas por dos varones se observa que el vínculo de apego del niño se consolida con el papá que desde un primer momento deja su vida laboral para ocuparse de la crianza en los primeros tiempos del niño. Mientras que el otro padre toma el rol de proveedor económico el hogar.

El artículo de Moraes Martinez y Barbieri (2011) sostienen que quien gesta y pare en familias formadas por dos mujeres, la mujer que gesta y pare es la primera que sale al ámbito laboral, mientras que la otra continúa con las cuestiones relativas a la crianza del menor. Esto coincide con la investigación realizada por Balma et al. (2023).

En la investigación de Lopes de Almeida Amazonas et al. (2013) se menciona la adopción de varones homoparentales es difícil por el perjuicio y el estigma que estos padres deben atravesar, pero la aceptación de la homosexualidad hace que estos padres puedan crear un ambiente seguro y abierto para criar a sus hijos. Los autores concluyen que el amor y el cuidado son los pilares de las familias homoparentales. Esto se relaciona con lo conceptualizado por Camacho y Gagliesi (2013).

De todo lo expuesto, se puede inferir que independientemente de la orientación sexual de los cuidadores o padres y de la estructura familiar, siempre y cuando haya un cuidador que brinde seguridad, cuidado y afecto, se podrá criar a un hijo desde las bases seguras del apego (Bowlby, 2012).

Al respecto, Balma (2023) y Alizade (2012) plantean que las familias homoparentales vienen a desafiar el concepto de padre-madre tal como lo conocemos, ya que la idea de familia basada en mamá y papá como progenitores fue el modelo ideal de familia planteado por el psicoanálisis. Pero, función materna o paterna va más allá de la sexuación de las personas que ejerzan estos roles e implica pensar a la parentalidad independientemente de la genitalidad de quien ejerce esta función. Además, estas familias vienen a cuestionar y desafiar los vínculos por consanguineidad.

Para concluir, se puede evidenciar la escasez de investigaciones empíricas sobre la temática. Se observa que todas las investigaciones aquí relevadas son de tipo cualitativas, con excepción de una que poseía un diseño mixto. Sería interesante continuar haciendo

investigaciones cuantitativas con instrumentos que permitan indagar el apego en estas constituciones familiares que dejan por fuera los roles madre-padre y la consanguineidad.

Declaración

Los autores no recibieron apoyo económico o financiación para apoyar la investigación ni la autoría y/o publicación de este artículo. No hay interés económico o beneficio de la aplicación directa de esta investigación.

Declaración de autoría

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Conflicto de Intereses

Los autores de este manuscrito declaran que no existe ningún conflicto de interés financiero, personal, académico o institucional que pudiera haber influido en la realización de este estudio, el análisis de los datos o la interpretación de los resultados.

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Systematic review

Introduction to the Dynamic-Maturational Model of Attachment and Adaptation: A Function-Based Approach to Understanding Developmental Psychopathology

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ABSTRACT

This article introduces the Dynamic-Maturational Model (DMM) of attachment and adaptation (Crittenden, 2016; Crittenden, & Landini, 2011; Crittenden et al., 2021), a contemporary and well-researched model of attachment that is particularly relevant to practitioners who work with children, adults and families in social work, social care, mental health, child care, fostering and adoption, criminal justice and related settings. This article explains how attachment theory can inform our understanding of human behaviour in situations of stress, threat or danger, and how to understand individuals whose behaviour is problematic or who may become a danger to themselves or others.

Introducción al Modelo Dinámico-Maduracional del Apego y la Adaptación: un Enfoque Basado en Funciones para Comprender la Psicopatología del Desarrollo

Palabras clave:
Apego
Modelo dinámico-maduracional (DMM) de apego y adaptación
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RESUMEN

Este artículo presenta el Modelo Dinámico-Maduracional (DMM) de apego y adaptación (Crittenden, 2016; Crittenden y Landini, 2011; Crittenden et al., 2021), un modelo contemporáneo y bien investigado de apego que es particularmente relevante para los profesionales que trabajan con niños, adultos y familias en trabajo social, asistencia social, salud mental, cuidado infantil, acogida y adopción, justicia penal y entornos relacionados. Este artículo explica cómo la teoría del apego puede informar nuestra comprensión del comportamiento humano en situaciones de estrés, amenaza o peligro, y cómo comprender a las personas cuyo comportamiento es problemático o que pueden convertirse en un peligro para sí mismas o para los demás.

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Attachment and Human Development

Attachment theory provides a model for understanding the self-protective strategies we use throughout our lifespan to survive and maintain a sense of safety. Early empirical research in the field of attachment focused primarily on how early experiences of care – including problematic or harmful care – influence the development of our strategies for gaining protection and comfort (Ainsworth, 1985; Ainsworth & Bowlby, 1991; Ainsworth et al., 1978; Bowlby, 1995, 2000; Crittenden et al., 2014; Landini et al., 2015). More recent research has shown that attachment strategies are important and relevant across the whole of the lifespan and in all human societies (Allam & Baim, 2017; Crittenden et al., 2021; Dallos & Vetere, 2021; Howe, 2011a, 2011b; Landa & Duschinsky, 2013a). Attachment theory is therefore just as important for understanding adult attachment as it is for understanding children's.

Attachment theory has a lot to offer professionals who work with children, adults and families who are under stress, in crisis or behave in ways that are problematic or unsafe. By looking at a client's history, carefully listening to the ways in which they talk about their lives and their struggles, and assessing their current strategies of self-protection (that is, their attachment strategies), professionals can make more accurate assessments and formulate plans that are more likely to help people make needed changes and access support (Crittenden & Spieker, 2023; Crittenden et al., 2024; Spieker et al., 2021).

Understanding attachment patterns can also help practitioners to more readily identify the behaviour patterns that the client uses to maintain safety and comfort and which also, in some cases, serve to keep the client stuck in behaviour that no longer serves them as adults. The task is then to help the person understand when and how they are using the strategy, and to help them to develop other strategies more suited to their current situation (Baim & Guthrie, 2014).

Through careful and empathic listening, the worker may help the client to look at their story with new hope and determination. This is powerful and transformative work. Such an approach means that workers can improve the quality of the helping relationship and improve outcomes for vulnerable adults, children and families. It is an approach that makes personalisation, choice and control a more realistic hope for many people.

Attachment and Basic Survival Strategies

From birth, human infants (and most other mammals) display a range of instinctive behaviours to signal when they are afraid, hungry, tired, cold, hot, in pain or otherwise unsettled. When distressed, the infant will instinctively cry, cling and reach out towards the (hopefully) protective person, that is, an attachment figure. These actions attempt to meet four basic survival needs:

- Faced with perceived *danger*, we seek *safety*.
- Faced with perceived *distress*, we seek *comfort*.
- Faced with perceived *isolation*, we seek *proximity* to our attachment figure(s).
- Faced with perceived *chaos,* including internal chaos, we seek *predictability*, that is, what is familiar to us.

Thus, the term *attachment* refers to several related processes: staying *safe*, seeking *comfort*, regulating *proximity* in relation to attachment figures, and seeking *predictability* (Crittenden, 2016).

The strategies that an infant learns to use with their attachment figures arise from their instinct to adapt, which is as important as their instinct to attach. Seen in this way, we can see that patterns of attachment develop within the context of thousands of everyday interactions between the infant and their attachment figure(s). The attachment behaviour of the infant is their best solution for obtaining the protection and comfort they need, from the particular attachment figure(s) they depend on.

The process is personal, interpersonal and adaptive; the ways in which the attachment figure does or does not respond to the infant's signals of distress will create the early template for how the infant learns to recognise and regulate their emotions and interact with their attachment figures (Howe, 2005; Gerhardt, 2004; Fonagy, 2001). These early experiences and patterns of response typically become deeply embedded within the neural pathways of the brain and the central nervous system (Eagleman, 2016; Siegel, 1999; van der Kolk, 2014; Panksepp, 2005; Perry, 2008). This is why our early attachment patterns impact so profoundly on our later abilities to regulate our emotions within the context of relationships, particularly intimate and sexual relationships.

In adulthood, we may use the same self-protective strategies that we used as children. This can help us to understand why, for example, an adult being abused in a relationship may not realise they are being harmed; they may not see the abuse as harmful, and indeed they may even find some safety in the predictability of the violence or abuse. If the situation is predictable, at least they can organise a strategy to survive within it – a strategy that has kept them alive so far.

The Dynamic-Maturational Model

Crittenden (2016), a former doctoral student of Mary Ainsworth, has developed a range of attachment assessments that apply across the lifespan. This has led to her development of the Dynamic-Maturational Model of attachment and adaptation (DMM), a name that reflects the dynamic and developing potential of adaptive strategies within each person, across their lifespan (Crittenden & Baim, 2017; Crittenden & Landini, 2011; Crittenden et al., 2021b; Farnfield et al., 2010).

The DMM deliberately avoids using clinical categories or labels. Instead, the DMM considers attachment strategies as serving a crucial survival function in their original time and context and considers these strategies on a continuum of attachment security. In this way, the DMM can be seen as a strengths-based, non-labelling and non-pathologising model. It does not focus on symptom-based diagnoses but instead concentrates on *understanding* the function and meaning of human behaviour. Based on the DMM's rigorous empirical support and scientific validity (Crittenden et al., 2021c), it is likely to play an expanding role in our understanding of human development and psychopathology. The DMM is taught internationally, including in the UK and Ireland, and has been validated in a wide range of studies and described in more than 500 publications. The research continues in more than 20 countries with many different populations.

Typically, those who face serious and chronic dangers in childhood and are unprotected and uncomforted must adapt their mental processing and behavioural responses to cope with such

dangers (Crittenden and Landini, 2011; Crittenden, 2002; Dallos et al, 2020; de Zulueta, 1993; Schore, 2003). The DMM stresses that the strategies, when first developed in childhood, were adaptive in that they promoted the child's survival at that time. It is only later that the use of these same strategies may become maladaptive, that is, used out of their original context.

For example, a child who compulsively complies with the demands of an abusive parent is simply doing their best to survive; the compulsively compliant strategy is keeping them alive. However, if they still use a compulsively compliant strategy in adult relationships, they can easily fall into relationships where they are exploited, victimised or otherwise abused, and they may have no strategies for escape or even an awareness that things could be different for them.

This is crucial to our understanding of psychological disturbance: The very same strategy that is adaptive in infancy, childhood or adolescence may be maladaptive later in life. This is a key insight from attachment theory, and it reminds us that as practitioners we must never have in mind that we are 'treating' a strategy. Instead, we recognise the value of that strategy in keeping the person alive when they faced significant dangers, and we help them avoid over-applying that strategy while at the same time helping them to *add to their repertoire of strategies* (Baim & Morrison, 2023; Cozolino, 2002; van der Kolk, 2014).

Space does not allow a full account of the DMM in this guide. See Crittenden and Landini (2011) for a detailed explanation. There are a range of validated tools for the assessment of attachment for different age groups. The adult attachment interview (AAI) is the most relevant for working with adults (George et al., 1996; Main et al., 2008; Steele & Steele, 2008).

Attachment and Adaptation: the A, B and C Patterns

Readers may be familiar with attachment terminology such as *avoidant/dismissing, secure/autonomous,* or *coercive/ambivalent* to describe attachment strategies. Rather than using these terms, this article instead offers the terminology A, B and C to describe the patterns. These are the original letter names given by Mary Ainsworth, with the advice of Bowlby (Crittenden & Claussen, 2000). The category labelled by some authors as *disorganised* is, in the DMM, conceptualised as a combination of A and C patterns and, potentially, a complex and multivalent attempt to cope with unresolved trauma and loss. Regarding the term 'disorganised attachment', this is a construct which has now undergone a definitive reworking by the originators of the term in response to 30 years of misunderstanding and misapplication of the concept (Main & Solomon, 1990; Granqvist et al., 2017).

Ainsworth, a USA-based psychologist who collaborated closely with John Bowlby, was the first to identify the A, B and C patterns in babies and infants (Crittenden & Ainsworth, 1989). She did this through her field work in Uganda and through her research using the 'strange situation procedure', the first empirical measure of attachment in humans. In the procedure, which involves a series of timed separations and reunions between mother and baby, Ainsworth observed three patterns of response:

- Some infants, when their mothers departed and returned, did not display distress (the A pattern).
- Some infants became upset when their mother left the room, and when she returned, they settled down when she comforted them (the B pattern).
- Some infants became highly distressed when their mother left the room and found it very difficult to settle when she returned, despite their mother's efforts to comfort them (the C pattern).

Ainsworth's study (Ainsworth et al., 1978) included observations of the parent-infant dyads over the course of the year prior to the strange situation procedure. This allowed the researchers to integrate their observations in the experimental situation with their observations of patterns of interaction between parent and infant during the previous year. This milestone research offered a rich seam of evidence supporting our understanding of how and why the A, B and C patterns are formed.

Integrating the work of Ainsworth, Bowlby and Crittenden, the following three sections explain the early life experiences that influence the development of the A, B and C strategies, and how the childhood strategies may further develop in adulthood. We begin with the B strategy, which balances thoughts and feelings.

Development of the 'B' Strategy

Two critical factors have a decisive influence on the development of a baby's self-protective strategies (that is, their attachment strategies): *predictability* and *attunement* of care.

- *Predictability* is important because it allows the baby to learn basic routines by making cause-and-effect links, for example, "If I cry, something happens that helps me to feel better."
- *Attunement* is important because an attuned response is an accurate response; it will tend to lessen the baby's distress and make it feel safe, comfortable, fed, rested, etc.

If, when a baby cries out, it receives a response that is both *predictable* and *attuned,* it will learn that its thoughts and feelings have equal self-protective value. The baby learns that information *inside its body* – physical feelings of hunger, tiredness, pain, hot and cold, boredom – have important self-protective value, because if the baby connects with its feelings and expresses them in the form of a cry, it will be helped to feel better by its predictably protective and responsive attachment figure.

Similarly, a baby learns that information *outside the body* – that is to say, their perception of their environment and cause-and-effect links such as 'if I cry, someone helps me feel better' - has equal self-protective value. Babies are capable from birth of learning such cause-and-effect links, through the processes of basic reinforcement of behavioural routines.

If the baby is growing up with attachment figures who offer predictable responses, and if these responses are attuned and responsive to the baby's needs, the baby will learn to value equally these two sources of information – the only two sources of information they have access to: the information inside and the information outside their body.

This will typically lead to the development of a 'B' attachment strategy in close relationships, that is, a strategy that *balances* thoughts (cognition) and feelings (affect). As this person approaches adulthood, they will be well prepared to give and receive care in an integrated way that satisfies both them and other people, including their children if they become a parent. This person is able to reflect

on and balance their own thoughts, feelings, abilities and goals with those of other people and adjust their behaviour accordingly, trusting that other people can respond to their expressed needs (Gerhardt, 2004).

Development of the 'A' Strategy

If, by contrast, the attachment figure's response to the baby's signals is *predictable* but *not attuned*, the baby is likely to develop a markedly different attachment strategy – the 'A' strategy.

When it cries, this baby may be consistently ignored, rebuffed, criticised or handled brusquely or ineptly. In severe cases of maltreatment, the baby may be screamed at or physically harmed. The common factor is not the severity of the discomforting response, but how predictable the response is.

In such circumstances, where the danger of being made to feel worse is predictable, the baby will soon learn to limit its tears, anger or clinginess, because such displays consistently increase its distress. It learns, 'when I feel bad, no one helps, and when I cry I feel worse'. As it grows, the child learns that thinking – in particular, thinking about cause and effect – is critical to survival. This child becomes *cognitively organised*, meaning it relies on its thoughts and distrusts/cuts off from its feelings. The child knows that thinking is what protects it, and to display fear, anger, sadness or the need for comfort puts it in danger or makes it feel worse.

The emphasis on cause and effect consequences may lead this child to develop ways of thinking and behaving that prioritise the outer world and discount inner experience. At the milder end of the continuum, which is normative in safe contexts, the A strategy may take the form of people-pleasing (being a 'good boy' or a 'good girl'), an emotional 'stiff upper lip,' or high academic and professional achievement.

Moving to the more concerning part of the continuum, a person developing an A strategy may also develop compulsive care-giving behaviours, putting the other person first. As an adult, if they have children and/or form relationships, they may become intolerant or abusive when faced with tears, clinginess, fear or anger in their own children or partner, because such displays have proved to have such negative consequences for them in the past.

Further still along the continuum, they may become highly controlling and even punishingly dominant as a way of regulating relationships to stay at a correct distance. Alternatively, they may become socially isolated, because human contact has proved to be so troubling and predictably damaging. In some circumstances, this can translate into superficial social promiscuity, where the person seems to have a wide circle of social contacts, but these contacts are kept superficial for reasons of self-protection. In some people, this social promiscuity can translate into sexual promiscuity, again following the pattern of achieving some level of human contact but at an emotional distance, where feelings are protected by the superficiality of the encounter.

People with extreme 'A' strategies may also experience psychotic episodes (for example, delusions or hallucinations that are either highly critical of them or which provide comfort and predictability) or sudden and uncharacteristic emotional outbursts, sometimes known as 'intrusions of "forbidden" negative affect'. The analogy might be that of a pressure cooker lid: the A strategy keeps the lid on powerful emotions, until the pressure is too great, and the lid explodes.

Sudden outbursts of emotion can include panic attacks (runaway fear); violence (explosive anger); convulsive and inconsolable sobbing; or sexual acting out (inappropriate, problematic or abusive comfort seeking).

In such circumstances, adults using such extreme 'A' strategies often find that their troubled thinking and problematic behaviour lead them into contact with mental health services, where they may be diagnosed with conditions such as psychotic illness, anxiety disorder or a personality disorder.

Development of the 'C' Strategy

The 'C' pattern develops when the infant experiences unpredictable and inconsistently attuned care from their attachment figure(s). The parent/carer sometimes responds sensitively, and sometimes not, sometimes too soon and sometimes too late. There are many reasons why a carer may be unpredictable, from mild distractibility, busyness with other tasks or looking after the baby's siblings, to – much more dangerously – serious substance misuse, domestic violence, unresolved trauma or mental illness.

The unpredictable parental response is very confusing for the baby, as it is not able to predict a causal link between crying and receiving care and attention. Its crying and other attachment displays sometimes means it receives the care and attention it needs, and sometimes not. But the baby can't predict when and how its attachment figure will respond. This baby is likely to learn that crying, when *exaggerated*, is more likely to get results, because the exaggerated display is difficult to ignore and is more likely to gain a parental response.

Consequently, the baby's tears become exaggerated, its anger becomes a temper tantrum, its sadness is inconsolable, its need for comfort is expressed in clinginess and displays of helplessness. As the child grows older, it may act out in any way that gains its unpredictable attachment figure's attention. This can include behaviour that is very harmful to the child or to other people. This could include extreme risk-taking in order to garner protection from their attachment figure. This behaviour confuses the attachment figure, who may be unaware that their inconsistency worsens the child's distressed and distressing behaviour.

When the C pattern is firmly established, typically by toddlerhood, both parent and child may together descend into a downward spiral of anguished struggle.

The child developing a C strategy learns that it is pointless to try to see the other person's point of view because other people's minds cannot be predicted. The child learns to stay firmly in its own perspective. It also learns that cause-and-effect contingencies have little value. This is because the child has grown up in an unpredictable environment, where cause and effect cannot be predicted in the normal way, without the added ingredient of heightened emotional expression.

Moreover, the child learns that to truly get its needs met and the attention it craves, it must not only gain the parent's attention, but must hold it. When the parent finally does respond, the child must continually change direction and create problem after problem, in order to keep the attachment figure engaged in an ongoing, everlasting sequence of unsolvable problems.

This is the essence of the C pattern, which is two-fold: first, *exaggerate* my genuine feelings of sadness, fear, anger or needing

comfort, and then, when I have my attachment figure's attention, *keep changing the problem*.

If an adult using a prominent C strategy comes to the attention of social services, they may have a wide range of presenting problems. In the mild part of the continuum, this person may appear overwhelmed by feelings of sadness, fear, helplessness or anger.

Where the C pattern is in a more extreme form, the person may feel either intimidating or menacing to the professional or, with their expression of vulnerability, invite rescue from the professional.

People using a C strategy may also have previously been given one or more diagnoses such as pathological jealousy or a personality disorder such as borderline, emotionally unstable or anti-social.

In the most extreme cases, where their emotions of anger and fear are running rampant and unchecked, people may develop delusional beliefs about themselves as being all-powerful (which may include thoughts about wanting to wreak angry revenge on people who have done them wrong) or relentlessly persecuted by powerful and deceptive people (paranoid and fear-driven beliefs such as 'they are all out to get me/there is danger everywhere').

Discussion

As mentioned, Crittenden (2016) pays particular attention to the way in which attachment strategies become more complex in line with the child's development and as they negotiate stage-specific tasks such as going to school, forming friendships, puberty, and so on. The DMM is an evolving, evidence-based model of attachment and adaptation that offers a step-change in our understanding of attachment and an alternative way of conceptualising psychological and emotional difficulties from a function-based (as opposed to a symptom-based), biopsychosocial perspective (Crittenden & Landini, 2011; Thompson & Raikes, 2003; Crittenden et al., 2021a, 2021c, Landa & Duschinsky, 2013b).

In describing the DMM, it is important to first point out that the DMM is distinctive in that it focuses on all the attachment strategies as potential *strengths*, not as disorders or dysfunctions (Baim & Morrison, 2023). To expand on this point, the DMM is a strengths-based, non-pathologising and non-labelling model, wholly suited to the emerging emphasis in the psychological treatment literature on strength, growth, flexibility, adaptation, positive life goals, prosocial living, positive psychology, social capital, post-traumatic growth, personal development and adaptation, and co-production of assessment and therapy between therapist and client. This contrasts with other approaches that focus on disorder, dysfunction, destructiveness, weakness, illness, labels, risk, problematic thinking, and symptom-based diagnoses. As such, the DMM is a theory that is very much a part of the broad paradigm shift taking place within the psychological and psychiatric research and treatment towards an emphasis on biopsychosocial functions (including systemic/contextual factors), rather than diagnoses based on symptoms and seeing individuals in isolation (Dallos, 2006; Dallos & Vetere, 2021; Engel, 1979; Johnstone & Boyle, 2018; Maté, 2019; McGoldrick et al., 1999 ;van der Kolk, 1996; Wallin, 2007). The DMM also fits well with the increasing adoption of trauma-informed approaches within health, education, criminal justice and social care settings.

The DMM offers a model of attachment across the lifespan that addresses the developmental processes and clinical applications described by Bowlby (1971) and Ainsworth (1978). The DMM began in Ainsworth's laboratory with two samples of maltreating families with infants and young children (Ainsworth et al, 1978; Crittenden & Ainsworth, 1989) and expanded to a life-span theory of adaptation and treatment of maladaptation (Crittenden, 2016; Crittenden et al., 2014; Landini et al., 2015). As such, the DMM is highly relevant to professionals who work with families. In the DMM, the patterns of attachment provide a description of interpersonal behaviour as a well as a system for diagnosing psychopathology that is focused on the *function* of behaviour rather than the surface appearance of the behaviour (the symptom). It is unlike other theories of psychopathology in that its perspective began with infancy studies and progressed forward developmentally, rather than beginning in adult disorder and attempting to reconstruct the developmental precursors of disorder (Crittenden & Baim, 2017). The DMM represents a comprehensive integration of existing ideas and research findings into interventions that work. One of the standout features of the DMM is how open it is to revision and change suggested by different critical perspectives and emerging empirical research.

It will be useful for the reader to understand that there are two main branches of attachment theory, both derived from primary research done with Mary Ainsworth, the creator of the Strange Situation Procedure, the first scientifically researched empirical assessment of attachment. One branch of attachment theory has been termed the 'ABC + D' model, or the Berkeley model, (Landa & Duschinsky, 2013a, 2013b; Duschinsky et al., 2021) which includes the concept of 'disorganisation' (D) – a construct which has, as mentioned earlier, recently undergone a definitive reworking by the originators of the term (Granqvist et al., 2017). The DMM is the other major branch of attachment theory and is the model we use in this book. Readers may be familiar with attachment terminology such as *dismissing attachment style, balanced/secure,* and *preoccupied/ ambivalent*. The DMM instead uses the letters *A, B,* and *C* to stand for the attachment patterns. As described earlier, these are the original letter names suggested by Bowlby to offer a neutral, non-stigmatising label to the three patterns (Claussen et al., 2002).

Based on the DMM's rigorous empirical support and scientific validity (Crittenden, Spieker and Farnfield, 2021c), it is likely to play an expanding role in the scientific understanding of human development and psychopathology. The DMM is taught internationally and has been validated in a wide range of studies and described in more than 500 publications (International Association for the Study of Attachment-IASA, 2024). The research continues in more than 20 countries with many different populations. Notably, the DMM is a core theoretical model (along with compassion-focused and trauma-informed approaches) referenced in the recent *Power, Threat and Meaning* (PTM) framework published by the British Psychological Society (Johnstone & Boyle, 2018; Boyle & Johnstone, 2020). This landmark publication describes a paradigm-shifting approach which has far-reaching implications for the whole field of psychological assessment, formulation, and intervention. The DMM integrates ideas from evolutionary biology, psychoanalytical theory, cognitive neuroscience, social ecology, Gestalt Theory, person-centred therapy, and many other forms of psychotherapy. Systemic family therapy is one of the more prominent modalities integrated with the DMM.

In the DMM, attachment is conceptualised as a bio-psycho-social

theory about how we organise to protect ourselves from danger. Put another way, in DMM terms, attachment is an *interpersonal* strategy to respond to threat or danger which reflects an *intrapersonal* strategy for processing information. Notice from this DMM definition of attachment how important the interpersonal aspect of attachment is. Using this definition of attachment, we see that our attachment strategies don't just sit within us; instead, they emerge within the interpersonal context. What this means is that a person's attachment strategies are contextual; the strategy used may vary depending on the context and the person. This is a crucial distinction, because other attachment theorists will tend to ascribe the strategy to the person, rather than to the person-in-context.

Furthermore, in contrast to earlier assumptions that our attachment strategies are fixed or 'set in stone' by age three or four, empirical research in the past forty years points to the notion of neuroplasticity and that our brains can make highly significant changes and learn new patterns across the lifespan (Barrett, 2017; Cozolino, 2002, Eagleman, 2020). Applying the notion of neuroplasticity to the concept of attachment, research in psychotherapy outcome studies gives us confidence and hope that attachment strategies can be adapted, changed, and made more flexible across the lifespan.

It is important to remember that the A and C patterns are, in their milder forms, normative in situations of safety. However, among clinical and especially referred populations, it is most common to see the concerning and endangering aspects of type A and C strategies. In other words, the extreme forms of the A and C strategies are also normative, but in contexts in which there is danger of a *predictable* (A strategy) or *unpredictable* (C strategy) type. The way in which the DMM describes the increased complexity of the Type A and C strategies amongst populations exposed to greater risks and increased danger, as described above, is particularly helpful. By depicting these strategies along a continuum from normative to endangering, the DMM gets beyond the secure versus insecure debate and focuses to a much greater degree on understanding strategies as adaptive to contexts.

The context is important when we consider what is 'normative' (i.e. 'normal' or typical) in each cultural, social, or political context. 'Normal' strategies in a relatively safe, open society will be very different from 'normal' strategies during dictatorship, war, civil crisis, occupation by foreign powers, or other severe and chronic dangers faced by large populations. Translated to the home environment, we can see that 'normal' behaviour may take on a very wide range of presentations, depending on the types of danger the family members currently face or have faced in the past. One important implication of this approach is how we conceptualise so-called 'personality disorders,' the definition of which partly depends on what is considered 'normal' behaviour in each society. We need to work with an understanding of how many diagnoses are dependent on cultural and social definitions of what 'abnormal' thinking and behaviour is. This becomes even more crucial when one is working with immigrant populations who may have faced grave dangers in their countries of origin, and who may struggle to adapt to new (and hopefully safer) cultural contexts after arrival in the new country. If they are still adapted to the old dangers, when the dangers are no longer present, their strategies can be misinterpreted and misunderstood unless the professionals include a thorough assessment of how the person's strategies once served a useful function in their previous cultural context.

As we move to the more extreme strategies, the likelihood increases that at some point in the person's life, they will need help from professional services because they are likely to struggle with unresolved trauma, loss, or depression, or to pose a danger to themselves or other people. At the extremes of adaptation, it is likely that the person will need intensive support and possibly institutional help or containment for short or long periods of time. This is not always the case, because much depends on the person's access to social supports, helpful family members, friendship networks, and other resources (including inner resources). It also depends on how extreme their strategy is, how inflexibly it is used, and whether the person can use other strategies when needed. Given the large numbers of factors, DMM assessments are highly individualised; they do not use broad diagnostic labels such as 'borderline,' 'OCD,' or 'PTSD,' but instead offer individualised classifications, reflective of each person's strategies in their developmental context.

Another advantage of the DMM is its emphasis on adaptation and change, which reflects Bowlby's (1971 and 1995) commitment to a systemic view of relationships and the importance of context in understanding behaviour. The dynamic nature of the DMM also offers a hopeful message about the potential for change, particularly through containing and attuned relationships. One way of thinking about goals of psychological treatment in relation to the DMM would be to say that progress would be represented by 're-organising' the mind in the direction of the integrated 'B' pattern (even if one moves towards 'B' this would be progress, even if never fully organising a 'B' strategy).

Finally, it should be remembered that these more severe patterns may be considered strategic and adaptive in situations of danger, whether this arises from inter-personal factors, or national crisis such as war, forced migration, famine, disease, or natural disaster. This reflects Crittenden's (2016) central idea that attachment strategies are self-protective responses to a dangerous environment. Thus, all attachment behaviour can be considered purposeful or functional to the individual at the time it is first displayed, even if the same behaviour is later problematic or harmful to others (i.e. when it becomes maladaptive).

Typical Patterns Seen in Maltreated Children and Maltreating Parents

The full version of the DMM includes several additional features which give more complete detail about the sub-classifications of the A, B and C strategies and outlines in greater detail the ways in which information is transformed in the concerning and endangering parts of the model. Because maltreated children are essentially never securely attached and the use of these strategies increases maltreated children's safety and comfort, the DMM focuses more on 'adaptation' rather than security, as compared to other models of attachment.

What is particularly important to note about the DMM is that it allows for a highly flexible 'mixing' among the strategies, recognising that people and their strategies are complex and that many people will have blends of A and C strategies, some in a more integrated way than others. Indeed, the 'B' pattern itself is a mix of A and C strategies, but in an integrated way. The DMM model also incorporates an attachment-based conceptualisation of psychopathy (Baim, 2020).

Broadly speaking, there is a correlation between the age when the strategy was organised and the harm experienced in childhood.

Examples of age-salient dangers are separation/abandonment in early childhood; rejection, teasing, mocking, and bullying in middle childhood; and deception, betrayal, romantic rejection, and premature home leaving in adolescence. Endangered children are at risk for psychological problems (de Zulueta, 1993; Duschinsky & White, 2020; Gerhardt, 2004; Hertzman, 2013; Keyes et al., 2012; McLaughlin et al., 2012; Perry, 2008; Read et al., 2004). The most severe disturbances (e.g., eating disorders, personality disorders, the psychoses, and violent or sexual forms of criminality) typically develop in the transition to adulthood. These problems may require a series of age-salient threats to coalesce (Cicchetti & Valentino, 2015; Crittenden, 2016; Crittenden & Baim, 2017; Landini et al., 2015). By early adulthood, information can be utterly transformed: true and false, pleasure and pain, and safety and danger can become reversed in the person's mind. At such extremes, care or affection can be perceived as treacherous; this causes profound problems of trust in relationships — including therapeutic relationships. And in personal relationships, the confusion of pleasure and pain, safety and danger, true and false, can lead to behaviour in relationships and sexual encounters that is dangerous to the self and / or others.

Why the focus on danger rather than safety? For the answer, we can go directly back to the research and writings of John Bowlby, who combined his work as a psychiatrist, psychologist and psychoanalytically trained psychotherapist with studies of ethology and evolutionary theory (Duschinsky & White, 2020; Bowlby, 1971, 1980, 1995, 2000). Bowlby observed that in the broad scope of human evolution, danger has been the norm, and human beings have evolved to adapt to predictable and unpredictable dangers of a mild or life-threatening sort. (It is possible, for example, that the C strategy has historically been the most common strategy used by humans over evolutionary history, because it is the best strategy for dealing with unpredictable dangers — including unpredictable access to basic resources and unpredictable threats from competing groups.) Later in life, these functional and context-specific adaptations, when used out of their original context, can lead to highly destructive or self-defeating behaviour — indeed, behaviours with labels such as *dissociation, personality disorder, psychosis, paranoia, anxiety* and scores of other mental health diagnoses that are based on symptoms. Yet in their original form and context, these behaviours may well have been life preserving and safety promoting strategies. Therefore, they should be seen in their original context as *strengths, not deficits,* because they have served a self-protective function. This has many practical implications for how we think about and offer interventions.

As children mature, their attachment strategies can increase in complexity, since normal neurobiological development enables processing of sensory information at increasingly sophisticated levels. Put simply, maturity offers us the opportunity to think with increasing complexity as we grow older. The term 'Dynamic-Maturational Model of Attachment and Adaptation' was chosen to reflect the potential of adaptive strategies to change within individuals across their lifespan (Crittenden & Landini, 2011). These strategies are seen as existing on a continuum of attachment security and are viewed as adaptive when first developed by a child. A child who anxiously hides, dissociates, becomes a 'people pleaser', cries, fights, distracts, becomes hypervigilant, rapidly changes focus or complains may be using an adaptive response to survive in some families and communities. Those same behaviours, used later in life, may lead to very different outcomes — including behaviour that is neglectful or abusive to others. This is crucial to our understanding of psychological disturbance: the very same strategy that is adaptive in childhood or adolescence may be *maladaptive* later in life.

This guide does not have sufficient space for us to provide full coverage of Crittenden's elegant model, particularly the extreme patterns at the bottom of the circle. Readers who wish to learn more about the DMM are encouraged to read Crittenden (2016) or Crittenden and Landini (2011) or Landini et al. (2015), or visit IASA-DMM.org or familyrelationsinstitute.org.

Disorganisation

Thus far, we have not mentioned the impact of unresolved trauma and loss on attachment strategies. However, it will be recalled that in addition to the three basic attachment strategies (A, B and C), the Strange Situation Procedure identified a group of children who were 'unclassifiable' and who were later reclassified by Main and Solomon (1990) as exhibiting a 'disorganised' response. This occurs when there is no discernible pattern to the person's self-protective strategy and may emerge when a child's attachment figure is frightened, frightening, traumatised, or disorganised themselves (or some combination of all these). In effect, they are both *unpredictable* and *the cause of the distress*. The child faces an unsolvable dilemma in trying to gain comfort and safety from the very person who is causing their distress. The result is wildly fluctuating behaviours, including violent or provocative outbursts or incongruent actions that try simultaneously to approach and avoid the attachment figure (for example, sitting on the carer's knee while turning away and grimacing, or physically lashing out, which is both pushing away and making physical contact). Hence the child is subject to deeply conflicted impulses, resulting in their mental processes and external behaviour becoming *disorganised.* Children who have been exposed to such experiences are at particular risk of emotional and behavioural problems. Indeed, Howe (2005) points out that the key distinction is not between secure ('B') and insecure ('A' and 'C') attachments, but rather between *organised* (i.e. the A, B and C patterns) and *disorganised* attachment states.

It is important to note that there is wide variation in the attachment field about how broad a category the 'disorganised' designation should be (Landa & Duschinsky, 2013b). Some authors find richly strategic patterns among maltreated populations (Landini et al., 2015). For other authors, as many as 80 per cent of clinical populations are classified as having a disorganised strategy. In Crittenden's Dynamic-Maturational Model of attachment and adaptation, 'disorganisation' is a far smaller category and is conceptualised as only one of several ways that the mind copes with unresolved trauma and loss. (Other ways that the mind may find to cope with unresolved trauma and loss include blocking, dismissing, displacing, or becoming pre-occupied with the event.)

Summary

The DMM expands Ainsworth's model of individual differences in middle class, non-maltreating families with a wider array of strategies used in maltreating families and families with mental illness. Seen in the context of the family system, children's

attachment strategies are understood as the child's best solution for obtaining safety and comfort from the caregivers on whom their lives depend. The DMM offers an alternative to symptom-based diagnoses of psychopathology by focusing instead on the function of the 'symptom' behaviour (Crittenden & Ainsworth, 1989, p. 442-463; Crittenden & Baim, 2017; Fonagy, 2001; Wallin, 2007).

Crittenden's expansion of Ainsworth's work includes more complex strategies used by older children and adults. These comprise compulsive Type A strategies (A3-8), coercive Type C strategies (C3-8) and A/C combinations. These strategies reflect commonly recognised forms of maladaptive behaviour but differ from symptom-based diagnoses in that they are seen as a functional attempt to reduce danger and increase comfort and safety. They differ from the ABC+D model (where D denotes 'disorganisation') in finding both organisation and adaptive function in disturbed behaviour. When the function better fits the past context in which the behaviour was learned than the current context, the behaviour can be maladaptive and even dangerous.

It is worth remembering, however, that it is not the danger itself that creates psychological and interpersonal problems. Problems arise due to the short-cuts in information processing that must be made when the danger is more than the individual can cope with and when such danger must be faced without protection or comfort from a trusted caregiver. Complicating the danger even more is the fact that many parents who maltreat their children have themselves experienced unprotected and uncomforted danger and have entered adulthood and parenthood with the transformations of information and strategies associated with endangerment (de Zulueta, 1993; Milaniak & Widom, 2015; Rothschild, 2000).

The Dynamic-Maturational Model (DMM) of attachment and adaptation offers a comprehensive model that helps us understand even the most extreme or endangering forms of human behaviour and mental processing as being *functional* and *comprehensible*. The DMM is a powerful way of moving beyond the labels of mental disorder, illness, disease, and dysfunction, to focus instead on the adaptive function of human mental processes within differing contexts.

See Crittenden (2016) or Landini et al. (2015) for fuller coverage of the DMM and the research supporting its clinical applications (Crittenden et al., 2021a, 2021c; Landa & Duschinsky, 2013a, 2013b, Pocock, 2010).

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Systematic review

Clinical Applications of the Dynamic-Maturational Model of Attachment and Adaptation: Assessment, Formulation and Principles of Care

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ABSTRACT

Earlier in this journal issue, I offered an introduction to Dr Patricia M. Crittenden's Dynamic-Maturational Model (DMM) of Attachment and Adaptation. The DMM is a bio-psycho-social model, informed by neurodevelopmental research, and as such it offers a developmental understanding of the wide range of adaptations used by people who are endangered or endangering to others, or who may need psychological or social care support for a wide variety of reasons. The DMM is a strengths-based, non-labelling and non-pathologising model which conceptualises adaptations to danger as self-protective strategies that promote survival in their original context, but which may later lead to problematic, dangerous or self-defeating behaviour. This article focuses on the clinical applications of the DMM, which includes DMM-informed principles of assessment, formulation and care.

Aplicaciones Clínicas del Modelo Dinámico-Maduracional de Apego y Adaptación: Evaluación, Formulación y Principios de Atención

Palabras clave:
Apego
Modelo dinámico-madurativo (DMM) de apego y adaptación
Modelo biopsicosocial
Dra. Patricia M. Crittenden
Evaluación y formulación
Tratamiento y cuidado

RESUMEN

En un número anterior de esta revista, ofrecí una introducción al Modelo dinámico-madurativo (DMM) de apego y adaptación de la Dra. Patricia M. Crittenden. El DMM es un modelo biopsicosocial, basado en la investigación del desarrollo neurológico, y como tal ofrece una comprensión del desarrollo de la amplia gama de adaptaciones utilizadas por las personas que están en peligro o que ponen en peligro a otros, o que pueden necesitar apoyo psicológico o social por una amplia variedad de razones. El DMM es un modelo basado en fortalezas, no etiquetado y no patologizante que conceptualiza las adaptaciones al peligro como estrategias de autoprotección que promueven la supervivencia en su contexto original, pero que más tarde pueden conducir a un comportamiento problemático, peligroso o autodestructivo. Este artículo se centra en las aplicaciones clínicas del DMM, que incluye principios de evaluación, formulación y atención basados en el DMM.

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Attachment-Informed Assessment, Formulation, and Treatment Planning

This section outlines a series of topics and activities that practitioners can use with individual adults, with couples, and with families, to carry out cost-effective assessments informed by the Dynamic-Maturational Model (DMM) of attachment and adaptation (Crittenden, 2016). The method described is an adapted version of a type of assessment called a 'screening formulation,' as distinct from the more detailed and resource-intensive form of assessment known as a 'family functional formulation.' What distinguishes an attachment-based formulation from standard diagnostic procedures is that in an attachment-based formulation, the various assessments are brought together to create – in a collaborative, co-produced dialogue between professionals and the person / people in focus - a functional formulation of the person's (or the couple's, or the family's) difficulties. The idea is to condense and categorize the most essential and relevant information about the family, couple or individual and communicate it clearly to the person and to other professionals involved with them. The advantage of using an attachment-based formulation is that it can be done much more economically and efficiently and without specially trained DMM-informed coders, yet it can still provide a function-based formulation. In practice, the attachment-based formulation can be done with individuals, couples, and families where the problems are relatively straightforward to understand. Where there is great complexity, or where there are multiple problems, or where the individual, couple or family have been subject to many prior treatments and services, it may be justified to offer the full range of DMM assessments and the more rigorous Family Functional Formulation (or, for individuals, an objective, blind-coded report by a qualified AAI coder) – where this is available.

Focus on Personal History and Family / Social / Cultural Identity and Belonging

In learning about the developmental history of the person we are assessing (or each person in a couple or family), we gather important biographical information about important relationships and life events. This should be information that is relevant to the formation of the person's identity, beliefs, values, self-protective strategies, and sense of who they are as a person. This part of the assessment process can be accomplished using any of a wide variety of history-taking protocols. This might include, for example, creating a family tree / genogram, or mapping out the social network around the individual or everyone in the family or couple. In doing the social network mapping, you can explore what interpersonal connections the person has. What is the quality of these connections? How do they achieve a sense of belonging? What is their sense of who they are and where they fit into society, i.e. their sense of identity, and their sense of where they belong?

Strengths

What are the person's strengths? These can be divided into personal strengths, interpersonal strengths, transpersonal strengths, and any other strengths they can identify. It can help to identify not just the strengths, but where and why and how those strengths were developed, where they have been useful in the past, and where and how they continue to be useful today.

Themes of Significance, Growth and Contribution (Giving Back)

Extending the theme of strengths, you can explore how the person has tried to achieve a sense of being significant, effective, or powerful. Can they provide examples of when they have accomplished a goal, trained for a job, improved a skill, or been kind or supportive to someone? What stories of strength can the person recall?

Using this approach, you can also help the person identify what is most important to them, for example, having a relationship, having children / being a parent, having work, doing meaningful things, having friends, being healthy, playing music, or cooking, or creating art. Then the client can be helped to develop a plan for meeting those needs and aspirations in positive ways. What are their hopes and aspirations? Where might there be possibilities for growth, internally and interpersonally, in any aspect of life? Where might there be opportunities for them to contribute to society, for example by volunteering, making reparations, or assisting in support groups for people with similar experiences? How has the person tried to achieve a sense of being significant or powerful?

Developmental History Related to Danger and Safety

Closely related to history taking is the specific focus on the person's history of encountering danger, and how they tried – successfully or otherwise – to cope with danger at the time and how the experience of the danger affected them in the short, medium and long term. One useful method of helping a person to think about and reflect on these dangers is to create with them a timeline of significant positive, negative, and neutral events in their life, from birth to the present day. The timeline should include the major dangers that the person has faced, both in early life and more recently. Dangers might include accidents, abuse, neglect, verbal abuse, parental separation, conflict, divorce, or death. Dangers can include having a mentally ill parent, substance misuse in the family, criminal activity, having a family member in jail, being separated or removed from the home as a child, being rejected by peers, suffering economic hardship, racism, other forms of oppression, natural disaster, political unrest, war, and many other forms of danger. Where a danger is identified, the person should be encouraged to consider whether there was anyone around at the time to help them, to comfort them, to protect them, and / or to hear and validate their feelings in response to the dangerous events. Where people have encountered dangers that were beyond their zone of proximal development at the time, such events are far more likely to manifest as unresolved traumas or losses if there was no attachment figure present to help them, comfort them, protect them and validate their feelings.

The assessment should include understanding the client's experiences and memories of danger, protection and comfort (or lack of protection and comfort) across their lifespan. This should include consideration of ongoing psychological trauma and unresolved loss (Reupert et al., 2015; Schützenberger, 1998). When considering a person's experience of danger in the past, it will be useful to reference the *danger scale* (adapted from Crittenden & Landini, 2011; Crittenden, 2021):

1 – 2 Developmentally normal, expected dangers, from which the child was adequately protected and comforted. *Examples:* being hungry or tired (infancy); falling over (toddlerhood), skinned knees, competition with a sibling (preschool); seeing parents argue, being teased, being rejected by peers (school-age); being rejected by a girlfriend / boyfriend, experimenting with drugs / alcohol, arguing with parents (adolescence).

3 – 4 Developmentally normative dangers for which one was protected, but not comforted OR developmentally inappropriate dangers from which one was *protected and comforted*. *Examples:* being bullied (school-age and adolescence), serious accidents/illness not requiring hospitalisation, physical punishment of young child for dangerous behaviour, distant family death, victim of crime.

5 – 6 Developmentally inappropriate dangers from which one was *neither protected nor comforted*. *Examples:* serious accident or illness requiring hospitalisation, bullying, chronic rejection / exclusion from school, close family (non-parent) death, victim of crime, mentally ill parent, physical / sexual abuse (non-familial) foster care or siblings in foster care, substance using parent, war.

7 – 8 Parentally inflicted dangers (no comfort, no protection) or self-inflicted dangers. *Examples:* physical, emotional or sexual abuse/neglect within family, being sent away to live away from parents, triangulated deception, being deceived, child in care, running away, self-harm, overdosing

9 Events that would be threatening to adults as well. *Examples:* death of spouse / child, death of parent - especially in childhood, repeated unexplained hospitalisation of an attachment figure.

10 Ongoing serious endangerments in the present. *Examples:* Partner abuse, neighbourhood violence involving self or family, criminality, dangerous psychosis, war, civil unrest, natural disaster.

When we take into account the danger scale, this brings needed context to significant life events such as those found in the Adverse Childhood Experiences (ACE) study of childhood trauma (Felitti, 2002). For an important critical perspective on the uses and limitations of the ACE questionnaire, see Eaton (2019).

It is important to be aware of when and where the person / family may feel there is danger intruding on their life currently, and in the present moment of the session. This may be implicit or explicit danger. One form of danger, for example, would be when the client is aware that making certain kinds of disclosures to you will result in sanctions or what they perceive as punishment. Or they may be concerned about current peer influences or threats which are currently active – for example, a threat from peers, from extended family members, or from the police, courts, or social services. This will keep them on alert, and we should be realistic about our expectations of clients in these circumstances. Another type of danger the client may perceive is the pain and fear associated with recalling life events, relationships, traumas, and losses that are unresolved. Such topics will demand sensitivity, attunement and clear boundaries and contracting about what the purpose is of discussing these topics.

Relationships and Sexuality

Assessment and intervention should address how the person / family members function in relationships, particularly close relationships (including, where relevant, sexual relationships). What is the intrapersonal and inter-personal function of their sexual behaviour? Is the sexual behaviour, for example, a way of coping with feeling afraid, rejected, unloved and needing comfort? Is the person seeking comfort in ways that are problematic, risky or abusive? This information can be learned as supplemental to the history taking activities described above. Reflecting on the person's functioning in relationships – including sexual relationships – how does the person's history correspond with their functioning in relationships? In other words, can you make sense of how and why they function in relationships as they do, based on what you have learned about their past? If not, this will often signal that significant therapeutic work is needed. This aspect of the assessment should also include how the person / family functions interpersonally with you.

Information Processing and Correcting for Bias: The Client and the Worker

Assessment should also consider how the person processes information – that is to say, how the person balances and integrates their perceptions, thoughts, and feelings. Does the person *omit* crucial information from their awareness, such as their own or other people's roles in an event? Or do they omit feelings and focus only on facts – or vice versa? Does the person make significant *errors*, such as misattributing cause and effect, or blaming the wrong person for an event? Do they *distort* information, for example by minimising or exaggerating feelings or responsibility? Do they *deny* information that they are fully or partially aware of? Do they deny factual information, or deny their own feelings and perspective? Do they *falsify* information about events, emotions or their actions or intentions, and treat this information as true? Are they deceiving themselves and/or you? Do they attempt to get you to collude with or believe the falsified version of events? How aware is the person of their self-deception or their deception of you? (Deception can be fully conscious and intentional, wholly unconscious, or somewhere in between).

When we take an information processing approach in thinking about our clients, we should also consider how we hold our clients in mind. What are our own dispositional representations about the client and the family as a whole? For example, what conscious or unconscious biases may be influencing us? Are we making assumptions about the client or the family? What stereotypes or culturally 'scripted' roles might be getting played out in our interactions with the client or the family? Are we aware of patterns of response that we tend to have when facing individuals or families with these problems or with these backgrounds? How might professional dogma, professional assumptions, societal or cultural stereotypes be operating? For example, there may be professional dogma that assumes one person in the family is responsible, or that a person's actions are fully intentional, that one person in the family has 'groomed' another, or that a member of the family does not take responsibility or show any self-awareness because they do not verbally admit to their problematic, concerning, or harmful behaviour. It is important to test out any assumptions which can influence our professional judgment. Similarly, it is crucial to test out any assumptions that one person in the family is the villain or is somehow 'ill' or psychologically unwell in isolation, i.e., we need to understand how the person's troubles may be influenced by a troubled or unattuned family system. This is not about blaming or shaming anyone in the family. It is about trying to understand the system

as a whole and each person in the system. Thorough assessments allow for this kind of small scale and big picture perspective, so that professionals can better achieve an accurate understanding of the family and each person in the family.

Hirarchy of Needs: giving priority to the most crucial areas first. In our assessments, it is crucial to also consider people's basic needs. Therefore, it is useful to consider Maslow's (1943, 1954) well-known hierarchy of needs, including basic physiological needs to stay alive and healthy, such as food, water, shelter, basic sanitation, access to health care, and physical safety for the self and family members. Beyond these basic needs, Maslow's hierarchy of needs includes factors such as the need for belonging, for love and affection, for predictability in relationships, for self-esteem and for opportunities for creative expression and pursuing meaningful life goals (including employment).

Levels of Family Functioning

In cases where you are assessing an adult where there are concerns about their treatment of their child or children, or when making decisions about allocating services to the family, professionals may find it useful to consider the following levels of family functioning adapted from Crittenden (1992, 2016):

- Independent and Adequate. The family can adequately meet the needs of the children. The family can also face problems and crises, and deal with them adequately.
- Vulnerable to Crisis. The family are normally functioning well or adequately, but they need short term (e.g. up to a year) assistance with an unusual problem such as divorce, chronic illness, family death, serious crime, the birth of a disabled child or the entry of a disabled child into school.
- Restorable. The family has many problems that demand a range of new skills and possibly therapy or other types of intervention or service. After one to four years of support and intervention, it is expected that the family will function adequately and with no or minimal services.
- Supportable. The family will need long-term functional support to help meet the physical, emotional, educational, and other basic needs of the children. This is likely to continue until the children are grown. Examples of families that are in the supportable range include families where the parent / main carer has an intellectual disability or where the parent / main carer is drug or alcohol dependent.
- Not Supportable with Services Currently Available. The family has a very high degree of need and there are currently no services available in the area sufficient to enable these families to meet the basic needs of the children and keep the children safe. Removal of the children may be the only option remaining.

Gradient of Interventions

Professionals can use as a guideline the following gradient of interventions (Crittenden, 2016, p. 270). This gradient will allow professionals and agencies to set the intervention at a level best suited to the individual and / or the family (e.g. parent-child dyad; sibling dyad; couple dyad):

- Basic needs and support for the parent / carer and family. The parent / carer needs basic support regarding housing, physical safety of the family, money, food and water, and / or other basic needs as a matter of priority, before other needs are addressed. Ref: Maslow's Hierarchy of Needs (Maslow, 1943, 1954).
- Parent education. The parent / carer can integrate but needs new information. Parenting skills programmes may be suitable at this level.
- Short-term counselling. The parent / carer can integrate and has appropriate information about parenting. However, they need short-term counselling to help them reflect on their parenting and to consider other perspectives and possibilities.
- Parent-child intervention. The parent / carer can describe problems in their interactions with their child, including their own contribution. However, the parent has difficulty spotting discrepant information and cannot integrate where they do see discrepant information. At this level, carefully guided parent-child dyadic interventions may be beneficial.
- Adult psychotherapy *(personal, not focused on parenting)*. The parent / carer is not yet ready for parenting interventions at levels 2, 3 and 4. They are not aware of why they do what they do in relation to their child, and their responses are maladaptive, even dangerous. The parent needs psychotherapy to help them understand their 'triggers,' to come to terms with past dangers, and to recognise discrepancies and make meaning from them. The parent / carer will also benefit from having an experience of being empathically understood as a bridge to them responding more empathically to their children.
- Long-term support. Long-term functional support to help meet the physical, emotional, educational, and other basic needs of the children and the family. This is similar to item 4 under the previous section addressing levels of family functioning.

Critical Cause of Danger

This is the danger around which the person or family has adapted a self-protective strategy. Focus on the critical cause of danger encourages us to narrow the definition of 'the problem' so that we do not try to focus on everything at the same time – just the most important things for the person or family currently. For example, it may be about surviving abuse or neglect, or surviving abandonment, separation, or chronic emotional abuse. The danger can also be a current danger, such as relationship violence, drug abuse, or being investigated by social services about child protection concerns for your children. The critical cause of danger is often hidden, and part of the reason for this is that the dangers often lie far in the past, and the person may have little or no understanding of the reasons why they originally adapted the coping strategy, and whether or why they still use the strategy in situations where it no longer applies.

Critical Focus for Change

The idea behind addressing the critical focus of change is to direct treatment where it is most likely to have the maximum effect, and to have cascading and beneficial effects for the individual or within the family (Crittenden, 2016). Attachment and the quality of interpersonal relationships is often a critical cause of change. In addition,

understanding and reducing the danger is often a critical cause of change. When the danger is reduced, the person's strategy can change.

Developing a Treatment Plan Based on a Function-Focused, Biopsychosocial Approach

Using the information from the assessments in the previous section, the clinician can bring all the areas together to formulate a treatment plan based on a biopsychosocial understanding of the person's / couple's / family's difficulties. When we describe an integrated, biopsychosocial approach, we are describing a way of assessing, understanding, and offering interventions that consider people in their context (Engel, 1979). This can help professionals and services to work more efficiently and effectively at the level appropriate to the individual and the family concerned.

Discussion

Based on this approach to assessment and formulation, a treatment plan can build on strengths and address needs, while also being aware of risks. It should specify the number of sessions the person / family should do, which approaches and exercises should be chosen, a rationale for the sequencing of treatments, which adaptations / variations are likely to prove most fruitful, and what the aims are. The treatment plan should always allow for the possibility of modifying the plan as work proceeds. Thorough assessment should result in a comprehensive functional formulation of the person's / family's troubles that looks beyond symptoms and into their underlying function. What purpose did this strategy serve when it was first used? What purpose does it serve now? Can other strategies work better?

Principles of Practice for Attachment-Based, Integrative Treatment for Adults and Families

The following ideas capture the essence of integrative treatment that is attachment-based and informed by the Dynamic-Maturational Model (DMM). The following section draws on material from Crittenden and Baim (2017), Crittenden and Landini (2011), Crittenden et al. (2014, 2021a) and Landini et al. (2015).

The Central Importance of the Therapeutic Relationship

The basic premise of the attachment-based, integrative approach is that treatment is the process of using an informed, regulated relationship to promote the person's ability to establish and maintain adaptive relationships. Establishing a therapeutic relationship is crucial because the relationship with the professional can function to correct the experience of earlier, mis-attuned relationships. In effective therapy of many types, the therapist becomes a transitional attachment figure for the client, assuming crucial functions of a nurturing parent. This can help the client to develop a felt sense of security and trust in relationships, to learn to trust and regulate their own emotions, and to develop healthy intimacy. To do this, it is crucial that the professional appreciate the person as they are, particularly regarding the aspects of their experience that they may be unaware of.

Treat People, not Diagnoses

A key principle underlying the integrative, attachment-informed approach is that we treat *people*, not their 'disorder' or diagnosis. This is because diagnoses tend to be based on clusters of symptoms or behaviours, and if we focus on treating a symptom, or a cluster of symptoms, we are likely to miss the chance to understand the meaning and function of the symptoms. Eliminating or reducing symptoms may of course serve immediate needs, yet the challenge remains to help the person and the family to make lasting changes. In broad terms, integrative, attachment-informed treatment is a relational encounter where we help the client to: 1) understand how their past influences their present; 2) become more conscious of their self-protective strategies; and 3) function in more integrated ways, both internally and inter-personally.

In offering integrative treatment, rather than treating disorders, the priority is to offer treatment by using *principles* rather than packages, protocols or programmes (see Carey et al. (2015) for comprehensive coverage of principles-based counselling and psychotherapy). To put this another way, the question is not, 'What is the most effective treatment for Borderline / Depression/ PND / Psychosis/ OCD / ADHD / PTSD / PD / Anxiety / Addiction / Phobia / Sexual offending (or any symptom-based or behaviour-based diagnosis or criminal category)?' The question is instead, 'What (varied) treatment approaches and techniques might be effective in helping this person, and this family, at this time, in this context, and in what sequence, in what amount, through what process, with which person / people, and with what in place around the process to help support the individual and the family in their process of change (especially when there are ruptures / lapses)?'

Using these questions, we can responsively adapt to individuals and families. Rather than fitting people and families into packages and programmes, and thereby giving people information they may be unready to use, we can instead guide people to use information more adaptively and within their zone of proximal development.

Understanding Contradictory Thought Processes and how They can Affect Parenting

Difficulties can develop when a person has contradictory thought processes and lacks the skill, insight, self-reflection, and other integrative processes for selecting the response that best fits the current situation. In family dynamics, danger often arises when there is, for one or more individuals in the family, an irresolvable conflict, tension or contradiction between their needs to protect the self, their partner and their progeny (Crittenden et al., 2021a). This implies that treatment would need to focus on resolution of or reframing this conflict, tension or contradiction. An example of a maladaptive short-cut would be a parent who has unresolved trauma from an abusive childhood where they experienced violence from a parent. When their child is distressed, this parent may consciously want to protect and comfort their child, yet on a preconscious level, they may fear the child's aggression. The same principle applies in couple relationships. An additional complication is that, on the neurological level, the preconscious 'triggered' memory of their childhood abuse is often represented in the brain more rapidly and given priority (Mather & Sutherland, 2011; see also the concept of 'fast' and 'slow' thinking in Kahneman, 2011). This can result in parental aggression,

i.e., child abuse, or parental freezing, collapse or withdrawal, i.e., neglect. In other cases, contradictory dispositional representations (DRs) can lead to unpredictable and contradictory responses from the parents, or, in the context of couples, from one or both partners in a couple.

A crucial ingredient of therapy when addressing such unresolved issues is helping the person to learn how to regulate arousal and to resolve past dangers that are currently generating trauma-based psychological responses. The point is that a psychological process that was adaptive in childhood can become maladaptive later in life. To understand dangerous or problematic behaviour, we must consider both the context in which it was learned and that in which it is applied (Crittenden & Baim, 2017). It is notable that the focus on information processing and DRs as underlying adaptive or maladaptive strategies allows therapists to formulate clear hypotheses about the treatment needs and zone of proximal development of a whole family, or of specific family members. These hypotheses can be readily tested by choosing specific techniques or approaches.

Focus on the Family System and Choose Different Treatment Strategies for each Family Member

The integrative, attachment-informed perspective sees problematic behaviour and psychiatric symptoms in the interpersonal contexts of the family and the system of professionals involved with the family. This contrasts with assigning maltreatment to parents or psychiatric diagnoses to individuals. The attachment-based, integrative perspective that is informed by the DMM defines behaviour that occurs between people as interpersonal, meaningful, and dynamic, and provides a powerful rationale for working with the entire family. Assessment of attachment can reveal family members' protective strategies, the historical experiences that have shaped the strategies, and the underlying information processing that generates self, partner, and child-protective behaviour. Knowing the strategies, experiences, and psychological processes of family members can inform treatment planning (Crittenden & Baim, 2017).

The idea is not to treat 'bad' or 'disordered' parents or 'dysfunctional' or 'ill' children, but instead to promote positive changes in mental wellbeing and interpersonal functioning throughout the family. Working with a child in isolation, without addressing the family's functioning, can inadvertently set the child up for more severe danger as other family members struggle to reestablish the family's familiar functioning. For example, a compulsively compliant and obedient child who becomes assertive or emotionally expressive because of therapy may find themselves in more danger if the parent interprets their assertive communication as disrespectful (Crittenden, 2016). Or a highly argumentative or aggressive child, on trying out new responses in the home, may be called 'a weakling' or 'a wimp' (or far worse) if they don't fight back when provoked. This highlights how important it is for the whole family system to support change in an integrated way. This applies equally with adults in couples and families; changes in one partner may be supported or undermined by their partner or family members. Successful treatment may rely on support from within the family. With such an approach, professionals can help families to re-think the stories they have about each other, and to connect and support each other, rather than blame and scapegoat the supposedly 'sick' part of the family system.

Generating Family Functional Formulations Around Critical Causes of Danger, and the Critical Focus of Change

The attachment strategies represent different psychological processes, and consequently, different treatment approaches are needed for different families and individuals and sub-systems within families. Put another way, an approach that benefits one family member may harm another member of the family. This means that, during assessment, we need to learn about more than the type of maltreatment that is occurring in the family, or that family members are insecure. We also need to learn how each member of the family processes information and the strategies they use for self-protection in the family context. We also need to assess how consistent or varied the person's strategies are, and whether they differ depending on context or who they are interacting with. The risk of not doing this is that the treatment could focus on the wrong person, the wrong problem or the wrong relationship. The best and most effective treatments target the right person, the right context and the right relationships (Dallos et al., 2019, 2020).

A concept that may be helpful is the idea of identifying the *critical cause of danger,* mentioned earlier in this article. This is a danger that the person has faced which has caused them to develop a self-protective strategy. For example, the adult may have been required to learn ways of coping to deal with violence, parental substance misuse, sexual abuse, neglect, etc. in their childhood. The danger can be in the past, and in some cases, it will also be occurring in the present, for example an abusive partner, violence and crime in the community, unstable housing, substance misuse, and the threat of having children removed. When parents are faced with such past and current dangers, this makes it far more difficult to explore and reflect on strategies and adaptations (i.e., coping strategies) they have used in the past, and to flexibly try out new strategies. They are so focused on the past dangers that are unresolved, and the current dangers (some of which may be real, and some which may be exaggerated or transformed in some other way) that they have limited scope for change. Survival in the moment takes priority over adapting to hypothetical dangers in the future.

A related concept, equally important when we think about family functional formulations, is the *'critical focus of change.'* This was also mentioned earlier in this article. This concept refers to that part of a family system, be it an individual in the family, a couple, a dyad, a sub-system, or some influence on the family or context in which the family operates, which, if changed, would instigate an unfolding series of changes that would ultimately resolve other concerning aspects of the family's or individual's functioning (Crittenden, 2016). In practice, this means narrowing the definition of the 'problem' and not trying to solve every problem in the family or the individual. Focusing on the 'critical focus of change' means finding the point of maximum effect in the short, medium and long term for the individual and the family.

Taking this approach can lead to 'outside the box' interventions that may focus on structural, social and systemic changes that are integrated with interventions that are more psychological or medical.

Treatment as Incremental Experimentation within the 'Zone of Proximal Development'

Integrative treatment that is attachment-informed uses a recursive process based on the principles of action research (Zuber-Skerritt,

1996). To offer an example, treatment should offer opportunities for small 'experiments' that offer the opportunity for incremental gains and regulated 'failures' that can be treated in a supportive way that leads to reflection, revision and trying again in a new way with the benefit of the new information (Beck et al., 1979). This calls for close working with the person and the family to undertake collaborative, co-produced (i.e., not imposed) assessment, formulation, planning and intervention, with ongoing discussion and further collaborative modification of treatment. Using this collaborative approach, professionals can teach the process of integration by helping people to focus on discrepancies in informative ways. The response of the person will signal whether you proceed with the original plan or revise it as needs arise. This is what is meant by action research, a collaborative learning approach that is meant to capture the natural process of trial, error, and refinement that adaptive adults use.

Treatment should begin with the person's existing competencies and build on these in their *zone of proximal development* (ZPD) (Vygotsky, 1978). In family contexts, where the focus of treatment is the parents, the focus should be based on the ZPD of the *parents*, not the children. This contrasts with a treatment plan for the children, which would be based on the children's needs. Why focus on the ZPD of the parents and not the child? Because when the treatment plan for the parent is based on the child's needs, it might not meet the parent's treatment needs, aims or capabilities (Featherstone et al., 2018). The goal in working with the parent is to establish a process of successful change such that the parent becomes increasingly able to examine their own experience and implement more adaptive responses. As children mature, in general they become more able to process information in sophisticated ways that include linguistic, conscious, and ultimately integrative thought. Correspondingly, caregivers need to adapt to promote learning in their children's ever-changing ZPD.

The Professional may Become a Transitional Attachment Figure for the Individual or the Family

This is an important part of the therapeutic process. Where there is a relationship based on a feeling that the professional is a reliable source of support and attuned listening, one positive outcome is that the professional can serve as a role model, a container, and can help to create a cascade effect by treating the parents as we hope that they treat their children. Crittenden has written about the golden rule for interacting with troubled parents, which is to *treat parents as we hope they will treat their children* (Crittenden, 2016). This approach is enhanced when professionals understand that, for a period, they may become transitional attachment figures for the parents. If there is a basis of rapport, the relationship between the professional and the family may also be resilient enough to withstand inevitable ruptures. Crucially, such ruptures should be reframed as opportunities for attuned repair. As is the case with parent-child dyads, therapists and clients can strengthen their relationship by repairing breaches in synchrony. This is a process of reciprocal modification and can be guided by the attachment figure (that is, the most mature and experienced member of the relationship). As treatment nears completion, it is important to work through the ending of the relationship in sensitively guided ways, helping the individual or the family to direct their attachment needs to each other and to their friends, support groups, assisting agencies, etc. (Crittenden & Baim, 2017).

Repair 'Broken' Strategies and Increase the Array of Strategies

The individual or multiple individuals in the family may have strategies that are insufficient to deal with the current challenges they face. Such strategies may feel like they are broken, and this can lead to depression, disorientation, physical symptoms, and psychotic or delusional 'breaks' when the individual cannot generate strategies that fit their context. A key feature of treatment will be helping the individual to compassionately contextualize past strategy failures and to increase their flexible and integrated use of a wide array of strategies. Expanding the repertoire of strategies also means that the person gains access to all their memory systems, with no information 'off limits' to processing.

Concluding Treatment in Individual and Family Contexts

When adults develop the ability 1) to adequately reflect on their thoughts, feelings, behaviour and physical symptoms; 2) to consciously update their strategies, responses, ideas and beliefs in adequately adaptive ways, and 3) to continue to refine this process with minimal coaching and support - this is a strong indicator that treatment is nearing completion. Indicators of integration and resolution can include developing adequate strategies for dealing with triggering situations and developing healthy and conscious preventative and self-protective strategies to avoid recurrence of situations or trauma responses. Resolution can also include reflecting on the traumatising events to the degree that they are understood and placed in the past, the effects are understood, new decisions are made, new responses developed, and the events are no longer triggering when they come to mind.

In family contexts, when parents improve, children's symptoms are reduced, and child protection concerns are alleviated, parents should be guided to feel proud of their ability to adapt and to continue to adapt as a basic life process. In other cases, progress is made, but the children's needs are not met sufficiently or quickly enough. In these cases, a decision must be made as to whether changed services can help. If not, it is important to frame this as the lack of suitable services or resources (as opposed to the limitations of the parents). Blaming parents will not help them or their children, and there is much that we do not know about treatment and more that we cannot afford. In all cases, it is important to show family members what they have accomplished and how it helps them to live safer lives (Crittenden & Baim, 2017).

Conclusion

There are several advantages to the DMM conceptualization of assessment, formulation, planning and intervention. It is a theory of treatment that includes and integrates all types of treatment (e.g., psychodynamic, family systems, cognitive, behavioural, body oriented, mentalisation-based, etc. – there are more than 1,000 accredited treatment modalities) with *developmental processes*. Focusing treatment on protection and reproduction can streamline the treatment, thus lowering the cost and complexity of treatment. Furthermore, the array of DMM protective strategies gives meaning to complex and contradictory behaviour. This promotes the cooperation of parents and children.

Integrative treatment based on the DMM is principled, not packaged. It is based on the principle that we offer treatment

to *people*, not disorders. It engages parents and children with professionals, as opposed to rolling out programmes. Rather than giving people information they may be unready to use because it is outside of their zone of proximal development, the DMM integrative approach guides people to use information more adaptively (Crittenden & Baim, 2017; Dallos et al, 2019, 2020). Integrative treatment informed by DMM attachment theory is a strengths-based, non-stigmatising approach that assumes that distressed individuals have learned important things about protection from danger, and that early short-cuts in psychological processing have made it difficult for them to adapt to changing conditions. Thus, instead of focusing on maltreatment, symptoms, or insecure attachment, treatment should address safety — for self, family and others who are close — in the current context. The notion is that every strategy is the best strategy in some contexts, but no strategy is best in every context. Consequently, a major goal of integrative treatment is to increase the array of strategies that an individual can use, and then to help the individual to discover when to use each. This requires a conscious, reflective process.

The DMM definition of attachment is *learned strategies for protecting the self (and, in adulthood, one's partner and children) from danger*. Dangerous parental behaviour or behaviour in relationships is understood as misguided protective behaviour that is carried from childhood (when immaturity required psychological short-cuts) to adulthood, when it is misapplied (Crittenden & Baim, 2017). Using the DMM as an underlying framework for understanding strategies can enable professionals to make meaning of maladaptive behaviour. When professionals work with informed compassion, their relationships with clients improve. This, in turn, can facilitate adults learning more adaptive ways to care for their partner and children. When we talk with adults about the short-cuts that were essential in their childhood but are outdated now, we demonstrate respect for their accomplishment in surviving adversity. We also acknowledge their intention to protect their partner and family better than they themselves were protected, and we affirm their potential to continue learning. Adults typically find hope in the notion of life-long adaptation. This is the first step in a productive plan for change.

Author's Note

See Crittenden (2016) or Landini et al. (2015) for fuller coverage of the DMM and the research supporting its clinical applications (Crittenden et al., 2021a, 2021b; Landa & Duschinsky, 2013a, 2013b, Pocock, 2010).

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Statement

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Conflict of Interest

The author of this manuscript declares that there are no financial, personal, academic, or institutional conflicts of interest that could have influenced the conduct of this study, the data analysis, or the interpretation of the results.

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Revisión sistemática

Revisión Sistemática Sobre el Apego Adulto y la Repercusión en la Satisfacción de las Relaciones de Pareja

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INFORMACIÓN

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Estilos de apego
Dinámicas de pareja

RESUMEN

El presente estudio tiene como objetivo relevar las investigaciones científicas sobre la relación existente entre el apego adulto y la satisfacción en las relaciones de pareja.
Por esta razón, se realizó una Revisión Sistemática utilizando la declaración PRISMA sobre las bases científicas Google académico, Redalyc y Scielo. Se utilizaron como términos de búsqueda Apego y Satisfacción en la Relación de parejas, encontrándose un total de 519087 artículos. Se incluyeron sólo los artículos de acceso abierto publicados en inglés durante los últimos 5 años. Luego de filtraje, el cribado y el cribado definitivo, los cuales se encuentran desarrollados en el diagrama de flujo, se excluyeron 519072 artículos, seleccionando 20 que tomaban como muestra la relación de pareja adulta.
Los datos hallados confirman la existencia de una relación entre los vínculos de apego y la satisfacción en las relaciones de pareja. Asimismo, se observa que las estrategias de apego evitativo y ansioso tienen menor nivel de satisfacción en su relación romántica.

Systematic Review on Adult Attachment and the Impact on Relationship Satisfaction

ABSTRACT

The present study aims to survey scientific research on the relationship between adult attachment and satisfaction in couple relationships.
For this reason, a Systematic Review was conducted using the PRISMA statement on the scientific bases of Google Scholar, Redalyc and Scielo. The search terms used were Attachment and Satisfaction in Couple Relationships, and a total of 519,087 articles were found. Only open access articles published in English during the last 5 years were included. After filtering, screening and final screening, which are developed in the flow chart, 519,072 articles were excluded, selecting 20 that took the adult couple relationship as a sample.
The data found confirm the existence of a relationship between attachment bonds and satisfaction in couple relationships. Likewise, it is observed that avoidant and anxious attachment strategies have a lower level of satisfaction in their romantic relationship.

keywords:
Adult attachment
Couple relationship
Satisfaction
Attachment styles
Couple dynamics

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Apego y Satisfacción en la Pareja

Aquellos organismos que maduran extrauterinamente requieren de cuidadores que garanticen que esa maduración sea lograda con éxito para satisfacer sus necesidades psíquicas y biológicas. Bowlby (1993) ha denominado como *figura de apego* a aquellos cuidadores que realizan en nuestra especie la inversión parental que se sostiene a lo largo del desarrollo de los infantes. La persona por naturaleza tiende a formar vínculos significativos con su figura de apego, y es ella quien define los límites de accesibilidad, en base a su historia personal y su contexto. La creación de este lazo es fundamental para la supervivencia del individuo y permite la formación de estructuras de significado que posibiliten la interpretación de la realidad.

En definitiva, la conducta de apego hace referencia a las distintas formas que adopta la persona para construir vínculos a lo largo de su ciclo vital, buscando mantener la proximidad con la persona deseada (Bowlby, 1993, p. 41).

Las conductas de apego se manifiestan a través de distintas estrategias de acuerdo al vínculo que se establezca con la figura de apego durante la infancia. Estas estrategias se clasifican en: seguro (B), inseguro-evitativo (A), o inseguro-ambivalente (C), y cada una de ellas puede influir en la satisfacción de la relación de pareja a futuro.

Estos modelos de apego son inconscientemente incorporados como modelos vinculares para las relaciones adultas de pareja. Con relación a lo que entendemos por *pareja*, y haciendo referencia a las palabras de Neuburger (1998), se la define como “dos personas que se encuentran y eligen por diferentes cualidades; físicas, intelectuales y morales, pero también por razones inconscientes, relacionadas con el pasado de cada uno”. Esta historia personal es importante para el vínculo que se genera entre ambos, ya que juega un papel clave en la configuración de la estrategia de apego y como consecuencia de ello, afecta la satisfacción y estabilidad de la relación de pareja. Entendemos a la *satisfacción* en las relaciones románticas como la evaluación interna que hace una persona de los sentimientos positivos de su pareja y del atractivo de su relación (Rusbult, 1983). Dependiendo de la evaluación que pueda realizar la persona va a determinar el comportamiento hacia su pareja y cuán gratificante será ese vínculo a lo largo tiempo.

El objetivo principal de este trabajo es explorar y comprobar la existencia de una asociación entre las estrategias de apego y la satisfacción en la relación de pareja.

Método

El presente estudio se realizó siguiendo los estándares de la declaración PRISMA (Urrutia y Bonfill, 2010; Munive-Rojas y Gutiérrez-Garibay, 2015), de acuerdo pasos de calidad para la revisión sistemática exceptuando los ítems 3, 4, 5, 6, 12, 13, 15, 16, 19, 20, 22, 23, 24, y 25 específicos para estudios de revisión meta analíticos.

Procedimiento

En relación al objetivo del estudio y considerando el método elegido, se decidió incluir los siguientes ítems de la declaración PRISMA: 1 (título), 2 (resumen estructurado), 7 (fuentes de información), 8 (búsqueda), 9 (selección de los estudios), 10 (proceso de extracción de datos), 11 (lista de datos), 14 (síntesis de resultados), 17 (selección de estudios), 18 (características de los estudios), 21 (síntesis de los resultados), 26 (conclusiones), 27 (financiación).

La búsqueda exhaustiva realizada en los repositorios mencionados en el apartado de método permitió seleccionar un total de 20 artículos: 0 de la red SCIELO, 17 de GOOGLE ACADÉMICO y 3 de REDALYC.

Estrategia de Búsqueda

Se llevó a cabo el día 29 de agosto del 2024 una búsqueda exhaustiva de los artículos científicos sobre cómo se asocian los estilos de apego con la satisfacción y estabilidad de las relaciones, publicados en las bases Scielo, Redalyc y Google Académico de acuerdo a dos categorías de palabras clave: (a) Apego, (b) Satisfacción en la relación de pareja (*attachment and couple relationships satisfaction)*. Dentro de los artículos científicos abordados, se tomaron en cuenta otras revisiones sistemáticas.

Originalmente se encontraron 519087 artículos. Los criterios de Inclusión/Exclusión utilizados fueron: (a) Artículos publicados en inglés, (b) Artículos publicados durante los últimos 5 años. Se obtuvieron un total de 1208 artículos. Se realizó un cribado definitivo en el que se excluyeron los artículos que no se circunscribían a la temática seleccionada. Siguiendo los criterios mencionados, se incluyeron finalmente 20 artículos (ver Figura 1).

Resultados

En los artículos considerados, se reporta: el/los autor/es y año de publicación, el título del artículo, el instrumento de medición que se utilizó, la muestra y los resultados relevantes. La información mencionada se reporta en la Tabla 1.

Figura 1
Diagrama de Flujo

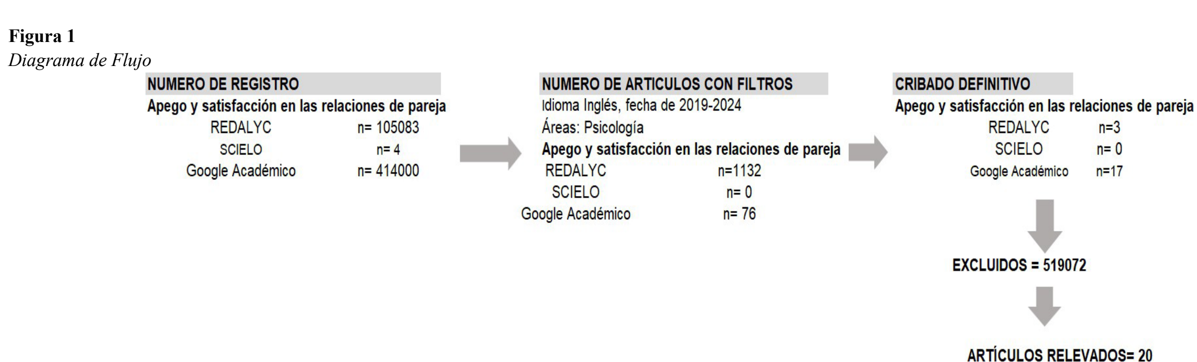

Tabla 1

Revisión Sistemática de la Relación entre Apego y Satisfacción en las Relaciones de Pareja

Autor/año	Artículo	Instrumento	Muestra	Resultados relevantes
Barros, R. de S. N., Soares, A. B. y Hernandez, J. A. E. (2019).	Social skills, empathy, love, and satisfaction in the family life cycle	Inventario de Habilidades Sociales (SSI) de A. Del Prette y Del Prette (2001) con 42 ítems	446 adultos casados, residentes del Área metropolitana de Rio de Janeiro. Brasil	Para los hombres la satisfacción está dada por la pasión, autocontrol proactivo, decisión/ compromiso. En las mujeres se da por el compromiso, la sensibilidad afectiva, decisión/ compromiso y pasión.
Bretaña, I., Alonso-Arbiol, I., Lavy, S. y Zhang, F. (2019).	Apego, Resolución de Conflictos, Satisfacción Marital, y Cultura en Mujeres	Cuestionarios de auto-registro que evaluaban las dimensiones de apego, estrategias de resolución de conflicto (percibidos en uno mismo y en la pareja) y la satisfacción marital. Para analizar las diferencias culturales entre las variables se llevó a cabo una comparación de medias con análisis de varianza (ANOVA).	343 mujeres con edades que oscilan entre 18 y 68 años.	Se demostraron variaciones en cuanto al apego inseguro (ansioso-evitativo) y la resolución de conflictos a nivel individual y en la pareja. Sin embargo, no hay diferencias en lo que respecta a la satisfacción marital entre mujeres de distintos países. Por otro lado, mujeres de culturas colectivistas tienden a obtener puntuaciones altas en una estrategia de apego evitativo. En la resolución de conflictos, los países más individualistas tienen una tendencia mayor a evitar los conflictos mientras que las mujeres de países colectivistas se auto perciben como exigentes. Las mujeres españolas consideran que sus parejas resuelvan los conflictos de manera positiva, seguidas por las de Israel, Turquía y EE.UU. En términos de satisfacción marital, las mujeres de culturas femeninas (España y Turquía) obtienen puntuaciones más altas en comparación con las de culturas masculinas (Estados Unidos e Israel).
Candel, O. S. y Turliuc, M. N. (2019).	Insecure attachment and relationship satisfaction: A meta-analysis of actor and partner associations. Personality and Individual Differences, 147, 190-199.	Revisión sistemática		Se obtuvo como resultado la confirmación de que existe una relación negativa entre el apego inseguro y la satisfacción en la relación de pareja, y que el efecto del protagonista es más fuerte en comparación con el nivel de la pareja. A su vez, la relación entre la inseguridad en el apego y la satisfacción en la relación de pareja varía según el tipo de publicación, la edad, el estado de la relación, la duración y la región.
Da Costa, C. B. y Pereira Mosmann, C. (2020).	Aspects of the marital relationship that characterize secure and insecure attachment in men and women	Experiencia en Relación Próxima, Escala de Conflicto Conyugal, Cuestionario de Comportamie nto de Resolución de Conflictos, Cuestionario de Comunicación y Escala Revisada de Ajuste Diádico.	485 participantes del sur de Brasil.	Se obtuvo como resultado que las variables testeadas caracterizan el apego seguro o inseguro. Es así como se llega a la conclusión de que el tipo de apego resulta relevante en la evaluación del funcionamiento individual y conyugal.
Elveđi, L. (2023)	Rana privrženost i privrženost u partners kimodnosima			Busca describir las diferencias entre los estilos de apego en los aspectos de las relaciones de pareja como por ejemplo creencias, satisfacción, resolución de conflictos.
Gauvin, S. E., Maxwell, J. A., Impett, E. A. y MacDonald, G. (2024).	Love Lost in Translation: Avoidant Individuals Inaccurately Perceive Their Partners' Positive Emotions During Love Conversations. Personality and Social Psychology Bulletin, 01461672241 258391	Modelo de Juicio de Verdad y Sesgo	303 parejas	Personas con apego evitativo pueden ser menos sensibles o receptivas a cuestiones positivas de la relación y las emociones de su pareja.
Grey, C. (2024).	Are you Satisfied? A Look at How Adult Attachment Style and Perfectionism Influence Romantic Relationship Satisfaction.	Se utilizó un análisis de ruta para probar el modelo.	214 adultos en relación. romantica.	Se comprobó una relación directa entre niveles altos de evitación del apego y menor satisfacción en la relación. No se probó relación significativa entre apego ansioso y la satisfacción en la relación. Se demostró una relación directa entre el apego evitativo y el ansioso con el perfeccionismo desadaptativo.Pero no entre el perfeccionismo desadaptativo y satisfacción en la relación

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Guzmán-González, M., Barrientos, J., Gómez, F., Meyer, IH, Bahamondes, J. y Cárdenas, M. (2019).	Apego romántico y satisfacción en las relaciones de pareja en hombres gay y lesbianas en Chile. *The Journal of Sex Research* , *57* (8), 1026–1035.	Entrevista a los participantes.	259 individuos en una relación de pareja del mismo sexo. El rango de edad para los hombres es entre los 18 y 66 años, mientras que para las mujeres es de 18 a 57 años.	Se obtuvo como resultado una asociación negativa entre la evitación del apego y la satisfacción en la relación, pero no entre la ansiedad por el apego y la satisfacción en la relación. Por otro lado, no se observaron efectos moderadores en relación al género.
Huang, C. Y., Sirikantraporn, S., Pichayayothin, N. B. y Turner-Cobb, J. M. (2020).	Parental attachment, adult-child romantic attachment, and marital satisfaction: An examination of cultural context in Taiwanese and Thai heterosexual couples. *International journal of environmental research and public health, 17*(3), 692.	Medida de apego adulto ECR-R.	100 parejas tailandesas (edad M = 45,59 años, SD = 10,86) y 73 parejas taiwanesas (edad M = 39,55 años, SD = 9,13).	Los resultados arrojados mostraron que la ansiedad por apego romántico se relaciona negativamente con la satisfacción en parejas casadas taiwanesas. En cambio en las parejas tailandesas, ni la ansiedad ni la evitación del apego se asociaron con la satisfacción en el matrimonio.
Kanaganayagam, S. (2024)	Attachment (Avoidance and Anxiety) in Relation to Marital Satisfaction in Couples Born between 1980 and 2000.	Se utilizó un cuestionario demográfico y tres instrumentos para recopilar datos: la escala de experiencia en relaciones cercanas, versión corta, la escala de satisfacción conyugal de enriquecimien to y la escala de integración del uso de las redes sociales. Se aplicaron las técnicas de análisis de datos de Hayes, regresión y correlación para determinar la asociación entre la satisfacción conyugal y los tipos de apego (ansiedad, evitación). El análisis de datos se realizó utilizando la macro Hayes PROCESS para encontrar la moderación de las variables.	en parejas heterosexuale s que viven en los EE. UU., nacidas entre 1980 y 2000.	Se reveló que existe una correlación entre el estilo de apego (ansiedad y evitación) y la satisfacción conyugal, y que los niveles más altos de uso de las redes sociales tuvieron un resultado moderador estadísticamente significativo sobre la fuerza o dirección de la relación entre el apego (ansiedad, evitación) y la satisfacción conyugal.
Kaur, J., y Soni, S. (2024).	Investigación de la relación entre rasgos de personalidad, estilos de apego y satisfacción relaciona l en relaciones románticas de pareja. *Revista Internacional de Enfoques Interdisciplinarios en Psicología , 2* (4), 731-764.	Escala de apego para adultos, la Escala de evaluación de relaciones y la NEO-FFI. Los análisis principales se basaron en la correlación de rangos de Spearman y la prueba U de Mann-Whitney.	Estudio transversal e incluyó a 77 parejas heterogéneas con edades comprendidas entre 25 y 45 años.	Se concluyó que la ansiedad y la evitación del apego tuvieron una correlación negativa con la satisfacción en las relaciones. En las medidas de neuroticismo de la personalidad las mujeres obtuvieron puntuaciones más elevadas que los varones. Por otro lado, en cuanto a la extroversión, los hombres obtuvieron valores más altos que las mujeres.
Krapić, N. y Daraboš, D. (2024).	Attachment Styles and Satisfaction With Different Aspects of Romantic Relationships: Dyadic Analysis. *Psihologijske teme, 33*(2), 459-481.	Se utilizó el Cuestionario de Relaciones Interpersonale s, que mide cuatro estilos de apego: seguro, despectivo, preocupado y temeroso	se evaluaron 215 parejas heterosexuales	Se arrojaron resultados positivos sobre la calidad y estabilidad de las relaciones de los hombres con apego seguro , en cambio, con el apego inseguro (evitativo y ansioso) se obtuvieron resultados negativos sobre la calidad de la relación, la satisfacción con la pareja y la evaluación general de la relación en los hombres. También indica que las mujeres que tienen parejas con apego inseguro, están menos satisfechas.
Mohd Hasim, M. J., Hashim, N. H. y Mustafa, H. (2023).	Married life: Measuring adult romantic attachment and satisfaction. Couple and Family Psychology: *Research and Practice, 12*(3), 119.	Entrevista a los participantes.	400 (n = 400) personas casadas en Penang, Malasia, participaron en este estudio.	Se obtuvo como resultado que los participantes con estilo de apego seguro son los que presentan mayor nivel de satisfacción en el matrimonio en comparación con los de estilo de apego preocupado, despectivo y temeroso.

Autor/año	Artículo	Instrumento	Muestra	Resultados relevantes
Moradi Janati, A., Salehi, S. y Shaygan Majd, F. (2024).	El papel mediador de la regulación emocional en la relación entre los estilos de apego y el bienestar psicológico. Caspian Journal of Health Research, 9 (2), 85-94.	Escala de bienestar psicológico, los estilos de apego de adultos y el cuestionario de regulación emocional.	Muestreo por conveniencia. Participaron 250 parejas (125 hombres y 125 mujeres)	Los resultados de este estudio revelaron que la regulación emocional juega un papel mediador en la relación entre los estilos de apego y el bienestar psicológico.
Peters, S. D., Meltzer, A. L. y McNulty, J. K. (2024).	La inseguridad en el apego propio y de pareja interactúa para predecir la satisfacción y la disolución matrimonial. Ciencias de la personalidad y psicología social.		539 parejas de Recién casado	Tres de las cuatro estrategias de apego (a excepción de la evitación del apego propio y la evitación del apego de la pareja) dieron como resultado la disolución matrimonial en serie a través de la satisfacción marital inicial y los cambios en la satisfacción. Los resultados arrojaron evidencia de los efectos interactivos del apego y destacan la importancia de las características de ambos miembros de la pareja para mantener relaciones de pareja satisfactorias.
Sommantico, M., Parrello, S. y De Rosa, B. (2020).	Satisfacción en las relaciones lésbicas y gays entre italianos: apego adulto, apoyo social y estigma internalizado. Archives of Sexual Behavior , 49 , 1811-1822.	Experiences in Close Relationships Revised (ECR-R), cuestionario autoadministrable que evalúa las estrategias actuales de apego en las relaciones románticas Multidimensi onal Scale of Perceived Social Support (MSPSS), cuestionario que evalúa la percepción de apoyo social. Measure of Internalized Sexual Stigma for Lesbians and Gay Men (MISS-LG) es un cuestionario autoadministrable que mide el estigma sexual internalizado La Gay and Lesbian Relationship Satisfaction Scale (GLRSS) es un cuestionario de 24 ítems que mide la satisfacción en las relaciones de parejas lesbianas y gays.	305 lesbianas y hombres gay de 19 a 72 años y en una relación del mismo sexo durante al menos 6 meses.	Los resultados indicaron que los estilos de apego, el apoyo percibido y el estigma internalizado se correlacionaron negativamente y predijeron la satisfacción en las relaciones. Los resultados indicaron que los estilos de apego, el apoyo percibido y el estigma internalizado se correlacionaron negativamente y predijeron la satisfacción en las relaciones.
Shinde, S., Sanghvi, N. y Hinduja, D. (2023).	Estilos de apego y satisfacción marital: un estudio para asociar patrones de apego y satisfacción en los matrimonios , 132 (1), 15-15.	Escala de apego adulto de 18 ítems de Collins y Reed con una escala Likert de 5 puntos y el Índice de satisfacción de parejas de 16 ítems (CSI-16) de Funk y Rogge.	65 participantes casados pertenecientes a diferentes partes de la India	Arrojó que las personas con un estrategia de apego cercano tienden a experimentar satisfacción en sus relaciones más que aquellos con apego de ansiedad. Las personas con estrategia de apego dependiente muestran mayor satisfacción en las relaciones que aquellos con apego ansioso.
Udani, M., Shah, Y., Hardinge, B. y Carvalho, M. J. (2019)	Satisfacción en las relaciones y su vínculo con el apego y el perdón de los adultos. JIGYAASA, 152. (2019)	Se utilizó la versión revisada de Apego Adulto (Collins 1996) Índice de Satisfacción de Pareja (CSI) escala de motivación interpersonal relacionada con la transgresión, formulario de 12 ítems (TRIM-12)	Grupo de 89, participantes en el grupo de edad de 18 a 25 años.	Los resultados revelaron una correlación negativa entre la satisfacción en la relación y el apego ansioso. Estos hallazgos tienen implicaciones importantes para permitir una mejor comprensión de las relaciones y los factores que influyen en la satisfacción.
Uluyol, F. M. y Özen-Çıplak, A. (2024).	Dyadic relationship of adult attachment patterns and interpersonal schemas in marital adjustment: Actor–partner effect model. Family Relations.	Completaron medidas de esquemas interpersonale s, apego adulto y ajuste marital.	230 parejas casadas turcas	La ansiedad por el apego está relacionada indirectamente con el ajuste marital en las parejas a través de los esquemas interpersonales. Sin embargo, la evitación del apego está relacionada tanto directa como indirectamente con el ajuste marital a través de los esquemas interpersonales.

Autor/año	Artículo	Instrumento	Muestra	Resultados relevantes
Vollmann, M., Sprang, S. y van den Brink, F. (2019)	Apego adulto y satisfacción en la relación: el papel mediador de la gratitud hacia la pareja. *Journal of Social and Personal Relationships, 36* (11-12), 3875-3886.	Se utilizó un cuestionario en línea que evaluaba la evitación del apego y la ansiedad, la gratitud hacia la pareja y la satisfacción en la relación	362 participantes, en su mayoría mujeres entre 18 a 70 años de edad	El análisis de regresión reveló efectos directos y negativos tanto de la evitación como de la ansiedad en la satisfacción en la relación. En contraposición, el análisis bootstrap reveló un efecto indirecto negativo de la evitación, pero no de la ansiedad, en la satisfacción en la relación a través de la gratitud hacia la pareja. Los niveles más altos de apego evitativo se vinculan con una menor gratitud hacia la pareja, lo que se asocia con un grado de menor satisfacción.

Nota: los resultados relevados están ordenados por orden alfabético según el autor.

Los artículos arrojan datos homogéneos. De acuerdo con la investigación realizada por Udani et al. (2019) sobre las estrategias de apego y la satisfacción en las relaciones románticas, se observa una mejora negativa entre el apego ansioso y la satisfacción en la relación romántica, lo cual refuerza la idea de que este estilo de apego puede deteriorar la calidad de las relaciones. Por el contrario, los resultados obtenidos por Guzmán-González et al. (2019) indican una asociación negativa entre la evitación del apego y la satisfacción en la relación, pero no entre la ansiedad por el apego y la satisfacción en la relación. Por otro lado, los investigadores no observaron efectos moderadores en relación al género de las personas que conformaban las parejas estudiadas.

Al mismo tiempo, Vollmann et al. (2019) realizaron un analisis de regresión y un analisis bootstrap en relación a las variables mencionadas. En el primer tipo de analisis se identificaron efectos directos y negativos entre la satisfacción de la relación y la evitación o ansiedad. Sin embargo, el segundo tipo de analisis realizado y sus resultados coinciden con los hallazgos de Guzmán-González et al. (2019) ya que se identificó un efecto indirecto y negativo de la evitación, pero no de la ansiedad, en la satisfacción de la pareja a través de la gratitud que se tiene hacia ella. De esta manera, los hallazgos sugieren que los niveles más altos de apego evitativo se asocian a una menor gratitud hacia la pareja, lo que contribuye a la disminución de la satisfacción en su relación.

En línea con estos hallazgos, Gray et al. (2024) amplió el enfoque de investigaciones previas al considerar la posible conexión entre el perfeccionismo desadaptativo y el apego. Su investigación reveló una relación directa entre altos niveles de evitación del apego y menor satisfacción en las relaciones románticas. Sin embargo, a diferencia de Udani et al. (2019), Gray no encontró evidencia significativa sobre el impacto del apego ansioso en la satisfacción relacional.

Al igual que los resultados obtenidos por Gray et al. (2024) revelaron que las personas con apego evitativo pueden ser menos sensibles o receptivas a cuestiones positivas de la relación y las emociones de su pareja.

Por otro lado, Kanagayagam (2024) examinó la relación entre los estilos de apego y la satisfacción marital en parejas estadounidenses, evaluando también el papel moderador de las redes sociales en estas dinámicas. A pesar de incluir esta variable adicional, sus resultados estadísticos demostraron una correlación clara entre las estrategias de apego y la satisfacción conyugal, reforzando la idea de que la forma en que las personas se vinculan afecta significativamente la calidad del vínculo.

Para concluir, una investigación reciente de Peters et al. (2024) ofrece una perspectiva innovadora que contrasta con los datos anteriores. Al examinar la relación entre la inseguridad en el apego propio y el de la pareja, y su impacto en la satisfacción y posible disolución del matrimonio, los autores sostienen que los datos empíricos no permiten establecer una conexión clara entre la interacción del apego inseguro y la ruptura de la relación. Sin embargo, subrayan que las características personales de cada individuo desempeñan un papel crucial en la satisfacción del vínculo, más allá del apego. Estos hallazgos sugieren que, si bien la forma en que las personas se relacionan con sus parejas influye en la satisfacción de la relación, no existe una relación directa entre un nivel bajo de satisfacción y la resolución de la relación. Esto destaca la importancia de considerar factores adicionales, como las características personales y contextuales, en la comprensión de la dinámica relacional.

Discusión

En el presente trabajo, se realizó una revisión sistemática con el objetivo de investigar la relación existente entre apego adulto y satisfacción en las relaciones de pareja. Se incluyeron los artículos en inglés publicados en los últimos cinco años utilizando como términos de búsqueda Apego adulto y Satisfacción en las relaciones de pareja en los repositorios REDALYC, SCIELO y GOOGLE ACADÉMICO. Se descartaron los artículos duplicados o que no tenían relación con la temática, obteniendo un total de 20 artículos relevantes.

Los hallazgos obtenidos confirman la relación positiva entre vínculos de apego seguro y la satisfacción en la relación de pareja. Por el contrario, las estrategias de apego evitativo y ansioso se asocian con un menor nivel de satisfacción en su relación romántica. Además, se encontraron correlaciones entre los distintos tipos de apego y diferentes variables personales o contextuales, como por ejemplo el perfeccionismo desadaptativo de alguno de los miembros y el uso de redes sociales.

A partir de los datos obtenidos, es de gran importancia trabajar en la prevención y detección temprana de estrategias de apego desadaptativo por medio de talleres tanto para los padres como para los hijos. De igual manera, resulta fundamental brindar espacios de intercambio y psicoeducación para las parejas adultas con profesionales especializados en la temática.

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Declaración

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Declaración de Autoría

Noralí Marilisa Vizcay: Conceptualización, análisis formal, visualización y redacción -borrador original-

Sofía Nazarena Di Giuseppe: Conceptualización, análisis formal y visualización y redacción -borrador original-.

Silvana Milozzi: Administración del proyecto, supervisión y validación

Conflicto de Intereses

Los autores de este manuscrito declaran que no existe ningún conflicto de interés financiero, personal, académico o institucional que pudiera haber influido en la realización de este estudio, el análisis de los datos o la interpretación de los resultados.

Referencias

Las referencias marcadas con un asterisco indican los trabajos incluidos en la revisión.

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El Rol del Apego en el Desarrollo del Lenguaje y la Comunicación a lo Largo de la Vida

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INFORMACIÓN

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Palabras clave:
Teoría del apego
Desarrollo del lenguaje
Comunicación adulta

RESUMEN

Este estudio tiene como objetivo comprender el papel del apego infantil en la adquisición del lenguaje y el desarrollo de las habilidades comunicativas en la adultez. Se realizó una revisión bibliográfica en dos bases de datos (PubMed, Web of Science), recopilando estudios relacionados a la Teoría del Apego y el desarrollo de las habilidades comunicativas desde la infancia a la adultez. Se observó que el desarrollo del lenguaje requiere precursores como pautas de apego seguro para optimizan el aprendizaje del lenguaje y que, posteriormente la evolución de las habilidades comunicativas se ven favorecidas por vinculaciones sanas y consistentes en la vida de los individuos, además de otros agentes como la calidad educativa, vínculos de pareja, entre otros. Los datos recopilados sugieren que el desarrollo del lenguaje no es un proceso estático en el tiempo, sino que varía en función de la etapa del ciclo vital en la que se manifiesta. Además, se integra la habilidad para sobrellevar procesos reflexivos y la capacidad de sostener relaciones afectivas.

The Role of Attachment in Language and Communication Development Across the Lifespan

Keywords:
Attachment theory
Language development
Adult communication

ABSTRACT

This study aims to understand the role of infant attachment in language acquisition and the development of communicative skills in adulthood. A literature review was conducted in two databases (PubMed, Web of Science), compiling studies related to Attachment Theory and the development of communicative skills from infancy to adulthood. It was observed that language development requires precursors that optimize the learning process and that, subsequently, human interaction is based on the search to meet their needs, define oneself, and form relationships with others, mediated by interactions sustained in childhood. The data collected suggest that language development is not a static process over time but varies depending on the stage of the life cycle in which it occurs. Additionally, it integrates the ability to cope with reflexive processes and the capacity to sustain affective relationships.

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La adquisición y el desarrollo del lenguaje han sido estudiados en búsqueda de comprender elementos esenciales en el habla como la fonética, la prosodia y la sintaxis, así como su vínculo con la cognición y la adquisición de conocimientos (Vivas, 2016). Su función comunicativa ha sido fundamental para la conformación de sociedades, permitiendo la transmisión de ideas, juicios y facilitando la cohesión de la comunidad (Guillen-Chavez et al., 2021). Paralelamente, la Teoría del Apego a través de los postulados de Bowlby (1973) ha sido uno de los motores de investigación más relevante en el estudio del comportamiento humano (Jethava, 2022). Pareciera entonces que ambas corrientes de estudio comparten espacios comunes en investigaciones relacionadas con los vínculos afectivos.

El desarrollo del lenguaje es un fenómeno complejo y multicausal, que depende de diversos factores, como la madurez neuropsicológica, el desarrollo afectivo y cognitivo, y los contextos donde se desenvuelve el niño (Silva, 2014). Esto propicia diferencias no solo en la adquisición, sino también en la velocidad y calidad de este (Carvalho et al., 2016). Específicamente, la familia es el primer contexto donde los niños pueden interactuar con otros, siendo fundamental para el desarrollo de habilidades comunicativas desde la adquisición del lenguaje hasta el ejercitamiento en años posteriores.

En vista de un fenómeno no tiene únicamente orígenes educativos, surge el objetivo de recopilar investigaciones que aborden el apego y el desarrollo del lenguaje a lo largo del ciclo vital, intentando develar la influencia socioemocional en la evolución de la expresividad oral. Este proceso investigativo se guía mediante la pregunta ¿cuál es el rol del apego infantil en la adquisición del lenguaje y desarrollo de habilidades comunicativas en la adultez?

Metodología

Se realizó una búsqueda bibliográfica a través de dos bases de datos principales: PubMed y Web of Science, centrada en estudios relacionados con la Teoría del Apego y el Desarrollo de las Habilidades Comunicativas desde la infancia hasta la adultez. Los criterios de inclusión para esta investigación fueron estudios empíricos publicados entre 2015 y 2024, en inglés y español, que asociaran al menos dos de los siguientes conceptos: (a) Teoría del Apego, (b) Desarrollo del Lenguaje, (c) Comunicación Adulta y (d) Habilidades Comunicativas. Se incluyeron solo aquellos estudios que abordaran la relación entre estos conceptos y el carácter relacional del desarrollo de las habilidades comunicativas, es decir, aquellos que exploraron las interacciones tempranas en la formación de patrones comunicativos. Además, se consideraron artículos interdisciplinarios provenientes de áreas como psicología, lingüística y sociología. Para complementar la búsqueda, se revisaron artículos y estudios en literatura interdisciplinaria que contribuyeran a enriquecer la comprensión de los procesos comunicativos en el desarrollo humano. Posteriormente, se realizó un examen preliminar de los estudios encontrados, determinando su relevancia y ajustándose a los requisitos establecidos. Finalmente, se excluyeron aquellos estudios que no se centraron en el análisis de la dimensión relacional en el proceso de desarrollo del lenguaje y las habilidades comunicativas (Figura 1). El proceso de búsqueda y filtrado de artículos se encuentra reflejado en la figura 1.

Teoría del Apego: Consideraciones Generales

La Teoría del Apego es uno de los marcos conceptuales más difundidos en el estudio del comportamiento social (Guzmán-González et al., 2016). Esta teoría describe la necesidad universal de los niños de crear relaciones socioemocionales estrechas con sus cuidadores, quienes les proveen de protección durante situaciones que puedan ser amenazantes o susceptibles de estrés (Bowlby, 1969). Se comprende que por medio de esta interacción comienza a conformarse la habilidad para la regulación emocional y el afrontamiento de agentes estresores, así como también, se favorece el desarrollo cognitivo y la formación de pautas de comportamiento (Zimmer-Gembeck et al., 2017).

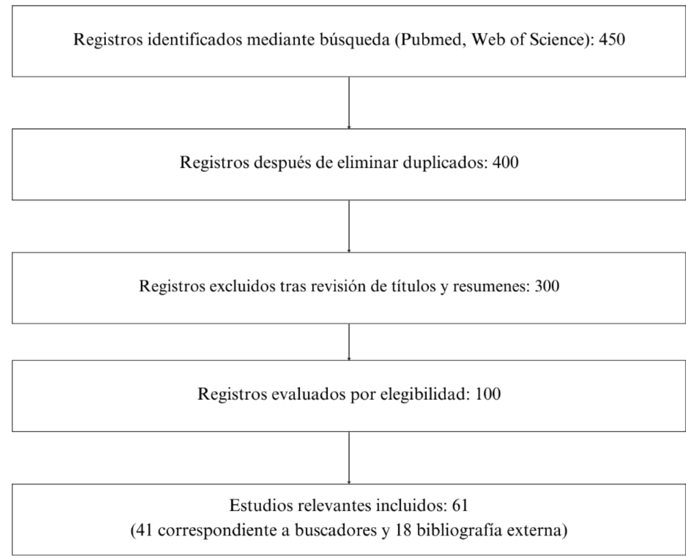
Los estilos de apego, seguro e inseguro, manifiestan el modo de respuesta de los cuidadores primordiales y su estabilidad en el cuidado (Papapetrou et al., 2020; Díaz-Mosquera, 2022). Estos estilos abarcan un espectro que va desde conductas que faciliten la capacidad de expresar libremente sus sentimientos, pensamientos y autonomía en la exploración, hasta la aparición de ansiedad, conductas antisociales, depresión y baja autoestima (Coutinho et al., 2020).

De acuerdo con la Teoría del Apego, la calidad del vínculo generado con las figuras de apego en la infancia repercute tanto en las representaciones de sí mismo como de los otros (Guzmán-González et al., 2016) siendo traducidas en lo que Bowlby (1973a, 1973b) denominó Modelos Operativos Internos (IWM). Los Modelos Operativos Internos son representaciones mentales que los niños desarrollan a partir de sus interacciones con los cuidadores, las cuales influyen en la forma en que interpretan sus relaciones futuras, las emociones y el comportamiento tanto propio como ajeno. Estos modelos actúan como “esquemas” que guían la percepción, la interpretación y la reacción ante las experiencias emocionales y sociales (Speidel et al., 2022). Según Bowlby (1973a, 1973b), los IWM son estructuras cognitivas que permiten a los individuos predecir y organizar sus interacciones sociales, basándose en las experiencias previas de cuidado y apego. La calidad de estos modelos, por tanto, está directamente influenciada por la seguridad o inseguridad del vínculo afectivo con las figuras de apego.

Cuando los cuidadores son sensibles y consistentes, el niño desarrolla un IWM seguro, lo que favorece una mayor capacidad de autorregulación emocional y una visión positiva de sí mismo y de los demás. Por otro lado, los niños que experimentan figuras de apego inconsistente o indiferente pueden desarrollar IWM inseguros, lo que puede derivar en dificultades para formar relaciones saludables a lo largo de la vida (Bowlby, 1973a, 1973b). Este proceso emerge de la interacción de los cuidadores primordiales con el niño, además de los factores ambientales, modelando su punto de vista acerca del entorno social y cómo se adapta a este (Bowlby, 1973a, 1973b).

La relación entre el apego y el lenguaje ha sido un fenómeno estudiado por distintas disciplinas según sus enfoques y fines particulares. Especialmente, la psicología del desarrollo ha sido precursora en investigaciones donde se señala el lenguaje como resultado de procesos psicológicos de diverso orden (Figura 2). Un ejemplo de ello es el estudio del pensamiento en edades tempranas (Hernández-Cáceres, 2012). A continuación, se presenta una investigación recopilatoria sobre el desarrollo del lenguaje desde el nacimiento hacia la adultez, basados en estudios desde 2015 hasta el presente.

Figura 1
Flujo de Extracción de Publicaciones y Proceso de Filtrado Bibliográfico



Lenguaje y Teoría del Apego en Infancia

El inicio de la adquisición del lenguaje es un proceso que transcurre entre los 6 a 10 meses de vida (Cohen y Billard, 2018), periodo en el cual los recién nacidos desarrollan notables habilidades de percepción del habla a pesar de tener sistemas auditivos inmaduros, independiente de la experiencia prenatal (Eggermont y More., 2012 como se citó en Gervain., 2020). La figura 2 grafica la interacción entre desarrollo de habilidades y apego.

Inicialmente, los bebés desarrollan interacciones que, en palabras de Jiménez (2010) son necesarias para el desarrollo lingüístico posterior y sienta las bases para las habilidades comunicativas. En estas interacciones se destacan las aptitudes visuales, descritas como la necesidad de observación mutua, seguimiento visual y observación referencial. Una característica que responde a los procesos de imitación y contagio, permitiendo que los bebés puedan identificar tempranamente las gesticulaciones capaces de develar los estados emocionales de la madre (Stern, 1985; Kuboshita, 2020).

Las aptitudes auditivas, por otro lado, se manifiestan como la capacidad de localizar el sonido y prestar atención (Jiménez, 2010). Desde una perspectiva evolutiva, estas aptitudes fueron primordiales para la supervivencia inicial y necesarias para el reconocimiento temprano que cimenta la relación con el cuidador primordial, proporcionando una huella mnémica de los actos comunicativos en el cerebro del bebé (Rakison, 2005 citado en Papalia, 2009; Abrams et al., 2016).

Las aptitudes motrices, pre orales y pragmáticas explican el proceso previo del infante, incluyendo las gesticulaciones, imitación verbal y el entendimiento de la secuenciación sonido silencio. Estas habilidades reflejan la necesidad de los infantes balbuceantes de concretar una meta específica, usualmente ligada a la obtención de objetos distantes (Jiménez, 2010). La Teoría del Apego vincula las funciones de estas primeras palabras con la habilidad materna de una interpretación acertada y respuesta eficiente a estos primeros indicios del lenguaje, denotando la sensibilidad parental hacia los requerimientos de sus hijos (Ainsworth, 1979). A su vez, se destacan los procesos sincrónicos relacionales, como una "danza diádica", que predice la seguridad en el apego en bebés, la capacidad de auto-regulación, la empatía y las competencias simbólicas primigenias (Tronick, 1989 como se citó en Gómez, 2019).

Alrededor de los 17 meses, emerge el juego simbólico y la imaginación (Cohen y Billard, 2018), momento en que los niños tienden a manipular objetos y establecer funcionalidades o significados con categorizaciones que fomentan sus habilidades sociocognitivas (Creaghe et al., 2021). Estudios indican que entre los 14 a 26 meses, los niños expuestos a un vocabulario más diverso por parte sus cuidadores tienden a presentar tasas más altas de variabilidad léxica, mostrando distintos patrones de interacción con su entorno. Particularmente, concluyen que las interacciones generadas con los niños en esta etapa son mejores predictores de las habilidades lingüísticas que poseerán entre los 9 a 13 años que los factores socioeconómicos y las habilidades del niño (Gilkerson et al., 2018).

Paralelamente, investigaciones demuestran que el estado mental de la madre juega un rol central en el desarrollo del lenguaje. Sugieren que madres quienes utilicen más lenguaje mentalizante, es decir, la capacidad para entender y narrar el comportamiento de otros en términos de sus estados mentales (Escobar et al., 2013), tienen hijos con mayor capacidad de transmitir sus deseos, pensamientos y creencias. Esto se logra mediante la conformación de una destreza metacognitiva que permite distinguir los estados mentales propios y ajenos (Becker et al., 2017; Hughes y Devine, 2020; Zegarra-Valdivia y Chino, 2017, como se citó en Białecka-Pikul et al., 2021). Este proceso es paulatino y jerarquizado, iniciado alrededor de los 3 años y medio e influenciado por aspectos como la cultura, el género y las competencias lingüísticas, puesto que, con un léxico aumentado y mayor complejidad sintáctica, la Teoría de la Mente es más eficiente (Medina et al., 2016).

La Teoría de la Mente (ToM) se refiere a la capacidad de comprender y atribuir estados mentales, tanto propios como ajenos,

como pensamientos, creencias, deseos y emociones, que influyen en las acciones y comportamientos de las personas. Esta habilidad es esencial para la interacción social, ya que permite anticipar y entender las intenciones de los demás, así como tomar decisiones fundamentadas sobre cómo comportarse en diversas situaciones sociales (Premack y Woodruff, 1978). Durante la adolescencia, la Teoría de la Mente experimenta una mayor complejidad y refinamiento debido a los cambios cognitivos, emocionales y sociales característicos de esta etapa del desarrollo. A medida que los adolescentes comienzan a experimentar un mayor nivel de autoreflexión y comprensión de las perspectivas ajenas, se observa una mejora en su capacidad para interpretar las emociones y los pensamientos de otros, lo que les permite tener interacciones sociales más sofisticadas (Blakemore y Mills, 2014). Este proceso, aunque implica una mayor habilidad para la empatía y la resolución de conflictos, también puede estar marcado por retos en cuanto a la identificación de las propias emociones y la comprensión de las emociones complejas, lo que requiere de atención específica en este período del ciclo vital (Miller et al., 2016).

Existe un aumento en la adquisición de palabras complejas, influenciando el desarrollo y capacidad de sus habilidades mentalizantes (Białecka-Pikul et al., 2021). Esto destaca el desarrollo del pensamiento acerca de sí mismos, siendo capaces de describir al mundo mediante narrativas propias para reconstruir el pasado desde una perspectiva que cobre sentido (Linde, 1993 como se citó en Köber et al., 2018). Además, la habilidad para autorregularse, detectando la capacidad de pensarse a sí mismo y de expresión oral son predictores lineales del comportamiento externalizante desde la niñez hasta la adultez (Roskam, 2019). De acuerdo con Lind et al. (2020), la ToM mejora a través de la adolescencia, siendo un fuerte predictor de narrativas más coherentes en la adultez.

Apego y Habilidades Comunicativas en la Adultez

Los estilos de apego son dinámicas que permanecen relativamente estables a lo largo del tiempo y, la etapa de la adultez, las pautas conformadas en la infancia comienzan a influir en las vinculaciones estrechas y amorosas (Fraley, 2002; Fraley et al., 2011). Esto es especialmente evidente en situaciones que desencadenen sentimientos de estrés, donde el sistema de apego probablemente se active al reconocer escenarios que puedan implicar separación o rechazo (González-Ortega et al., 2021; Julian et al., 2013), siendo frecuentemente medido a través de dos dimensiones: ansiedad o evitación.

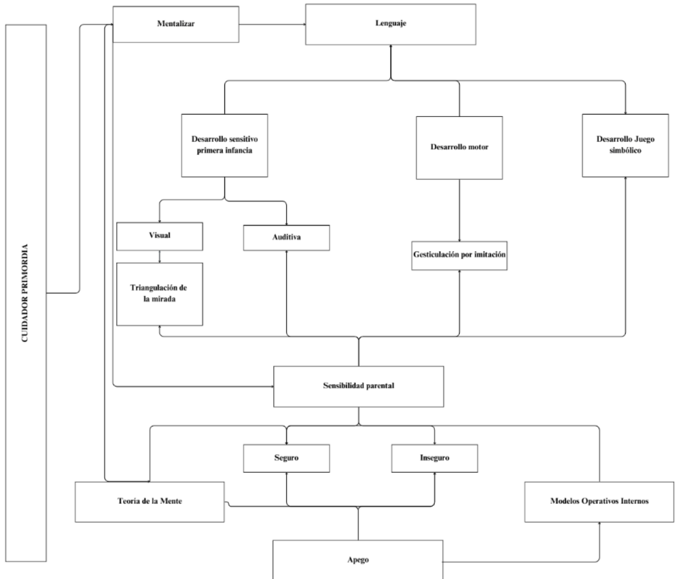
En personas adultas, la interacción entre el apego y el lenguaje tiende a manifestarse mediante la mentalización y las habilidades comunicativas, facilitando espacios de intimidad en distintas subesférases de la vida, tales como la resolución de conflictos, conductas de sociabilización, relaciones amorosas y parentalidad, entre otros (Figura 3).

Estudios sobre mentalización y apego adulto destacan el rol mediador de la capacidad mentalizante frente a la presencia de problemas interpersonales. Determinan que, en presencia de apego inseguro y problemas interpersonales, parece no existir efecto directo entre uno y otro cuando está presente la función reflexiva (Venta y Sharp., 2015, Wei et al., 2005). En ese sentido, se considera que el apego aumenta cuando las parejas mejoran su comunicación; ejemplo de lo anterior son los esfuerzos que realizan las parejas para reducir la angustia mediante conductas que se centren en el establecimiento de confianza y fomentan la autoaceptación (Gouveia et al., 2016).

Precisamente, en relaciones de pareja, se ha observado que quienes presentan pautas de apego evitativo tienden a solicitar menos ayuda a sus parejas, mientras que las personas de apego ansioso tienden a hipermentalizar las conductas de sus compañeros, en un intento de predecir los pensamientos del otro (Simpson y Steven, 2018). Por su parte, las personas con apego seguro se caracterizan por buscar ayuda apropiadamente cuando lo necesitan y enfrentar sus dificultades exitosamente al contar con un apoyo (Takano y Mogi, 2019; Rueda Mora et al., 2023).

En cuanto a las pautas comunicativas, se ha estudiado que tienen diferencias de acuerdo con el estilo de apego. Para Sessa et al. (2020) las personas con estilos de apego ansioso tienden a transmitir información de una manera mesurada y tienen dificultad

Figura 2
Interacción Apego y Desarrollo del Lenguaje en Primera Infancia



en comunicar contenidos desagradables, intentando reducir la ansiedad relacional que puede surgir de esta interacción. Debido a esta modulación, tienden a tranquilizar al oyente a diferencia de un estilo más directo.

Las habilidades comunicacionales en cuidadores de hijos adultos jóvenes se ven reflejadas en su capacidad de los cuidadores para consultar sobre relaciones románticas a sus hijos. Esta habilidad se correlaciona con la seguridad del apego y la calidad de la relación, sin necesidad de que las consultas sean frecuentes, preservando la comodidad y utilidad de estas instancias (Luerssen et al., 2019; Sessa et al., 2020).

Crittenden (2017) expone que las pautas de apego se presentan en las familias por medio de patrones comunicacionales desarrollados a través de esquemas relacionales, permeando en las interacciones familiares, el desarrollo de problemas personales, las interacciones sociales y las amorosas con otros. La asociación entre apego padre-hijo se sustenta en los esquemas comunicacionales de las familias, influyendo sus interacciones dentro y fuera del grupo familiar (Jiao, 2021).

Por su parte Whittington y Turner (2022) refieren que existe una relación entre los patrones de conversación abiertas y cerradas con la presencia de apego seguro, ansioso o evitativo, mencionando que las instancias de comunicación abiertas dentro de la familia se relacionen con la disminución de índices de ansiedad al transmitir un mensaje de valoración y escucha.

En su manifestación clínica, el estudio entre apego y lenguaje se ha abordado a través del Inventario de Apego Adulto (AAI por sus siglas en inglés), el instrumento más utilizado a nivel global por su alta validación de evaluación en estos aspectos. El AAI es una entrevista semiestructurada que contiene 20 preguntas relacionadas a los sentimientos y memorias de experiencias tempranas de los pacientes, categorizando sus tipos de apego como seguro o despreocupado, emergentes en la verbalización de los pacientes (Cassidy et al., 2012). Según Spinelli et al. (2019) las personas con apego despreocupado tienden a separar sus emociones de las narrativas acerca de su infancia, verbalizando pocas palabras sobre sus sentimientos y presentando inconsistencias entre la narrativa y la experiencia vivida, en oposición a las personas con apego seguro.

Waters et al. (2016) destaca que la coherencia en el AAI está relacionada con la sensibilidad paterna en su niñez. En casos del apego despreocupado, se desarrolla una estrategia que les ayude a sostener la angustia causada por la difícil experiencia de apego con sus cuidadores, tendiendo a la negativa emocional, narraciones en tiempo presente y reducción en la cantidad de palabras empleadas en términos generales.

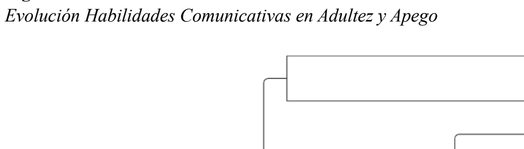
Discusión

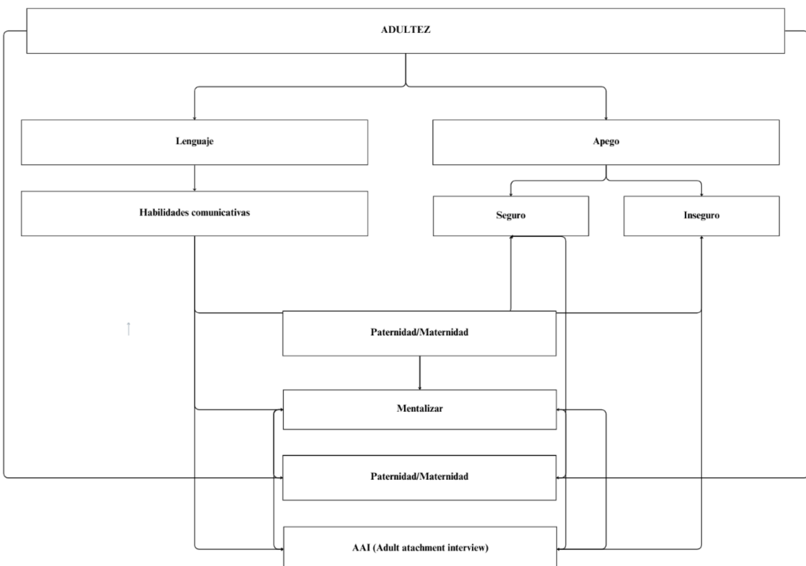
Las habilidades comunicativas se han establecido cotidianamente como una cualidad que pareciera ser innata en muchas personas. Para algunos lingüistas, las variaciones en la expresión oral desempeñan un rol central en la configuración de la sociedad actual y la reinvención de nuevas formas de comprender las dinámicas cotidianas (Mahecha-Ovalle, 2021). Mientras que, desde el modelo biomédico, las dificultades en la oratoria tienden a ser vistas como evidencia de algún tipo de trastorno del lenguaje, lo que limita el tratamiento a enfoques prácticos para resolver el problema.

Además, a pesar de la abundancia de estudios sobre los orígenes del desarrollo del lenguaje oral, no siempre consideran todos los factores involucrados en la construcción del sistema que permite a los humanos comunicarse entre ellos. A menudo, estos estudios se centran en una sola variable, como el entorno psicoafectivo, la cultura, la sociedad y la escolarización (Colas et al., 2020), creyendo que allí radica el origen del problema.

En ocasiones, la Teoría del Apego no está tan presente cuando se habla de habilidades comunicativas en la adultez, a pesar de que estos adultos fueron niños que vivieron una multiplicidad de interacciones que influyeron en su forma de expresarse hoy en

Figura 3
Evolución Habilidades Comunicativas en Adultez y Apego





día. Estudios previos, como el de Di Fini y Veglia (2019), han destacado que las relaciones de apego tempranas influyen en cómo los individuos narran sus experiencias y el sentido que otorgan a sus vivencias a lo largo de su vida. Los hallazgos de este estudio coinciden con esta perspectiva, al evidenciar que las figuras de apego juegan un rol fundamental en la construcción de modelos comunicativos que los adultos emplean en su vida cotidiana. Sin embargo, mientras que investigaciones anteriores se han centrado más en los factores educacionales o psicoafectivos para explicar las dificultades comunicativas (Colas et al., 2020), este estudio amplía el análisis al considerar que las dificultades en la expresión oral no solo provienen de aspectos educacionales o psicoafectivos, sino también de los modelos de apego formados en la infancia. De esta manera, se destaca que los adultos pueden experimentar dificultades comunicativas debido a la falta de una base segura en las interacciones tempranas, lo cual impacta la capacidad para expresar pensamientos y emociones de manera libre de prejuicios o restricciones.

Por lo tanto, se considera necesario para futuras investigaciones posicionar al apego como una variable clave en las dificultades comunicativas. Este enfoque subraya que la interacción temprana con figuras de apego puede influir en el desarrollo de modelos comunicativos más saludables y completos. Ante esto, investigaciones como la de Raby y Dozier (2019) subrayan que existe una escasa exploración sobre cómo el apego influye directamente en las dificultades comunicativas, dado que la mayoría de los estudios existentes se enfocan predominantemente en el impacto emocional y conductual del apego, sin abordar explícitamente cómo estos vínculos tempranos pueden afectar la capacidad de los individuos para comunicarse de manera efectiva en su vida adulta.

Conclusiones

Como se ha observado en esta revisión literaria, la adquisición y desarrollo del lenguaje no es un proceso estático en el tiempo, distinguiendo en cada etapa del ciclo vital una característica distintiva y propia de la evolución. En la niñez, cuenta con una serie de elementos precursores inmediatamente ligados a la posibilidad de comunicarse, siendo esencial el cuidado y la estimulación para este proceso. En ese sentido, el entendimiento de la interacción de la Teoría del Apego podría ser un factor protector para velar que el desarrollo cognitivo de los recién nacidos.

Si bien, desde la lingüística no existe una corriente clara de cómo se instauran los procesos comunicativos, parte de ellas apuntan a la relevancia de otro significativo que acompañe este proceso (Salinas-Quiroz, 2013; Lara, 2016). Particularmente, el rol de los cuidadores primordiales en este proceso no solo se ve visibilizado en la fluidez verbal o la prosodia del niño, sino que, sirve de andamiaje para la conformación del proceso de mentalización (Gálvez y Farkas, 2017). Posteriormente, en la adultez, las habilidades comunicativas propician instancias de sociabilización, así como la capacidad de comprender, apoyar y expresar ideas en torno a temas de relevancia para la persona.

Parece fundamental seguir realizando estudios en torno al rol del apego en distintos momentos de la vida, para establecer no solo intervenciones clínicas más propicias para el trabajo con los pacientes, sino también para el diseño de proyectos gubernamentales a favor de la salud mental, destinados a personas quienes la dificultad para expresarse ha disuadido la búsqueda de ayuda. La presente revisión bibliográfica no ha resuelto tales interrogantes, ni tampoco indaga en la influencia del género y la cultura en la interacción entre apego y lenguaje, además de que presenta un carácter limitado al utilizar dos databases en la investigación, instando a seguir desarrollando estudios acordes al campo de investigación.

Declaración

Los autores no recibieron apoyo económico o financiación para apoyar la investigación ni la autoría y/o publicación de este artículo. No hay interés económico o beneficio de la aplicación directa de esta investigación.

Conflicto de Intereses

La autora de este manuscrito declara que no existe ningún conflicto de interés financiero, personal, académico o institucional que pudiera haber influido en la realización de este estudio, el análisis de los datos o la interpretación de los resultados.

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Systematic review

Exploring Metacognition in a Spanish-Speaking Population: Adaptation and Validation of the Metacognition Self-Assessment Scale (MSAS)

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ABSTRACT

The study aimed to adapt and validate the Metacognition Self-Assessment Scale (MSAS) for Spanish-speaking populations. Metacognition, a multi-dimensional construct, holds a crucial role in understanding diverse psychological disorders and cognitive processes. Employing a modular approach to metacognition, the investigation focuses on specific sub-functions of metacognition such as self-monitoring, self-evaluation, and strategy selection. A sample of 138 Spanish-speaking individuals partook in the study, which encompassed the translation of the MSAS and the execution of reliability and validity tests. The results from confirmatory factor analysis support the original four-factor structure of the MSAS, including Self-Reflectivity, Critical Distance, Understanding Other Minds, and Mastery. Additionally, the study established convergent validity of the MSAS with the Toronto Alexithymia Scale (TAS-20), demonstrating a strong negative correlation between the two instruments. This adaption and validation of the Spanish version of the MSAS provides with a valuable instrument ready for clinical and investigative purposes. This contribution set the stage for future research on the role of metacognitive processes in psychological well-being, mental health, and in the psychotherapeutic process.

Explorando la Metacognición en Población de Habla Hispana: Adaptación y Validación de la Escala de Autoevaluación de la Metacognición (MSAS)

Palabras clave:
Aautoconocimiento
Evaluación
Psicoterapia
Mentalización
Estructura factorial
Psicometría

RESUMEN

El presente estudio tiene como objetivo adaptar y validar la Escala de Autoevaluación de la Metacognición (MSAS) para población de habla hispana. Empleando un enfoque modular de la metacognición, esta investigación se centra en analizar subfunciones específicas de la metacognición, como la auto-monitorización, la autoevaluación y la selección de estrategias. Una muestra de 138 individuos de habla hispana participó en el estudio, que incluyó tanto la traducción del MSAS, como la realización de pruebas de fiabilidad y validez. Los resultados del análisis factorial confirmatorio apoyan la estructura original del MSAS, que incluye cuatro factores: Autorreflexión, Distancia Crítica, Comprensión de la Mente del Otro y Dominio. Además, se estableció la validez convergente del MSAS con la Escala de Alexitimia de Toronto (TAS-20), demostrando una fuerte correlación negativa entre ambos instrumentos. Esta adaptación y validación de la versión en español del MSAS proporciona un valioso instrumento disponible para fines clínicos y de investigación. Esta contribución sienta las bases para investigar el papel de los procesos metacognitivos en el bienestar psicológico, la salud mental y el proceso psicoterapéutico.

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Exploring Metacognition in a Spanish-Speaking Population: Adaptation and Validation of the Metacognition Self-Assessment Scale (MSAS)

The concept of metacognition, initially introduced by Flavell (1979), has undergone a profound transformation over the past few decades, becoming a cornerstone in cognitive psychology. This multi-dimensional construct encompasses a broad range of cognitive abilities that surpass its original conceptualization. These abilities include self-regulation, decision-making, social cognition, theory of mind (previously termed "sociality" by Kelly, 1955/1991), and introspective accuracy, among other cognitive processes (Efklides, 2008). In the clinical domain, the significance of metacognition is underscored by its applicability in understanding a range of severe mental disorders, psychosis, and personality disorders in particular. For instance, in schizophrenia, poor metacognitive abilities have been associated with diminished social skills and neuropsychological deficits (Lysaker et al., 2011). A more comprehensive understanding of metacognition offers an integrated approach to treatment, not only addressing the symptoms but also targeting the underlying cognitive processes contributing to these disorders (Semerari et al., 2003). It is of interest for psychotherapy practice and research, as postulated by Semerari et al. (2002; 2014; see also Dimaggio et al., 2007), that metacognitive processes play a crucial role in understanding personality disorders. Moreover, patients may exhibit varying degrees of difficulties across metacognitive functions. For example, patients diagnosed with paranoid personality disorder may demonstrate dysfunction in decentration and differentiation metacognitive functions. Meanwhile, patients diagnosed with narcissistic personality disorders may exhibit difficulties in recognizing their own emotions and linking them to the external events.

The study of metacognition offers a significant framework for examining the intricacies of the psychological processes that determine mental health. It offers a profound insight into how individuals perceive, interpret, and respond to their internal and external environments. Given its pivotal role in mental health and cognitive functioning (e.g., deep learning, see Elbyaly & Elfeky, 2022), there has been an increased demand for reliable and valid tools to assess metacognitive abilities.

The contemporary comprehension of metacognition is predominately shaped by two overarching frameworks: the unitary and the modular approaches. The unitary approach, as exemplified by the Self-Regulatory Executive Function model (S-REF), asserts that metacognition is a continuum of interconnected abilities based on thought content (Wells & Matthews, 1994). According to this perspective, metacognitive abilities operate as an integrated system that impacts various cognitive processes, including attention, memory, and problem-solving. Dysfunctions in metacognition are viewed as central to the onset and persistence of psychological difficulties. Higher-order metacognitive beliefs drive these cognitive processes and ruminative cycles, sustaining maladaptive thinking patterns and increasing vulnerability to symptoms and psychopathology (Wells, 2000; Wells & Matthews, 1994). The S-REF model has been particularly useful in understanding how certain metacognitive beliefs contribute to emotional disorders, thereby presenting opportunities for therapeutic interventions tailored for children (Muir et al., 2023).

The modular approach, represented by the Metacognitive Multi-Function Model (MMFM), is distinctive from the unitary approach because it focuses on the mental functions and operations that constitute metacognition, rather than mental contents (Semerari et al., 2003). The MMFM breaks down metacognition into relatively independent sub-functions, including self-monitoring, self-evaluation, and strategy selection. This approach suggests that metacognitive dysfunctions are associated with psychopathology due to impairments in understanding one's own and others' mental states and processes (Dimaggio et al., 2007). These metacognitive difficulties hinder the development of stable self and other representations, which are essential for maintaining functional interpersonal relationships and self-regulation (Lysaker et al., 2011; Semerari et al., 2014). By isolating these discrete functions, the MMFM offers a more comprehensive understanding of metacognition and its role in psychopathology. This modular approach enables tailored evaluations and interventions by pinpointing specific areas of difficulty within metacognitive abilities.

Several tools have been developed to evaluate metacognition, each having its own set of advantages and limitations. Methods such as interviews and discourse analyses provide an in-depth understanding of one's metacognitive abilities but demand some time and specialized training (Semerari et al., 2003). These include already validated instruments such as the Metacognition Assessment Interview (MAI), a semi-structured clinical interview (Pellecchia et al., 2015; Semerari et al., 2012), and the Metacognition Assessment Scale (MAS), a rating scale for assessing metacognition in psychotherapy transcripts or narrative interviews (Carcione et al., 2008; Semerari et al., 2003). Self-report instruments such as the Metacognition Self-Assessment Scale (MSAS) have been developed because they are convenient and less time demanding (Pedone et al., 2017). However, they may be constrained by the individual's level of self-awareness and introspective accuracy (Efklides, 2008). These tools enable researchers and clinicians to systematically assess changes in metacognitive abilities over time, thereby providing insights into how metacognition contributes to therapeutic outcomes.

The MSAS, anchored in the MMFM framework and modular approach to metacognition, is a meticulously designed tool intended for a comprehensive assessment of an individual's diverse metacognitive capabilities (see Table 1). The MSAS is an 18-item self-report measure that utilizes a five-point Likert scale (1 = *Never*, 2 = *Rarely*, 3 = *Sometimes*, 4 = *Frequently*, 5 = *Almost always*) for response evaluation. It has been found to have a four-factor structure that aligns with the metacognitive abilities outlined in the MMFM: 1) Self-Reflectivity, involving monitoring and integrating one's own mental states; 2) Critical Distance, which encompasses differentiation and decentration; 3) Understanding Other Minds; and 4) Mastery, entailing the capacity to solve problems and cope with stressors (Faustino et al., 2021; Pedone et al., 2017). The original MSAS validation study demonstrated satisfactory reliability across all subscales, with Cronbach's alpha ranging from .72 to .87 (Pedone et al., 2017). The validation also included confirmatory factor analyses (CFA) with two subsamples from the general population of Naples, which confirmed the MSAS's robustness and utility for metacognitive assessment through satisfactory model fit. Faustino and colleagues (2021) conducted a validation study of the MSAS in the general Portuguese population, demonstrating its reliability

and validity across diverse cultural contexts. Their analysis, based on an exploratory factor analysis (EFA) with a sample size of n = 194 (80.6% female), confirmed the four-factor structure originally proposed by Pedone et al. (2017). The scale exhibited satisfactory psychometric properties, with Cronbach's alpha for the total MSAS scale yielding an acceptable level of internal consistency (α = .88). Moreover, test-retest procedures confirmed the scale's temporal stability, reinforcing its reliability over time. Construct validity was evidenced through significant Pearson correlations among the subscales and the total scale, suggesting robust inter-correlations within metacognitive domains.

Despite this, a significant gap exists in the availability of such tools for Spanish- speaking populations. The influence of cultural and linguistic factors on the reliability and validity of metacognitive assessments underscores the importance of adapting and validating the MSAS for Spanish-speaking populations. By serving as a valuable instrument for clinicians and researchers, this adaptation not only contributes to the expanding body of cross-cultural studies in psychology, but also ensures the preservation of the tool's reliability and validity across different linguistic contexts.

The primary objective of this study is to adapt the MSAS for a Spanish-speaking population and to examine its psychometric properties. This entails a comprehensive process, encompassing the translation of the scale, verification of its cultural relevance, and the execution of reliability and validity assessments. The study aims to establish whether the Spanish version of the MSAS preserves the original scale's four-factor structure. Through these efforts, the research aspires to provide a robust and culturally attuned tool suitable for diverse settings in the Spanish-speaking population, thereby contributing to the overall advancement of our knowledge of metacognition and its varied functions.

Method

This psychometric study has received ethical approval from the Bioethical Committee of the *Universitat de Barcelona* (IRB00003099).

Participants

The study was based on a convenience sample who were invited to respond to the questionnaire. The inclusion criteria of the study were (1) to be of legal age (18 years or older), and (2) have a sufficient comprehension of Spanish.

Participants were recruited by disseminating the questionnaire through social networks via a link that redirected an *ad hoc* online survey using *Microsoft Forms*. The survey included basic sociodemographic information and their responses to the MSAS and the Toronto Alexithymia Scale (TAS-20). A total of 138 individuals (93 females) agreed to participate in the study and signed the informed consent. The average age was approximately 34 years (SD = 16.04).

Instruments

Metacognition Self-Assessment Scale (MSAS)

To create a Spanish adaptation of the MSAS, we employed a rigorous translation and back-translation methodology based on the framework established by Triandis (1980). Two expert translators, fluent in both Spanish and English and experienced in cross-cultural settings, were enlisted for this task.

The first translator was a professional linguist, while the second was an academic with a deep understanding of Psychology and a track record of adapting English-language questionnaires for Spanish-speaking populations. Initially, the academic translated the questionnaire into Spanish. Subsequently, the professional linguist translated it back into English without prior exposure to the original English version. This dual-translation approach was followed by a comparative review of the back-translated and original English versions to ensure semantic integrity. A collaborative meeting with both translators and additional Ph.D. students was convened to scrutinize the accuracy of individual items and reconcile any discrepancies with the original English version. This iterative process was repeated until linguistic congruence was achieved (see Table 1 for the MSAS in Spanish resulting from this process). See the introductory section for more details about the MSAS.

Toronto Alexithymia Scale (TAS-20)

The TAS-20 is an assessment used to measure alexithymia, a construct inversely related to metacognition (Taylor et al., 2003). It consists of 20 items belonging to three distinct factors: Factor I focuses on the difficulty in identifying feelings; Factor II pertains to the difficulty in describing feelings to others; and Factor III is concerned with externally oriented thinking. The TAS-20 uses a 5-point Likert-type response scale (ranging from "strongly disagree" to "strongly agree") and was used in this study to assess its convergent validity with the MSAS. The Spanish version of the TAS-20 (Martínez Sánchez, 1996) demonstrated excellent internal consistency (α = .78 for the total group, α = .82 for men, and α = .77 for women) and good test-retest reliability (r = .72; p < .001).

Procedure

The MSAS (Pedone et al., 2017) was adapted to a Spanish-speaking population utilizing a back-translation of the items to ensure integrity to the original questionnaire. The translated scale and the already validated TAS-20 were disseminated through a link on social networks. To obtain a heterogeneous sample, it was distributed among people of different ages using the snowball method.

Prior to their involvement, participants were informed on the research goal and characteristics of the study. Those who agreed to participate signed the informed consent. Subsequently, they completed the online *ad hoc* survey, which included the sociodemographic form, MSAS and the TAS-20. The data was collected anonymously and was authorized through the acceptance of the informed consent by the participants.

Data Analysis

First, the descriptive statistics were computed for the MSAS, including mean, standard deviation (SD), skewness, and quantile scores. The four-factor model of the MSAS was tested and compared using a chi-squared (χ^2) difference test extracted from the ANOVA function in the R Studio stats package (R Core Team, 2018). Maximum likelihood with robust standard errors was

employed to estimate the CFA parameters. Model fit was evaluated using indices including RMSEA (< .08, I.C. 90%), χ^2 [*p*-value], CFI > .95, and Tucker-Lewis index (TLI) > .9, as suggested in previous literature (Erkut, 2010). The Akaike Information Criterion (AIC) and the Bayesian Information Criterion (BIC) were also used to assess model fit. Given that Cronbach's α may not be ideal for all scales, we also computed the total McDonald's omega coefficient (ω) (Viladrich et al., 2017) for these reliability estimates, using the *psych* package (Revelle, 2023) and formulated through structural equation modeling (SEM). To further validate the MSAS adaptation, its relationship with the TAS-20 was examined. It was hypothesized that specific subscales of the MSAS would negatively and significantly correlate with corresponding factors of the TAS-20. Multiple regression analyses were performed to explore these associations while controlling for other variables.

Results

Table 2 shows the descriptive statistics of the Spanish adaptation of the MSAS. Figure 1 displays the histograms representing the distribution of the scores of the subscales.

Table 1

Translated and Adapted Items of the MSAS: The Spanish Version

A	***CON RESPECTO A MÍ MISMO, HABITUALMENTE…***	**Nunca**	**Raramente**	**A veces**	**Frecuentemente**	**Casi siempre**
1.	Puedo distinguir y diferenciar mis propias capacidades mentales (por ej., recordar, imaginar, fantasear, soñar, desear, decidir, prever y pensar).	**1**	**2**	**3**	**4**	**5**
2.	Puedo definir, distinguir y nombrar mis propias emociones.	**1**	**2**	**3**	**4**	**5**
3.	Soy consciente de cuáles son los pensamientos o emociones que guían mis acciones.	**1**	**2**	**3**	**4**	**5**
4.	Soy consciente de que lo que pienso de mí mismo es una idea y no es necesariamente cierto. Me doy cuenta de que mis opiniones pueden no ser acertadas y pueden cambiar.	**1**	**2**	**3**	**4**	**5**
5.	Soy consciente de que lo que deseo o lo que espero puede no hacerse realidad y de que tengo un poder limitado para influir en las cosas.	**1**	**2**	**3**	**4**	**5**
6.	Puedo percibir y describir claramente mis pensamientos, emociones y las relaciones en las que estoy involucrado.	**1**	**2**	**3**	**4**	**5**
7.	Puedo describir el hilo que conecta mis pensamientos y emociones incluso cuando estos difieren de un momento a otro.	**1**	**2**	**3**	**4**	**5**
B	***CON RESPECTO A LOS DEMÁS, HABITUALMENTE…***	**Nunca**	**Raramente**	**A veces**	**Frecuentemente**	**Casi siempre**
1.	Puedo entender y distinguir las distintas actividades mentales como, por ejemplo, recordar, imaginar, fantasear, soñar, desear, decidir, prever y pensar.	**1**	**2**	**3**	**4**	**5**
2.	Puedo identificar y entender las emociones de personas a quienes conozco.	**1**	**2**	**3**	**4**	**5**
3.	Puedo describir el hilo que conecta pensamientos y emociones de personas a quienes conozco, incluso cuando difieren de un momento a otro.	**1**	**2**	**3**	**4**	**5**
C	***EN CUANTO A "PONERSE EN LA PIEL DEL OTRO", GENERALMENTE…***	**Nunca**	**Raramente**	**A veces**	**Frecuentemente**	**Casi siempre**
1.	Soy consciente de que no soy necesariamente el centro de los pensamientos, sentimientos y emociones de otros, y de que el comportamiento de los demás surge de razones y metas que pueden ser independientes de mi propia perspectiva y de mi propia involucración en la relación.	**1**	**2**	**3**	**4**	**5**
2.	Soy consciente de que otros pueden percibir hechos y acontecimientos de forma distinta que yo y pueden interpretarlos de forma diferente.	**1**	**2**	**3**	**4**	**5**
3.	Soy consciente de que la edad y las experiencias vitales pueden afectar los pensamientos, emociones y comportamiento de los demás.	**1**	**2**	**3**	**4**	**5**
D	***RESPECTO A SOLUCIONAR PROBLEMAS, GENERALMENTE…***	**Nunca**	**Raramente**	**A veces**	**Frecuentemente**	**Casi siempre**
1.	Puedo lidiar con el problema imponiendo o inhibiendo voluntariamente un comportamiento propio.	**1**	**2**	**3**	**4**	**5**
2.	Puedo lidiar con los problemas intentando voluntariamente seguir mi propio orden mental.	**1**	**2**	**3**	**4**	**5**
3.	Puedo lidiar con los problemas intentando cuestionar o enriquecer mis puntos de vista y mis creencias sobre estos problemas.	**1**	**2**	**3**	**4**	**5**
4.	Cuando los problemas están relacionados con las relaciones con otras personas, intento solucionarlos en base a como creo que es su funcionamiento mental.	**1**	**2**	**3**	**4**	**5**
5.	Puedo lidiar con los problemas, reconociendo y aceptando mis limitaciones a la hora de gestionarme a mí mismo y de influir en los acontecimientos.	**1**	**2**	**3**	**4**	**5**

Table 2
Descriptive Results of MSAS Four-Factor Structure

MSAS Factor	*M (SD)*	Skewness	Quantiles 25th	50th	75th
Self-Reflectivity	4.08 (.64)	-.26	3.57	4.14	4.86
Critical Distance	3.91 (.49)	.06	3.67	4	4.67
Understanding Other Minds	4.36 (.48)	-.12	3.75	4.33	5
Mastery	3.73 (.62)	-.26	3	4	4

Factor Structure

Five different models were examined to evaluate the adequacy of the theoretical model with the collected data. The CFA results for the hypothesized four-factor model are available in Figure 2, which includes the factors of self-reflectivity, critical distance, other minds, and mastery. All factor loadings (*see* Figure 2) were significant, ranging from λ = .22 to λ = .91 (p < .05). The fit indices suggest a satisfactory model fit: χ^2 with 46 estimated parameters was 211.27, p < .001, RMSEA = .07, CFI = .89, TLI = .86, AIC = 5,313.84, and BIC = 5,436.79.

We performed χ^2 difference tests and observed that none of the five alternative models exhibited a superior fit to the data compared to the original four-factor model (see Table 3). Additionally, we examined the inter-factor correlations among the different scales, and they were determined to be statistically significant.

Other Minds, Mastery; Two-factor model: Self-Reflectivity and Mastery.

Reliability

As evident from the factor loadings presented in Figure 2, the standardized coefficients for the MSAS subscales exhibit a range of values varying in strength. For example, the "Self-Reflectivity" subscale produced factor loadings ranging from .23 to .85, whereas the "Other Minds" subscale demonstrated coefficients ranging from a minimum of .38 to a maximum of .91. These variations in factor loadings underscore the importance of employing robust reliability measures, such as ω, for evaluating the internal consistency of scores within a single administration. This approach allows for a nuanced evaluation of individual scores across the items of the scale, ensuring reliability within a single assessment session.

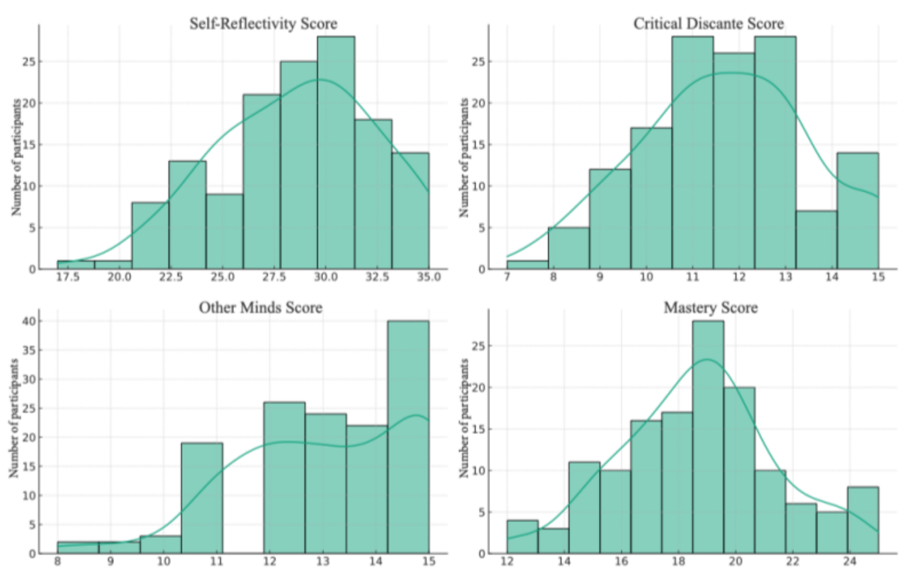
In Table 4, ω coefficients were found to be consistently reliable across all subscales. The "Other Minds" subscale demonstrated the highest reliability with a ω of .68. Conversely, the "Critical Distance" subscale showed the lowest reliability, with a ω of .55. This varying level of reliability across the MSAS subscales calls for further investigation into the constructs it aims to measure. Our results suggest that ω is a suitable alternative to traditional measures such as Cronbach's α for reliability assessment.

Relation to External Criteria

Our analysis explored the convergent validity between the MSAS and TAS-20, two measures theoretically related but methodologically distinct. The TAS-20 assesses "lack of metacognitive abilities" among other traits associated with alexithymia. Thus, it was hypothesized that low scores on metacognitive abilities (MSAS) would correlate with high scores on alexithymia (TAS-20).

From the correlation matrix (see Figure 3), MSAS Self-Reflectivity demonstrated moderate to strong negative correlations with TAS-20 factors, ranging from -.37 to -.47. This was particularly notable with TAS Factor I and TAS Factor II, which focus on difficulties in identifying and describing feelings, respectively. Further multivariate exploration through multiple regression analyses (see Table 5) substantiated these findings, revealing significant associations between TAS Factor I and TAS Factor II with the MSAS Self-Reflectivity subscale.

Figure 1
Histograms Representing the Distribution of the Scores of the Subscales of the MSAS



Note. The x-axis reflects the raw scores of each subscale of the MSAS.

Figure 2

Confirmatory Factor Analysis of the Spanish Version of the MSAS in a Sample of 138 Adults

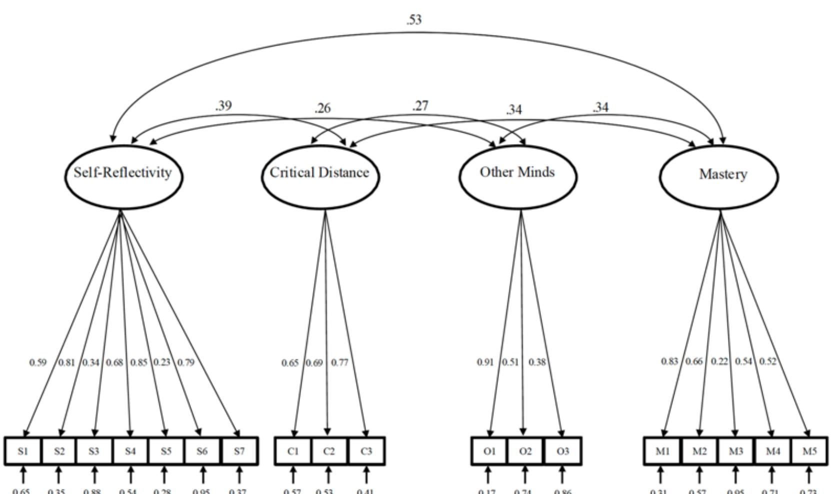


Table 3

Confirmatory Factor Analysis (CFA) of the MSAS

Model	Estimated parameters	χ2	RMSEA	CFI	TLI	AIC	BIC	χ2 diff (*df*)
Four-factor	46	211.27	.07	.89	.86	5,313.84	5,436.79	
Three-factor (A)	42	254.88	.08	.83	.8	5,351.46	5,465.62	47.27 (3)
Three-factor (B)	42	285.78	.09	.79	.75	5,382.36	5,496.52	67.77 (3)
Two-factor	39	328.68	.1	.73	.69	5,421.26	5,529.56	116.45 (5)
One-factor	37	395.02	.12	.64	.59	5,485.6	5,590.98	127.41 (6)

Note. Four-factor model: Self-Reflectivity, Critical Distance, Understanding Other Minds, Mastery; Three-factor model A: Self-Reflectivity, Critical Distance, Mastery; Three-factor model B: Self-Reflectivity, Understanding.

Figure 3

Correlation Matrix of the MSAS Subscales and TAS-20 Factors

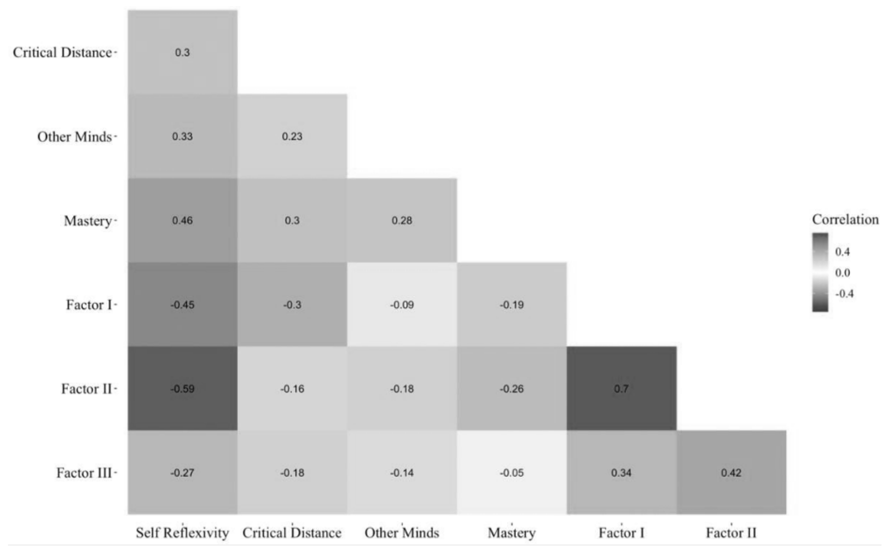


Table 4
Correlations and Reliabilities for MSAS Subscales

	(1)	(2)	(3)	(4)	Cronbach's alpha	McDonald's ω
1. Self-Reflectivity	1				.8	.87
2. Critical Distance	.3	1			.74	.75
3. Understanding Other Minds	.33	.23	1		.6	.66
4. Mastery	.46	.3	.28	1	.67	.76

These results align with the Pearson correlation coefficient of -.48 between the overall scores of MSAS and TAS-20, indicating a significant inverse correlation with a medium (but close to large) effect size. This supports the notion that individuals with high metacognitive abilities exhibit low levels of alexithymia, and vice versa.

These findings confirm our initial hypothesis and provide robust evidence for the convergent validity between MSAS and TAS-20. Individuals with elevated levels of alexithymia tended to score low on metacognitive abilities and demonstrated consistent patterns across distinct facets as assessed by the MSAS subscales.

Discussion

The primary objective of this study was to adapt the MSAS for application in Spanish-speaking communities. In accordance with the modular approach to metacognition, the MSAS was successfully adapted and validated. Our research contributes to the existing body of literature on metacognition by proving an important novel instrument. This newly validated tool broadens the scope for psychological interventions within Spanish speaking populations.

In the present study, the internal consistency metrics for the MSAS closely aligned with those found in both the original version and the Portuguese adaptation of the instrument. Additionally, the CFA affirmed the original four-factor structure of the MSAS, with all fit indices meeting the anticipated criteria (Faustino et al., 2021; Pedone et al., 2017). These results support the modular metacognition theory articulated by Semerari and colleagues (2003). According to this theory, metacognition is not a singular, unified construct but encompasses a range of interconnected cognitive abilities (see also Lysaker et al., 2011). This modular framework may explain the observed variations in internal consistency across the different subscales of the MSAS, suggesting that individuals may display intrasubject differences in their responses to items that assess simple versus complex cognitive abilities.

The study found moderate to strong negative correlations between our version of the MSAS and the TAS-20. This result is particularly noteworthy as it establishes the convergent validity of the MSAS and supports the predicted relationship between high levels of alexithymia and low metacognitive capacities (and vice versa). As indicated by the TAS-20, alexithymia is characterized by difficulties in identifying and describing emotions and by an externally oriented thinking style (Alkan Härtwig et al., 2014). These attributes stand in conceptual opposition to the metacognitive abilities assessed by the MSAS, which include self-reflectivity and emotional awareness. Our findings align with the modular theory of metacognition, suggesting that the ability to reflect on one's mental state is a foundational skill that influences other cognitive and emotional processes.

The strong negative correlation between MSAS and TAS-20 has noteworthy clinical implications. Specifically, it implies that interventions aimed at enhancing metacognitive abilities could potentially alleviate traits associated with alexithymia. This holds particular relevance for therapeutic strategies focused on augmenting emotional awareness and self-reflectivity to enhance overall psychological well-being (Semerari et al., 2003). Several authors (Dimaggio et al., 2007; Semerari et al., 2002; 2014) suggest the relevance of targeting specific metacognitive functions for a successful psychotherapeutic process with patients with personality disorders. Similar claims have been made for patients with psychosis (Lysaker et al., 2011), and even for those with physical illness presenting anxiety and depression (Capobianco et al., 2020).

Limitations

Our study presents several limitations that warrant consideration. First, the sample is relatively small, and half of it compromises university students obtained through accidental sampling, thus limiting the generalizability of our findings to broader and more diverse populations. Secondly, relying on the MSAS as a self-report tool may inadvertently measure participants' self-evaluation capacity rather than their actual metacognitive abilities (Hausberg et al., 2012). Additionally, the absence of clinical populations in our sample restricts the applicability of our findings to individuals with

Table 5
Multiple Regressions Between the MSAS subscales and the TAS-20 Factors

	Self-reflexivity			Critical Distance			Other Minds			Mastery		
Predictors	Estimates	CI	*p*	Estimates	CI	*p*	Estimates	CI	*p*	Estimates	CI	*p*
(Intercept)	5.54	5 – 6.07	**.0***	4.73	4.07 – 5.4	**.0***	4.99	4.37 – 5.61	**.0***	4.26	3.66 – 4.86	**.0***
Factor I	-.19	-.34 – -.04	**.01***	-.25	-.44 – -.07	**.01***	.02	-.15 – .19	.82	-.06	-.22 – .11	.48
Factor II	-.23	-.4 – - .06	**.01***	.21	.0 – .42	**.05***	-.18	-.38 – .01	.07	-.1	-.29 – .09	.3
Factor III	-.09	-.3 – .11	.37	-.22	-.48 – .04	.1	-.06	-.3 – .18	.63	-.03	-.26 – .2	.79
R^2	.27			.01			.05			.04		

Note. *$p < .05$.

psychological disorders where metacognition plays a significant role (Wright et al., 2024). Moreover, the varying levels of reliability across different MSAS subscales suggest that further refinement of the tool may be necessary.

Future Directions

To address these limitations, future endeavors should adopt several strategies. First, a more diverse sample, encompassing different age groups and clinical diagnoses, should be considered to enhance the generalizability of the findings. Second, a multi-method approach, incorporating interviews and behavioral observations alongside the MSAS, could be employed to overcome the limitations of self-reporting. Studies should also prioritize the validation of the MSAS in clinical populations with various diagnoses and treatments to expand its applicability. Additionally, considering the variability in reliability across MSAS subscales, future work should focus on refining the instrument, potentially employing item and confirmatory factor analysis to enhance its psychometric properties. Subsequent research can offer a more comprehensive understanding of metacognition and its assessment through the MSAS by addressing these limitations and incorporating these future directions.

Conclusion

The present study supports the validity of the Spanish adaptation of the MSAS, affirming its conceptually derived original four-factor structure and demonstrating strong internal consistency. Additionally, convergent validity was established through its correlation with the TAS-20, thereby reinforcing the theoretical foundations of a modular approach to metacognition (Flavell, 1979).

The findings significantly contribute to the existing literature on metacognition and introduce new possibilities for psychological interventions within Spanish-speaking communities. The observed strong negative correlation between MSAS and TAS-20 scores carries substantial clinical implications, suggesting that interventions aimed at enhancing metacognitive abilities could be a viable strategy for mitigating traits of alexithymia (Taylor et al., 1997).

Subsequent research should address the aforementioned limitations by incorporating a more diverse sample and utilizing multi-method assessments. Further refinement of the MSAS, especially addressing its varying reliability levels across different subscales, is also merited.

In summary, the successful adaptation and validation of the MSAS for Spanish-speaking populations marks a notable progression in metacognitive research. The provision of a robust and culturally sensitive assessment tool lays the groundwork for a more comprehensive and nuanced understanding of metacognition and its role in mental health (Moritz & Lysaker, 2018).

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Authors Contribution

All authors meet the criteria recommended by the International Committee of Medical Journal Editors, ICMJE. MAS contributed on Design, Data collection, Supervision, Analysis, Literature Review, Writing and Critical Review; DM contributed on Analysis, Literature Review, Writing and Critical Review; ACF contributed on Design, Data Collection and Writing; and GF contributed on Conception, Design, Supervision, Writing and Critical Review.

Disclosure Statement

Authors declare no conflicts of interest to disclose.

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The corresponding author for this manuscript will be Danielle Mullins, MSc, assuming the responsibility for keeping co-authors informed of progress through the editorial review process and any of the reviews.

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Estrategias Para Conductas que Atentan al Tratamiento en el Trastorno Limite de la Personalidad: una Visión y Aplicación desde Tres Modelos Terapéuticos

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INFORMACIÓN

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RESUMEN

El Trastorno Límite de la Personalidad (TLP) es una condición de salud mental caracterizado por inestabilidad afectiva, alta reactividad, impulsividad y dificultades en las relaciones interpersonales. Esto trae muchas veces problemas en el tratamiento que llevan a abandonos prematuros de consultantes en comparación con otros diagnósticos. En la actualidad existen terapias basadas en la evidencia para el TLP que poseen un carácter manualizado y centran su estructura en un marco de trabajo constante para poder lidiar con los problemas que atentan a la terapia, evitar los abandonos y recaídas clínicas. El objetivo del presente artículo es describir las principales estrategias usadas para intervenir en las Conductas que atentan contra la terapia, que se presentan en pacientes con TLP, para ello vamos a usar viñetas clínicas donde describiremos estrategias de tres de las terapias que más han ido recolectando evidencia científica para evitar estos problemas: la Terapia Conductual Dialéctica (TCD), la Psicoterapia focalizada en la transferencia (PFT) y la Terapia basada en la Mentalización (TBM).

Strategies for Therapy-Interfering Behaviors in Borderline Personality Disorder: A View and Application from Three Therapeutic Models

Keywords:
Borderline personality disorder
Transference
Mentalization
Dialectical behavior therapy
Psychotherapy
Patient dropout

ABSTRACT

Borderline Personality Disorder (BPD) is a mental health condition characterized by affective instability, high reactivity, impulsivity and difficulties in interpersonal relationships. This often brings treatment problems that lead to premature abandonment of consultants compared to other diagnoses. Currently, there are evidence-based therapies for BPD that have a manual character and focus their structure on a constant framework to be able to deal with problems that threaten therapy, avoid dropouts and clinical relapses. With the intention of maintaining an integrative position, it is possible to have strategies from three of the therapies that have been collecting the most scientific evidence to avoid these problems: Dialectical Behavior Therapy (DBT), Transference-Focused Psychotherapy (TFP) and Mentalization-Based Therapy (MBT).

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El Trastorno Límite de la Personalidad (TLP) es una condición de salud mental caracterizado por un patrón de inestabilidad afectiva con marcada respuesta emocional e impulsividad, ira intensa, dificultad en las relaciones interpersonales, conducta suicida e intentos autolesivos, sentimientos crónicos de vacío, alteración de la autoimagen, esfuerzos frenéticos por evitar el abandono y pensamiento paranoide con sintomas disociativos relacionados al estrés según los criterios de la sección II del Manual Diagnóstico y Estadístico de los Trastornos Mentales (5ª ed.; DSM-5, American Psychiatric Association, 2013) del modelo categórico de los trastornos de personalidad (Pérez et al., 2005; Trull et al., 2011). Sin embargo, en función de una evaluación ajustada a la realidad de la presentación clínica del TLP en la practica diaria, existe una propuesta dimensional en la sección III del DSM-5 centrada en el nivel de gravedad del sentido del self (identidad y autodireccionamiento) y el funcionamiento interpersonal (empatía e intimidad), además de la presencia de rasgos patológicos de personalidad como la afectividad negativa, desinhibición y antagonismo (Oldham, 2022). Así mismo, la nueva Clasificación Internacional Estadística de Enfermedades y Problemas Relacionados con la Salud (11ª ed.; CIE-11; Organización Mundial de la Salud, 2019) propone como elemento central la gravedad en el funcionamiento del self e interpersonal para la consideración de un trastorno de personalidad, incorporando un especificador de “patrón borderline”, definido por las nueve características familiares del DSM-IV/5, que incluyen “síntomas disociativos o características similares a las psicóticas (p. ej., alucinaciones breves, paranoia en situaciones de alta excitación afectiva)”(Bach et al., 2022; Blüml y Doering, 2021). Los pacientes con esta condición experimentan una alta reactividad con fluctuaciones en el estado anímico, conducta intensa e inconstante en sus relaciones interpersonales, así como ira extrema y conducta impulsiva como autolesiones y abuso de sustancias psicoactivas. Además, estas personas tienen elevados índices de abandono temprano a los tratamientos en comparación con otros que tienen diferentes condiciones psicológicas y trastornos de personalidad. En ocasiones, la inestabilidad emocional se aprecia con el terapeuta, lo que lleva a abandonos prematuros debido a rupturas en la alianza terapeutica (Yeomans et al., 1994).

Una variedad de enfoques terapeuticos se han desarrollado para el manejo del TLP: Terapia Cognitiva Conductual, Terapia Basada en la Mentalización (TBM), Terapia Enfocada en Esquemas (TEE), Psicoterapia Focalizada en la Transferencia (PFT) y Terapia Conductual Dialéctica (TCD). De estos, la TCD ha demostrado mayor efectividad en el tratamiento para el TLP acorde a la mayor cantidad de estudios elaborados a la fecha (Leichsenring et al., 2024; Stoffers et al., 2012; Storebø et al., 2020). Por otro lado, han surgido enfoques integradores como el Manejo Psiquiártico General (MPG) que es una terapia que incorpora estrategias de teorías contextuales como la TCD, y psicodinámicas como la TBM y PFT, cuyo proceso de cambio se centra en el balance emocional, funcionamiento efectivo interpersonal y la construcción de una narrativa autobiográfica más coherente y basada en la realidad, resultando una terapia que está ganando evidencia a medida que se implementa en equipos de diferentes partes del mundo (Choi-Kain y Gunderson, 2019; Dunand et al., 2024; Kramer, 2024).

El trabajo con estos consultantes es retador y requiere de conocer técnicas terapeuticas o habilidades como una necesidad que servirá como un mecanismo de supervivencia para los terapeutas para reaccionar a conductas provocadoras y agresivas de estos consultantes (Allen, 1997). Debido a las características de estos, es dificil comprometerse y establecer una relación terapéutica basada en el cumplimiento de acuerdos (O’Connell y Dowling, 2014). A fin de profundizar en este tema, repasaremos más detalles sobre los problemas relacionados al tratamiento y estrategias basadas en tres terapias de las mencionadas que más han desarrollado un marco seguro para el terapeuta: TCD, PFT y TBM.

Problemas en el Tratamiento y Abandonos Tempranos

La alta tasa de abandono entre los pacientes con TLP se considera generalmente relacionada con su psicopatología compleja, que incluye impulsividad, problemas de ira, hostilidad y dificultades para establecer relaciones de confianza, principalmente por alteraciones en desarrollo de la identidad, capacidad para mentalizar a los otros, regularse emocionalmente y vincularse saludablemente (Arntz et al., 2023; Bateman et al., 2023; de Freixo et al., 2023; Yeomans et al., 2017). El alto riesgo de abandono es problemático dados los altos niveles de disfunción, alto riesgo de suicidio y altos costos sociales asociados con el TLP. También es desmotivador para los terapeutas, que tienen que invertir mucho en el tratamiento de pacientes difíciles y se enfrentan a muchos pacientes que terminan el tratamiento prematuramente. Además, la interrupción prematura del tratamiento constituye una amenaza para la rentabilidad de las intervenciones intensivas y costosas para el TLP, que a menudo están disponibles solo para un número limitado de pacientes con TLP. Es comprensible que uno de los objetivos de las psicoterapias especializadas como la TCD, PFT y TBM, que se desarrollaron desde finales de los años ochenta del siglo pasado, fuera por tanto la reducción del abandono del tratamiento (Arntz et al., 2023).

Cuando se producen problemas para continuar con un tratamiento y/o abandonos se genera un impacto en los servicios de salud que obliga a mejorar la efectividad de la atención como una prioridad. Así mismo, se ha visto que el índice de completar un tratamiento es bajo con una variación de 8%, 33% y 37% en estudios individuales y cuando hay abandono temprano esto afecta la generalización de los estudios y el costo-efectividad (Barnicot et al., 2011).

En el estudio de Wnuk, se estudiaron a 180 pacientes que recibieron Terapia Dialéctica Conductual (TDC) y Manejo Psiquiátrico General (MPG) y un seguimiento de 1 año. Aquellos pacientes que abandonaron el tratamiento, se identificó que tenían mayores niveles de ira ($p = 0.01$), mayor comorbilidad de trastornos del eje I ($p = 0.03$), pobre alianza terapéutica ($p = 0.003$) y un número mayor de intentos suicidas a lo largo de la vida ($p = 0.05$) (Wnuk et al., 2013).

De Panfilis y colaboradores estudiaron a 54 pacientes que abandonaron tempranamente su tratamiento versus 108 que continuaron de un total de 162 pacientes con Trastorno Límite de Personalidad en un Servicio de Psiquiatría. El factor predictor de descontinuación temprana de tratamiento fue la historia de conducta suicida, mientras que la presencia de Trastorno de Conducta Alimentaria y Trastorno de Personalidad Evitativa fueron factores protectores (De Panfilis et al., 2012).

En una revisión sistemática de McMurran, en el que se incluyeron 25 estudios clínicos randomizados, se identificó que el no completar un tratamiento en pacientes con trastornos de personalidad estaba más asociado a una edad más joven, bajo nivel educativo y ocupacional,

además de baja competencia en habilidades como pobre capacidad de resolución de problemas, bajos niveles de persistencia y alta evitación (McMurran et al., 2010). Este mismo autor en el 2008 concluyó que altos niveles de impulsividad y pobres capacidades de resolución de problemas pueden estar implicados en el no completar un tratamiento en pacientes varones con trastornos de personalidad (McMurran et al., 2008).

Barnicot y colaboradores incluyeron 41 estudios en una revisión sistemática en el que se identificaron que el compromiso al cambio, la relación terapeutica y la impulsividad fueron factores predictores de abandono de tratamiento en personas con TLP, mientras que factores sociodemográficos no fueron predictivos (Barnicot et al., 2011).

A continuación, resumimos en la Tabla 1 los factores que influyen en el abandono de tratamiento.

Tabla 1
Factores que Influyen en Problemas en el Tratamiento/Abandonos

Sociodemográficos (jóvenes, desempleo, bajo nivel educativo)
Antecedentes de conducta suicida
Comorbilidades del eje I
Elevados niveles de ira e impulsividad
Baja alianza terapéutica
Pobre capacidad de resolución de problemas

Tipos de Conductas que Atentan a la Terapia

Conductas que Impiden que el Consultante Reciba Terapia

Este tipo de conductas no permiten el avance de la terapia y tienen la capacidad de castigar o extinguir conductas terapéuticas. Se identifica una barrera que no permite que se cumplan los objetivos ni los acuerdos (Boggiano y Gagliesi, 2020).

Conductas que "Queman" al Terapeuta

Estas conductas cruzan los límites personales del terapeuta. Tienen la capacidad de castigar o extinguir las ganas del terapeuta con tratar a un paciente en particular. Si bien es cierto la pasividad o la falta colaboración es un aspecto común en los consultantes con TLP, este debe moverse hacia el cambio respetando los límites esatblecidos (Boggiano y Gagliesi, 2020)

Linehan define 3 tipos de conductas que atentan a la terapia (Linehan, 1993):

- Falta de atencion
- Faltar a terapia
- Cancelar sesiones
- Abandonar la terapia
- Se presenta pero no presta atención
- Crisis continuas
- Internado constantemente
- Consumo de drogas antes de sesión
- Se retira o escapa de consultorio antes de terminar
- Se desmaya
- Presenta disociaciones
- No duerme y llega con sueño a la sesión
- Ensoñaciones diurnas por otras causas
- Falta de colaboración
- Incapacidad o negativa de trabajar en terapia
- Mentir
- Retirarse emocionalmente durante la sesión
- Discutir todo aquello que sugiere o dice el terapeuta
- No acordar sobre la jerarquía de las conductas problemas
- Frases cortas a las preguntas como "no lo sé" "no recuerdo".
- Falta de cumplimiento
- No entregar ni llenar el registro diario
- No mantener acuerdos realizados con terapeuta
- No completar tareas o completarlas de manera parcial
- Negarse a seguir ciertas recomendaciones como exposición
- Negarse a trabajar con objetivos esenciales como reducir conductas suicidas

Estrategias de Terapia Conductual Dialéctica

La TCD es una terapia originalmente desarrollada para el tratamiento de consultantes con TLP caracterizados por presentar un alto riesgo suicida. Esta terapia se apoya en la teoría conductual, filosofía dialéctica y práctica Zen. Promueve el balance de la aceptación y el cambio, con la finalidad de ayudar a personas a sobrevivir a sus problemas mediante el entrenamiento de habilidades y así contrubir a construir una vida que valga la pena ser vivida (Lynch et al., 2007; O'Connell y Dowling, 2014; Robins y Chapman, 2004).

Resaltar la Conducta que Atenta a la Terapia

En terapia es importante hablar acerca de lo que es claramente apreciable y no debe pasar desapercibido como el no acudir a sesiones. Más importante aún, de lo que afecta la continuidad y efectividad de un tratamiento. Aunque el terapeuta puede tener una hipótesis, suposiciones o interpretaciones con respecto a la conducta del cliente respecto a la terapia, es necesario el mantener una posición neutral a favor de una exploración profunda e imparcial del problema (Chapman y Rosenthal, 2016).

Así mismo, el resaltar efectivamente también incluye una justificación clara de por qué es importante discutir su conducta. Una forma de hacer esto es que el terapeuta resalte las contingencias, como el efecto negativo de las conductas que atentan a la terapia en el terapeuta, los procesos terapéuticos o la capacidad del cliente para alcanzar metas importantes (Chapman y Rosenthal, 2016).

El estilo de intervención para transmitir la apreciación del terapeuta puede ser variable. Algunos suelen ser directos, mientras que otros eligen un estilo mucho más irreverente. En el primer caso, se lleva a discutir el problema en la agenda de la sesión haciendo notar al consultante la preocupación y la importancia de poner "sobre la mesa" sus motivos. Por otro lado, la irreverencia puede ser útil para aumentar la conciencia, la atención y el compromiso en el proceso. El comentario inesperado del terapeuta sobre el comportamiento podría ayudar al cliente a cambiar de marcha y considerar una perspectiva diferente o comprender mejor los problemas con su pensamiento o comportamiento (Chapman y Rosenthal, 2016). Se aprecian algunos ejemplos en la Tabla 2.

Tabla 2
Estilos de Intervención Basado en TCD

Estilo del terapeuta	Viñeta clínica
Directo	Terapeuta: "Estoy preocupado por las dos faltas seguidas que has tenido en el grupo de habilidades. ¿Crees que podemos hablar de eso en esta sesión?"
Irreverente	Terapeuta: "Se me hace complicado el poder hacer terapia si no esta mi consultante aquí en sesión. ¿Lo has visto?"

Entendiendo el Problema: Análisis en Cadena

Otra estrategia importante es el evaluar los factores o variables que intervienen en el desarrollo de una conducta que atenta a la terapia. Es así que se realiza un análisis en cadena de los eventos que paso a paso llevaron al consultante a la conducta problema.

El terapeuta recopila detalles e indaga sobre vulnerabilidades, disparadores, pensamientos, emociones y acciones que se presentaron alrededor del evento central, además de las consecuencias para el cumplimiento de objetivos. En algunas oportunidades el realizar un análisis en cadena implica hablar acerca de detalles percibidos como desagradables para el consultante generando un sentimiento aversivo para lo cual el terapeuta debe tomar en cuenta (Chapman y Rosenthal, 2016).

Los componentes del análisis en cadena en función de las conductas que atentan a la terapia son (Chapman y Rosenthal, 2016; Linehan, 1993, 2015):

- Identificar y describir el problema en términos conductuales
- Reconstruir la secuencia de eventos conductuales y ambientales que llevaron al problema, ocurrieron y precedieron (vulnerabilidades, eventos precipitantes, emoción/conducta/pensamiento)
- Identificar el evento precipitante
- Identificar las consecuencias ambientales y comportamentales de la conducta (contingencias)
- Promover el insight al resaltar patrones
- Generar hipótesis sobre aquello que promueve la conducta
- Brindar instrucciones didácticas sobre temas importantes
- Clarificar la cadena

A continuación, resumimos estos componentes en la Tabla 3.

Tabla 3
Componentes del Análisis en Cadena para Conductas que Atentan a la Terapia

Componente de la cadena	Viñeta clínica
Conducta problema	"Estas 2 ultimas semanas me quedé dormido, olvidé que teníamos citas, se me pasó el no agendarlo en mi celular"
Vulnerabilidades	"Estuve trabajando mucho estas semanas, han sido muy estresantes" "Estuve hospitalizado por unos días por un accidente que tuve en mi auto, nada grave, pero creo que me ha tenido ausente de mi cabeza" "A veces me olvido de tomar mi medicina"
Emoción/conducta/pensamiento	"Me siento algo triste y desganado" "Me echo a la cama y no quiero pensar en nada, ni hablar con nadie" "Pasa por mi mente a veces que estoy volviendo a lo de antes, como si la vida pasara y no hago lo suficiente"
Evento precipitante	"Cuando quiero agendar la cita en mi celular me confío y lo guardo para más tarde"
Contingencias	"No me gusta esta situación, tener que hablar de esto me hace ver que no me estoy esforzando"

Manejando Deficit Motivacionales

La motivación al cambio en un consultante es un aspecto que debe evaluarse en todo momento en un proceso de terapia. Para muchos el adherirse a una estructura de tratamiento es un hecho complicado debido a experiencias anteriores de terapias fallidas y a la marcada desesperanza que surge en etapas iniciales. Sin embargo, es necesario explorar y conocer los motivos por los que anteriores tratamientos no han resultado efectivos (Chapman y Rosenthal, 2016).

Desde un enfoque conductual, la motivación no es una fuerza dentro del consultante que deba surgir e impulsarlo "mágicamente" hacia el cambio. Más bien, la motivación y compromiso con el cambio es evidente cuando el cliente habla sobre el cambio como una posibilidad, toma medidas y muestra un compromiso sostenido para hacer lo posible para que eso se cumpla y se convierta en una realidad. Sin embargo, hay muchas razones por las que un consultante carece de motivación como déficit de habilidades, falta de conocimiento de conductas que atentan a la terapia, creencias problemáticas, falta de comprensión o claridad sobre los valores (Chapman y Rosenthal, 2016).

Dentro de los enfoques específicos para trabajar lo déficit motivacionales en relación al cambio conductual, destaca la Entrevista Motivacional (EM). La EM es un estilo terapéutico centrado en la persona, que aborda el frecuente problema de la ambivalencia ante el cambio y, a través de estilo de conversación colaborativo, busca reforzar la motivación y el compromiso de la persona con el cambio (Miller y Rollnick, 2015). Cuando se habla del cambio conductual es importante hablar del modelo transteorico del cambio, el cual es un proceso circular donde la persona pasa por distintas etapas, desde la ausencia de una necesidad para cambiar hasta mantener las conductas que sostienen un cambio (Prochaska y DiClemente, 1982). Son cinco las etapas o estadios de cambio descritas por Prochaska y DiClemente (Precontemplación, Contemplación, Preparación, Accion y Mantenimiento) (DiClemente y Prochaska, 1982). Son las etapas de Precontemplación y Contemplación, aquellas en las que generalmente se encuentran los pacientes complejos y con altos niveles de ambivalencia, como lo son los pacientes con TLP. Si bien es cierto no se ha encontrado bibliografía específica sobre la utilidad de la EM en pacientes con TLP, las estrategias que la TCD utiliza para reforzar la motivación y el compromiso con el cambio conductual se relacionan con los principios de la EM (Expresar empatía, desarrollar discrepancias, ser hábil para relacionarse con la resistencia y apoyar la autoeficacia) (Miller y Rollnick, 2015).

- Dentro de las estrategias que se utiliza en TCD para incrementar la motivación para adherirse a la terapia, tenemos:
- Considerando los pros y los contras de cambiar versus no cambiar su comportamiento
- Destacando la aparente ambivalencia del consultante sobre el cambio
- Argumentar en contra del cambio para obtener contraargumentos del cliente (Abogado del diablo)
- Expresar que el consultante tiene la libertad de elegir no cambiar, pero si desea una vida mejor, la única opción es cambiar (Libertad para elegir y ausencia de alternativas)

Aprendiendo Habilidades

Los consultantes que presentan conductas que atentan contra la terapia pueden tener déficit en diversas áreas como regulación emocional, efectividad interpersonal, tolerancia al malestar y conciencia plena o mindfulness (Vásquez-Dextre, 2016). Estos deben aprender herramientas que les permitan enfrentar estos déficits orientados a aumentar la capacidad en la que reconocen el impacto de sus emociones sobre la terapia, reducir la intolerancia a seguir indicaciones, manejar la falta de asertividad en la comunicación que lleva a obviar sus motivaciones e incrementar la conciencia de las emociones, pensamientos y conductas en el aquí y ahora (Chapman y Rosenthal, 2016).

- Conciencia plena: Estrategias para que el consultante preste atención a su experiencia del momento presente, sin prejuicios y la descripción de sus experiencias en el aquí y el ahora (Marra, 2005; O'Connell y Dowling, 2014).
- Regulación emocional: Estrategias para que el consultante aprenda a comprender y etiquetar las emociones, modificar los factores que aumentan la vulnerabilidad a las emociones negativas, cambiar los eventos desencadenantes o desencadenantes de las emociones, cambiar el comportamiento de una manera que regule las emociones y observar y aceptar las emociones con atención plena (Marra, 2005).
- Tolerancia al malestar: Estrategias que implican distracción, calmarse a sí mismo y otras estrategias para ayudar al consultante a sobrellevar las emociones dolorosas y evitar exacerbar situaciones desafiantes o crisis (Marra, 2005).
- Efectividad interpersonal: Estrategias Implican ayudar al cliente a aprender a mantener el enfoque en objetivos importantes en situaciones interpersonales, comunicar deseos manera efectiva, mantener el respeto por sí mismo y construir o mejorar las relaciones (Marra, 2005).

Resolución De Problemas

Cuando se exploran las variables alrededor de una conducta que atenta a la terapia se tiene un mapa general de los eventos, lo cual nos permite plantear soluciones objetivas. Una manera de organizar los pasos de resolución de problemas es a través del acrónimo SOLVES (Chapman y Rosenthal, 2016). A continuación, lo describimos en la Tabla 4.

Estrategias de Terapia Focalizada en la Transferencia

TFP es una terapia psicodinámica manualizada individual diseñada para el manejo de trastornos severos de personalidad, incluyendo el TLP. Esta fue diseñada por Otto Kernberg, desarrollada a partir del concepto de que los sintomas del TLP son entendidos de la falta de integración de los afectos cargada en representaciones del self y los otros. Esta falta da integración significa que las representaciones negativas de uno mismo y los otros, y los afectos asociados, están escindidos totalmente de representaciones positivas, generando inestabilidad afectiva, en la identidad y las relaciones interpersonales. Asi el elemento central de esta teoria y tecnica es el concepto de difusion de identidad y su objetivo es la resolucion de este. De este modo el paciente se mueve de la confusion a la integracion (Levy et al., 2018; Yeomans et al., 2013).

Tabla 4

Acrónimo SOLVES para Resolución de Problemas

SOLVES	Ejemplo de caso
S=Señalar y describir el problema	Melissa ha conseguido un nuevo trabajo en donde después de 3 meses le están exigiendo que se quede más tiempo en la oficina. Esto ha ocasionado que pierda 02 sesiones de psicoterapia individual y se ha estado sintiendo "frustrada y desesperada" porque le cuesta enfrentar esta situación con su jefe.
O=Orientar tus metas	Melissa tiene claro que en terapia quiere lograr regular la manera en la que siente sus emociones como la ira y frustración cuando tiene problemas de pareja, así mismo establecer un soporte social basado en amistades saludables.
L=Listar soluciones	Melissa acude a terapia después de haber faltado 2 semanas seguidas. En la sesión su terapeuta le propone listar una serie de posibles soluciones a la conducta que atenta a la terapia a manera de "lluvia de ideas" sin juzgar su viabilidad en el momento.
V=Ver las posibles consecuencias y seleccionar una alternativa	Tras unos minutos de realizar una "lluvia de ideas", ambos repasan cada una de las posibles soluciones y las consecuencias de cada una. Melissa en primera instancia selecciona 02 alternativas: 1.- Hablar con su jefe sobre la necesidad de obtener permiso para poder acudir a sus sesiones de terapia individual todos los miércoles a las 6 pm (último turno del terapeuta) y compensar su trabajo en otros espacios de la semana. 2.- Renunciar al trabajo para encontrar algo que se adapte a sus horarios. Finalmente elige la primera alternativa. Asume las consecuencias de esforzarse y a la vez mantener su trabajo para el cumplimiento de sus objetivos.
E= Establecer un plan	Melissa y su terapeuta trabajaron juntos en elaborar un plan para abordar la manera en la que se enfrentará a su jefe y solicitar el espacio de tiempo necesario para poder acceder a su terapia, así como también las posibles barreras que podrían aparecer (no obtener permiso, realizar trámites engorrosos, etc.). Es necesario hablar acerca de la viabilidad y obstáculos de las soluciones propuestas para colocarlos en un plano realista.
S=Supervisar los resultados	Melissa y su terapeuta evalúan el efecto de haber puesto en marcha el plan. Melissa habló con su jefe quien este accede a su solicitud de acudir a su "consulta de salud", aceptando también el que pueda compensar su trabajo en días en los que haya mayor disponibilidad en la oficina.

Establecer un Marco y Contrato Terapéutico

Un importante aporte de la TFP es el combinar de manera existosa el analisis del mundo interno del paciente junto a un marco de tratamiento, llamado contrato que permite anclar este tratamiento en la realidad. El marco de tratamiento se establece antes de comenzar la terapia propiamente dicha a través de la negociación de un contrato tras una extenuante y completa evaluación clínica. El establecer un contrato es un proceso colaborativo en el que se exponen los motivos por los que se llevará terapia, así mismo se brinda el espacio para que el consultante pueda exponer alguna duda y clarificarse. La actitud del terapeuta es la de flexibilidad y apertura para explicar en términos comprensibles cada elemento que se abordará en la terapia propio al modelo.

El contrato terapuetico incluira elementos universales para el paciente y terapeuta para el cumplimiento de objetivos, tales como pago, asistencias e incluye elementos individuales, construidos para cada caso en particular y con participacion activa del paciente, así como también las consecuencias de atentar contra lo acordado (Yeomans et al., 2013, 2017).

La finalidad del contrato terapéutico es el de brindar una estructura y espacio en el que se pueda explorar y reflexionar sobre la dinámica del consultante con el terapeuta y cómo este se desarrolla para el cumplimiento de sus objetivos respetando los acuerdos planteados, así mismo interpretar el significado de las conductas que atentan al tratamiento (Yeomans et al., 2013, 2017). El contrato terapeutico esta orientado a anclar el tratamiento en la realidad debiendo construirse sobre la base de limitar las conductas de mayor riesgo tanto ara la vida del paciente como para el tratamiento, sin embrago debe ser lo suficientemente flexible para permitir que la patologia del paciente se exprese y pueda asi ser analizada y mirada en un entorno seguro. A continuación, se amplían las funciones del contrato en la Tabla 5.

Tabla 5
Funciones del Contrato Terapéutico (*Diamond et al., 2022*)

Establecer un entendimiento mutuo del problema para dirigirlo al tratamiento
Definir la realidad de la relación terapéutica al clarificar los roles y responsabilidades del cliente y terapeuta
Proteger al consultante, el terapeuta y la terapia, incluyendo la protección de la capacidad del terapeuta de pensar claramente
Minimizar las ganancias secundarias de la condición de salud mental
Proveer un espacio seguro para que los afectos del paciente sean experimentados
Ajustar el escenario para interpretar el significado de las desviaciones del contrato o marco de tratamiento
Proveer un marco terapéutico organizado que permite que la terapia se convierta en un ancla en la vida del paciente
Definir las opciones del paciente y discutir las posibles actividades de su vida que definen los elementos de identidad y conflictos internos

Cuando hay desviaciones del marco terapéutico, el referirse al contrato respalda la capacidad del paciente para salir del momento y ver su comportamiento desde perspectivas alternativas. Al hacer referencia al contrato y su falta de cumplimiento pueden experimentarse sentimientos intensos y reflexionar, en contraste con la necesidad sentida por el paciente de manejar los aspectos amenazantes de la experiencia afectiva a través de la actuación y la proyección (Yeomans et al., 2013). A continuación, describimos los elementos del contrato terapéutico en la Tabla 6.

Tabla 6
Elementos del Contrato Terapéutico (Diamond et al., 2022)

Responsabilidades del paciente:
Asistencia y participación en la terapia
Asociación libre de los aspectos que lo trajeron al paciente a la terapia (haciendo un esfuerzo de expresar pensamientos y sentimientos libremente sin censura)
Pago de honorarios
Hacer un esfuerzo de reflejar lo que el consultante reporta, en los comentarios del terapeuta o en la interacción
Responsabilidades del terapeuta:
Ajustarse a la programación
Prestar atención a todos los aspectos del consultante
Hacer un esfuerzo para ayudar al paciente a entender los aspectos más profundos de sus dificultades de personalidad
Clarificar límites personales
Viñeta clínica:
C: Hola de nuevo.
T: Hola. Me llama la atención que faltaste la semana pasada y no me avisaste. No es la primera vez que ocurre.
C: Siento que no necesito esto. Me han dicho que estoy mejor.
T: Me da gusto que te sientas mejor, sin embargo, has faltado sin justificación y eso no fue lo que acordamos en nuestro contrato.
C: No me gusta esta situación, tener que hacer esto.
T: Pensé que estábamos trabajando por el cumplimiento de tus objetivos. Para poder ayudarte es importante que primero mantengamos un respeto por la terapia y los acuerdos que establecimos. ¿Qué piensas sobre esto que sucede?
C: Tengo el presentimiento de que solo me quiere controlar y no soy un niño.
T: Es interesante esto que dices. Al parecer esto que te sucede conmigo es similar a lo que te ocurre con los demás y quieres evitar recibir órdenes. A ver si lo exploramos juntos.
C: Está bien.

Estrategias de Terapia Basada en la Mentalización

Mentalización es la capacidad de entender las acciones de uno mismo y de los demás en términos de pensamientos, sentimientos y deseos (Bateman y Fonagy, 2016; Daubney y Bateman, 2015). La TBM es una estructura de tratamiento colaborativa para la expansión de la mentalización y ayudar al cliente a identificar los estados mentales que están fuera de la conciencia del consultante. Este enfoque involucra que el terapeuta exhiba empatía y provea validación de la experiencia del consultante, clarificación y exploración de la narrativa e identificación del foco afectivo de la sesión. El terapeuta ayuda a ampliar la perspectiva del consultante en los eventos presentados en la narrativa, al presentar perspectivas alternativas. El proceso terapéutico se centra principalmente en el aquí y ahora de la sesión e involucra la relación con las figuras de apego, incluyendo al terapeuta, y cómo esto influencia en la capacidad de mentalizar (Fonagy y Target, 2006; Levy et al., 2018).

Para ayudarnos a comprender el cómo y el por qué de las formas en que la mentalización y la no mentalización pueden adoptar estas diferentes formas, debemos apreciar que la mentalización se basa en diferentes actividades sociocognitivas sustentadas por diferentes procesos neurobiológicos. Son cuatro dimensiones (o polaridades) que se presentan en la vida de la persona en el ambito cotidiano e interrelacional: Automático/controlado; Self/otros; Cognitivo/afectivo; Interno/externo.

Todas las personas avanzamos y retrocedemos a lo largo de estas dimensiones en respuesta a cambios en nuestro entorno y ajustes en lo que pensamos. En ocasiones podemos centrarnos en nuestros propios estados mentales, mientras que en otros momentos podemos estar más atrapados en lo que creemos que está en la mente de los

demás. A menudo encontramos que las personas que experimentan angustia emocional o dificultades de comportamiento tienden a estar más "atascadas" en un polo de una o más dimensiones. Una buena o eficaz mentalización supone que existe un "movimiento" flexible entre los polos de cada dimensión, logrando un equilibrio entre ellos en el procesamiento de las representaciones mentales. Dependiendo del contexto y del tema, la mentalización ineficaz puede verse muy diferente. Todos tenemos diferentes fortalezas y debilidades según dónde tendemos a aterrizar en cada dimensión de mentalización. Aunque hablamos de "fallos" en la mentalización, como si la mentalización fuera un proceso único que simplemente se detiene, estos fallos pueden aparecer de diferentes maneras, dependiendo de cómo esté funcionando el individuo en las diferentes dimensiones (Bateman et al., 2023).

Las conductas que atentan contra la terapia, así como cualquier otra conducta problema que se observe en el TLP, desde la perspectiva de TBM, está asociada a un fallo en la capacidad de la mentalización. Las personas con TLP tienen desequilibradas las distintas dimensiones de la mentalización, presentando una atención excesiva a uno de los polos de cada dimensión y generando, por consecuencia, una desatención al otro polo (Bateman y Fonagy, 2016). Este foco en un polo y desatención en el otro, facilita los problemas observados en la regulación de emociones, control de impulsos, interacción social y estilos de apego en las personas con TLP. Ante el fallo en la mentalización por parte de las personas con TLP, sobre todo en contextos sentidos como amenazantes o poco seguros, las personas suelen activar modos de pensar no mentalizadores o pre mentalizadores (se denomina asi, porque son similares a los modos de o pensar que se observan en los niños, antes de desarrollar su capacidad mentalizadora) (Bateman y Fonagy, 2016). Así, cuando falla la mentalización, la persona va a tener dificultades para diferenciar lo que piensa o siente, de lo que sucede en la realidad, estableciéndose una equivalencia entre lo que pienso y lo que es real, por lo que este modo se denomina equivalencia psíquica. En contraposición a la equivalencia psíquica, aparece otro modo pre mentalizado, denominado modo teleológico. En el modo teleológico, la certeza de lo verdadero no esta en mi pensamiento o en lo que siento, sino en lo que observo, necesitando que se produzca alguna conducta observable, hecha por otro o por mí, para comprender lo que sucede. El ultimo modo pre mentalizado, es el modo simulado. En el modo simulado surge una desconexión entre lo la cognición y el afecto de la persona, siendo testigos de relatos aparentemente mentalizadores, sin embargo, observamos una carencia de expresión y congruencia afectiva, siendo relatos circulares, vacíos sin resonancia afectiva. En el modo simulado, la persona simula mentalizar, por lo que en realidad hipermentaliza o pseudomentaliza, llegando en situaciones extremas, a la despersonalización, desrealizacion y disociacion. A continuación, describimos estas dimensiones y modos pre mentalizados en la Figura 1.

La TBM utiliza técnicas específicas que le dan peso a la validez de la terapia ya que esta se centra en el proceso más que en contenido, dando la posibilidad al paciente de desarrollarse y abrirse camino a la comprensión de sus estados internos y de otros por lo que el terapeuta es un observador constante y habilidoso de esa elaboración que permite la trascendencia (Bateman y Fonagy, 2016). Se mencionan a continuación brevemente:

- Apoyo, validación y empatía
- Clarificación y elaboración del afecto
- Identificar la Mentalización positiva
- Detenerse y desafiar al paciente
- Mentalización básica:
- Parar, escuchar y mirar
- Parar, rebobinar y explorar
- Mentalización de la transferencia

A continuación, presentamos algunas viñetas clínicas e intervenciónes del enfoque de la mentalización para manejar conductas que atentan a la terapia:

Modo prementalizador:

A. Equivalencia psíquica:

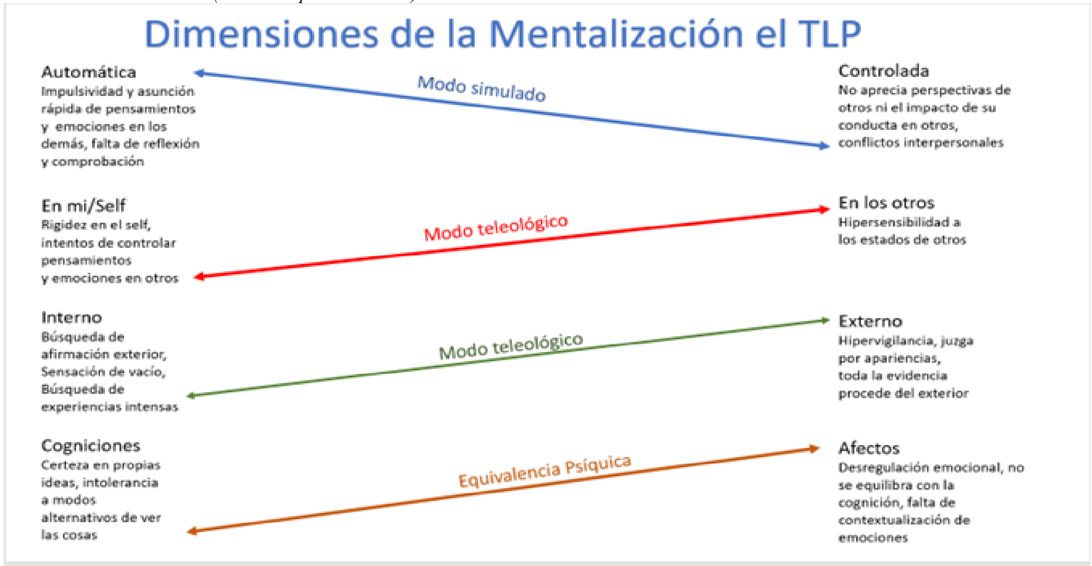
1. "Si es doloroso no voy a poder"

• Viñeta clínica 1:

P: No quisiera seguir en esta situación. Estoy sufriendo mucho.

Figura 1

Dimensiones de la Mentalización en el TLP (elaborado por los autores)



No creo poder seguir en un tratamiento y a la vez lidiar con que mi novio se haya ido.

T: Observo que la estás pasándola muy mal.

P: No sé hasta cuando vaya a aguantar.

T: ¿Cómo llegas a la conclusión de que no vas a poder?

• Intervención 1:

o No descalifica el sentir del paciente

o Valida la experiencia

o Terapeuta adopta postura de no saber e invita a retomar mentalización a partir de explorar la conclusión del paciente

2. “Solo los que les pasa lo mismo que yo o sienten lo mismo que yo, me van a entender”

• Viñeta clínica 2:

P: Creo que no me entiende y solamente me escucha y dice cosas agradables.

T: ¿A qué te refieres?

C: A este paso solo terminaré yéndome como siempre de las terapias donde estoy. No me entiende simplemente.

T: ¿Qué crees debería de pasar para que pienses que te entiendo?

P: No sé, que siente lo mismo que yo

T: Parece ser que asumes que no puedo entenderte por no sentirme como tu

• Intervención 2:

o Terapeuta cuestiona la creencia de un paciente que ha dejado de mentalizar, para favorecer un proceso mas reflexivo.

B. Modo teleológico

1. “Lo que los otros hacen me confirma que yo estoy mal”

• Viñeta clínica 1:

P: Estoy harta. Hasta aquí creo que llego en la terapia. He venido pensándolo bien y creo que es lo mejor.

T: Vaya, no veía venir esto. Para poder entender esto que dices, ¿podrías contarme lo que ha sucedido?

P: Lo siento, pensé que ya te lo había contado. Estoy pasando por un mal momento, esta semana ha sido de lo peor. Primero pierdo mi trabajo, mi novio me deja y acabo de pelearme con mi mamá. Siento que voy a explotar.

T: Ya veo. Eso debe sentirse muy mal. Ayúdame a entender un poco más. ¿A qué te está llevando todo esto que sientes?

• Intervención 1:

o Clarificas lo que está sucediendo

o Invitas al paciente a notar el componente afectivo

o El terapeuta no se detiene a explorar en el mensaje de no seguir en terapia e invita a la paciente a mentalizar el impacto del componente afectivo en su experiencia

• Viñeta clínica 2:

P: Quiero ser sincero por primera vez, espero que no se tome a mal. Estoy cansado de estar en terapia.

T: Eso me toma por sorpresa y a la vez me agrada saber que puedes ser sincero aquí.

P: Ya lo dije.

T: Ahora podríamos hablar sobre esa sensación de cansancio con la terapia, y creo que la sinceridad que has demostrado nos puede ayudar con eso.

• Intervención 2:

o El terapeuta valida el sentir del paciente y resalta la mentalización positiva, al ser el paciente honesto con él.

o Usa esa mentalización positiva que ha surgido en el paciente, para mentalizar otros aspectos en relación a su experiencia.

2. “Repite esa accion que me incomoda, me quiere hacer sentir mal”

• Viñeta clínica 3:

P: Cuando el psiquiatra me dice que debo tomar los medicamentos me siento como un niño pequeño. Solo quiere hacerme sentir que no puedo con esto. Me da ganas de darle la contra.

T: Oh, espera un momento. ¿Cómo es que llegaste a esto?

C: Solo eso

T: ¿Qué fue lo que te hizo?

P: Me repite lo mismo siempre.

T: ¿Por qué piensas que él te repite esto cada vez que se ven?

P: Bueno, un par de veces se dio cuenta que me olvidé de los medicamentos.

T: Ya veo, al parecer estaba haciendo su trabajo.

• Intervención 3:

o Parar, escuchar y mirar

o Terapeuta hace una pausa en la sesión, investigar los detalles de lo que sucede, resaltar quién siente qué acerca de quién y lo que se entiende desde su perspectiva.

3. “Si ellos no hablan, yo no hablo”

• Viñeta clínica 4:

P: No me gusta cuando los demás no dicen lo que piensan. Es la manera en la que me guardo las cosas, si no me hablan primero.

T: Es interesante. Me pregunto si también te sucede aquí, si no sabes lo que estoy pensando.

P: Si no me lo dicen, no hablo.

T: ¿Aún no me preguntarás lo que pienso?

P: Tal vez.

T: Eso sería un gran paso. Cuando no dices nada podrías estar preocupado por lo que pienso de ti.

P: Algo de eso pasa.

T: Cuéntame. ¿Ha sucedido algo así el día de hoy desde que comenzamos la sesión?

• Intervención 4:

o El Terapeuta pone el foco en la transferencia en sesión.

o Tiene la finalidad de mover la terapia hasta el aspecto del aquí y ahora.

o Vinculan el presente exterior al proceso actual del tratamiento, o mueven la emoción actual de la sesión hacia la vida exterior del paciente.

C. Modo simulado

1. Cambio de tema, evitación.

• Viñeta clínica 5:

P: Estaba solo en casa y estuve escuchando música, esas de las que me gustan y me hacen solo llorar, no quería salir a la cita. Pero bueno, ya no tiene sentido hablar de esto. El otro día…

T: Espera un momento, me estaba perdiendo en eso que contabas, luego pasaste a otro tema.

P: Es difícil.

T: ¿Qué pasó en el momento que estabas escuchando la música?

P: Me sentía muy mal, muy triste.

T: ¿Qué pasó que decidiste venir finalmente hasta acá?

P: Supongo que me armé de valor para continuar con esta terapia.

• Intervención 5:

o Parar, rebobinar, explorar

o Terapeuta nota la desconexión y el cambio de tema, para la interacción y retrocede hasta el punto en donde se estaba teniendo una adecuada mentalización, para explorar paso por paso lo sucedido.

Conclusiones

El TLP es una condición crónica caracterizada por inestabilidad emocional, ira inapropiada e impulsividad, sobre todo dificultades interpersonales, lo que genera un impacto en la transferencia durante el proceso terapeutico.

Las conductas que atentan a la terapia promueven al abandono temprano si es que no se abordan a través de estrategias que permitan comprender las limitaciones de los consultantes y fomentar un marco de tratamiento basados en acuerdos y responsabilidades en la diada terapeuta-consultante.

La TCD es una de las terapias que más han demostrado efectividad en el abordaje del TLP, logrando mayor adherencia al tratamiento y disminución de conductas de riesgo. Dentro de sus objetivos está el lograr que un paciente pueda resolver habilidosamente las barreras que le impiden ser ayudado. La TBM considera cualquier conducta problema que se produce durante la relación terapéutica, como un fallo en la mentalización, por lo que el terapeuta debe prestar bastante atención al momento en que se deja de mentalizar, parar, y favorecer una actitud mentalizadora por parte del paciente. Este proceso conlleva el uso de un conjunto de estrategias, que, partiendo de la postura de no saber, valida, clarifica, desafía, resalta la mentalización positiva, favorece la mentalización básica y resalta la transferencia que se produce en la sesión, para que esto también sea mentalizado.

Por otro lado, terapias psicodinámicas como la TBM y PFT han aportado una filosofía de respeto por la terapia valorando el proceso a nivel interpersonal y un contrato a seguir.

Es necesario considerar que las diferentes teorías de los modelos terapeuticos presentados se enfocan en los elementos centrales que componen el desarrollo de la personalidad, como el temperamento y su relación con la regulación emocional, el apego y la mentalización; por lo cual resulta útil en su aplicación y ayudar a comprender los factores de posible abandono en el proceso terapeutico.

El propósito de esta revisión fue el describir los principales modelos terapeuticos que han demostrado evidencia en el tratamiento de pacientes con TLP para mejorar la adherencia al tratamiento y evitar abandonos.

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Declaración de Interés

Los autores declaran no tener conflicto de intereses.

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Article

Temporary Perspective in Priests, Nuns and Catholic Seminarists

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ABSTRACT

The relation between religiosity and temporal perspective has been scarcely studied since the emergence of the psychology of religion in the early twentieth century. There is no known study with priests, nuns, and Catholic seminarians about it according to our database search. The objective of the present investigation was to explore if there were differences in the temporal perspective in a sample of catholic priests, nuns, seminarians, and laypeople. Zimbardo Time-Perspective Inventory (ZTPI) scores obtained for 128 subjects, between 18 and 70 years, at total and item level were analyzed using ANOVA. The lay group differs significantly from Catholic priests, nuns, and seminarians in the present hedonistic and fatalist present. The temporal perspective makes it possible to differentiate significantly between the laity and the three groups of Catholic religious for the fatalistic and hedonistic present.

Perspectiva Temporal en Sacerdotes, Monjas y Seminaristas Católicos

Palabras clave:
Perspectiva temporal
Psicología de la religión
Religiosidad
Sacerdotes católicos
Monjas católicas
Seminaristas católicos
Análisis transversal

RESUMEN

La psicología de la religión surgida a principios del siglo XX ha estudiado escasamente la relación con la perspectiva temporal. Y no se conoce ningún estudio con sacerdotes, monjas y seminaristas católicos al respecto según nuestra búsqueda en base de datos. El objetivo de la investigación fue explorar si existían diferencias en la perspectiva temporal en una muestra de sacerdotes, monjas, seminaristas católicos y laicos.
Se aplicaron los instrumentos psicométricos Inventario de Orientación Temporal de Zimbardo (ZTPI) a 128 sujetos, entre 18 y 70 años. Se realizó un estudio transversal cuantitativo con alcance descriptivo para comparar los grupos. Para ello se utilizó ANOVA y análisis de ítems. En la perspectiva temporal, se observa que el grupo de laicos se diferencia significativamente de sacerdotes, monjas y seminaristas católicos en presente hedonista y presente fatalista. La perspectiva temporal permite diferenciar significativamente entre laicos y los tres grupos de religiosos católicos con respecto al presente fatalista y presente hedonista.

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"Time" and "religion" are two human dimensions that potentially facilitate giving meaning to the human experience (James, 1902/2002; Lewin, 1942; Lowicki et al., 2018; Mead, 1932).

The person is a temporary being, and this dimension allows us to understand the self-organization of personal knowledge (Quiñones et al., 2015) and self-regulation in daily social life (Buhusi & Meck, 2005; Milfont & Schwarzenthal, 2014), among other things.

Cartwright (1951), in his compilation work on Lewin, displayed that an individual's behavior, mood, and morale depends on their psychological view of the past and future "existing at a given time" (p. 75). Extending this idea, Zimbardo and Boyd (1999, 2008) developed a conceptual model of time perspective (TP), is also understood as the attitude and focus of people towards one or more of the three temporal zones: Past, present, and future. It is argued that the focus tends to be relatively stable over time and, in general, people are focused on one of the dimensions, implying consequences on their cognitions, emotions, and behaviors. Zimbardo and Boyd (1999), suggest that the three temporal zones include five temporal dimensions:

- Past-positive, referring to the vision of positive experiences and experiences that the person has had in the Past (e.g. "I'm happy to think about my past");
- Past-negative, in which the attitude towards the Past focuses on negative experiences that may be due to stressful or traumatic situations, or negative evaluation of past experiences (e.g. "It's hard for me to forget unpleasant images of my youth");
- Present-hedonistic represents the focus on the search for enjoyment and delight (e.g. "I believe that getting together with one's friends to party is one of life's important pleasures.");
- Present-fatalist, represents a negative attitude towards current events and experiences, focusing on discouragement and hopelessness of what may happen with life (e.g. 'Since whatever will be will be, it doesn't really matter what I do");
- Future is the dimension that characterizes a focus on planning and goal achievement (e.g. "I complete projects on time by making steady progress").

In general, the temporal perspective has been empirically studied in the following fields of knowledge: Psychopathological disorders (Ryu et al., 2015), emotional and mood disorders (Droit-Volet, 2013), high-risk behavior (Boyd & Zimbardo, 2005), substance abuse (Keough et al., 1999); alcohol-related problems (McKay et al., 2018), basic psychology (Block et al., 2010), psychotherapy processes (Quiñones et al., 2017), meditation (Wittmann et al., 2015), case formulation in psychotherapy (Quiñones, 2021, 2024a, 2024b; Quiñones & Ugarte, 2022), psychological profile and bariatric surgery (Ugarte et al., 2020), psychological profile in type II diabetes (Quiñones et al., 2018), religiosity (Allport, 1950; Lowicki et al., 2018), among others.

In particular, it has been reported that people with a fatalistic present (Anagnostopoulos & Griva, 2012; Zimbardo & Boyd, 1999) and a hedonistic present (Roseanu et al., 2008) have been reported to have more psychological difficulties and are more exposed to depression. Furthermore, Fatalist present it is related to low self-esteem (Zimbardo & Boyd 1999; Anagnostopoulos & Griva, 2012), but no relationship was found between present hedonistic and self-esteem (Zimbardo & Boyd, 1999).

The hedonistic present perspective was positively correlated with risky behaviors, addictions, aggression, depression, sensation and the search for novelties (Daugherty & Brase, 2010; Rothspan & Read, 1996; Zimbardo et al., 1997), while the present fatalistic perspective was positively correlated with neuroticism, aggression, depression, characteristic anxiety and life dissatisfaction (Stolarski et al., 2014).

These five temporal dimensions configure one profile: balanced time perspective (PTB). Balanced time perspective (BTP) is understood as "the mental ability to switch flexibly among TPs depending on task features, situational considerations, and personal resources rather than be biased toward a specific TP that is not adaptive across situations" (Zimbardo & Boyd, 1999, p. 1285).

Numerous studies have shown exciting relationships regarding balanced time perspective, including correlations with subjective well-being (Drake et al., 2008; Stolarski et al., 2015, Stolarski, 2016) and with psychological well-being, self-esteem, and life satisfaction (García et al., 2016). Higher BTP is associated with higher life satisfaction and general happiness (Barsics et al., 2017; Simons et al., 2018), extraversion (Zajenkowski et al., 2016), positive orientation (Sobol-Kwapińska & Jankowski, 2016), satisfaction with interpersonal relations (Stolarski et al., 2016), mindfulness (Selma & Sircova, 2013) and emotional intelligence (Stolarski et al., 2011).

Moreover, the interest of psychology in religion has a history. One of its leading researchers was William James in his work "The varieties of religious experience" (1902/2002). Religion can be defined as adherence to common beliefs, behaviors, and practices associated with a particular tradition and community of faith, which provides guidance and supervision (Hill et al., 2000). In the psychological context, the classic work of Gordon Allport (1950) represented Religiosity as a relatively stable disposition assessable by self-report tests. Thus, with the pioneering work of Allport and Ross (1967), religious orientations began to be studied empirically. They distinguished two motivational approaches to religion: intrinsic religious orientation and extrinsic religiosity.

Intrinsic religious orientation characterizes people who see religion as a central motive in their lives and interpret it as an end in itself. And people with extrinsically oriented tend to use their faith as a means of achieving other goals. It is noteworthy that research on religious orientations has contributed to understanding their relationships with mental health (Ghorbani et al., 2012). Different authors suggest that the intrinsic orientation towards religion is associated with higher subjective well-being, while an extrinsic orientation towards religion is associated with negative emotions, anxiety, or depression (Ellis & Wahab, 2013; Koenig et al., 2004).

The relationship between religiosity and well-being is not homogeneous. While religious practices are often argued to serve as protective factors, the literature also suggests potential risks. For instance, Braam et al. (2001) found that in European elderly populations, regular attendance at religious services, particularly among Roman Catholics, was associated with lower levels of depression, although the impact varied depending on the sociocultural context. Braam et al. (2019) expanded on this perspective by identifying that the protective effects of religiosity in later life may depend on the prevailing religious climate, highlighting that religious practice is associated with lower depression rates both at the individual and national levels, particularly in traditional Catholic contexts with high levels of church attendance.

van de Velde et al. (2017) noted that while attendance at religious services improves mental health in highly religious contexts, private practices, such as prayer, might not have the same effects

in more secular environments. These observations emphasize that the influence of religiosity is mediated by contextual factors, such as the level of religiosity prevalent in the geographical and cultural environment. Additionally, Braam & Koenig (2019) highlighted that depending on the sample, religiosity can act as either a protective or a risk factor for mental health. This finding underscores the importance of examining not only religious practices but also religious struggles or conflicts, which are associated with higher levels of depression.

In the field of research on religious and spiritual beliefs and practices in human health, there is strong evidence of its impact (Koenig et al., 2012), such as: Better results when patients have greater faith and spirituality during treatment for cancer (Messina et al., 2010); correlation between religious practice and the reduction of cardiovascular mortality (Hummer et al., 1999); Lower mortality rates for patients who adhere to religious practices or who live in areas considered affiliated with religious practices (Jaffe et al., 2005). However, the complexity of these relationships, as noted by Braam et al. (2019), highlights the need to consider both the benefits and challenges that these dimensions may pose to mental health, depending on factors such as the type of religious practice and the level of religious conflict.

In this regard, Tokarz and Łowicki (2024) identified significant differences between Christian denominations, highlighting that religiosity can be associated with general well-being, such as life satisfaction and a sense of meaning in life, but these relationships are also influenced by specific characteristics of each denomination. In their study of Roman Catholics and Pentecostal Christians, they found that Pentecostals reported higher levels of religiosity and social support, reinforcing the idea that certain aspects of well-being, such as a sense of meaning in life, may depend on both general factors related to religiosity and denomination-specific characteristics.

This context demonstrates that the relationship between religiosity and well-being is multidimensional and influenced by various individual and sociocultural factors.

There is limited research on religiosity and time perspective. According to our database search, to date, the association between time orientation and religiosity has been explored in some relevant studies, albeit limitedly, and only one included an exclusive sample of nuns. Other studies have not included samples of priests, nuns, or seminarians. Lowicki et al., (2018) conducted a series of three studies with a predominantly Catholic sample (N > 700), providing an in-depth empirical view of the interaction between individual differences in the temporal framework of human experience and various characteristics of religiosity, including general belief in God, Allport's religious orientations, Huber's centrality of religiosity, and religious fundamentalism.

Their research found that the positive aspects of religiosity are correlated with a time perspective of a positive past and future. Furthermore, the present temporal focus was associated with instrumental and fundamentalist approaches to religious belief. Overall, their results suggest that religiosity is linked to a broad temporal profile and that the associations between time perspectives and religiosity remain significant even after controlling for personality traits.

Przepiórka and Sobol-Kwapinska (2018), on the other hand, provided evidence on how religiosity can moderate the relationship between time perspective and life satisfaction. Their study, conducted with Polish adults, showed that extrinsic religiosity (ER) attenuates the negative effects of a time orientation focused on a negative past and a fatalistic present, thereby improving life satisfaction. Meanwhile, intrinsic religiosity (IR) was more strongly associated with internal values and meaningful spiritual experiences, highlighting differences in how each type of religiosity influences time perspectives and psychological well-being.

Similarly, Stewart-Sicking & Piedmont (2022) explored how time perspective can predict religious affiliation and spiritual practices. They identified that a fatalistic present orientation is associated with lower levels of religious affiliation, while spiritual transcendence—defined as the ability to situate oneself beyond the immediate present and view life from a broader context—plays a crucial role in decision-making regarding religious participation. This concept reinforces the idea that the interaction between religiosity and time perspective encompasses profound existential dimensions.

Finally, Collazos-Ugarte et al., (2024) investigated time perspective in a sample of 283 Italian nuns, using the Balanced Time Perspective Scale (BTPS) developed by Webster (2011). They found that both emotional intelligence and intrinsic religiosity significantly contribute to a balanced time perspective (BTP), a positive temporal profile that balances perceptions of the past and future. Additionally, the study highlighted that emotional intelligence is mediated by intrinsic religiosity, amplifying its benefits on BTP. This finding underscores how religious beliefs not only influence perceptions of time but also contribute to a deeper understanding of emotions, fostering both individual and collective well-being in religious communities.

Therefore, it is essential to further investigate the potential links between time perspective and religion. In the present study, time perspective (TP) is defined according to Zimbardo and Boyd (1999) as "the often nonconscious process whereby the continual flows of personal and social experiences are assigned to temporal categories, or time frames, that help to give order, coherence, and meaning to those events" (p. 1271).

The purpose of this cross-sectional study was to explore whether there were differences in time perspective in an intentional sample of Catholic priests, nuns, seminarians, and laypeople.

Method

Participants

A non-probability convenience sample of 128 people between 18 and 70 years, divided equally into four groups: 32 priests, 32 nuns, 32 seminarians, and 32 laypeople. All participants resided in Chile, specifically in Santiago, Concepción, and Iquique. Participation was voluntary, with signed informed consent.

The exclusion criteria were not belonging to the Catholic religion, not being self-reliant, or being illiterate. In the case of laypeople, the group included individuals with varying levels of religious practice, ranging from regular churchgoers to those with minimal participation in religious activities. This variability was not controlled in the present study, and all lay participants who identified as Catholic were included regardless of their level of religious engagement.

Instruments

As participants are religious consecrated to God, Religiosity is implicit in the role they exercise, specifically in the role of Nun, Priest, and Seminarian. Likewise, the group of laypeople belongs to the Catholic religion, but they do not exercise a consecrated activity.

Zimbardo Time Perspective Inventory, ZTPI, version adapted for Chile by Oyanadel et al., (2014). It is an instrument of 56 items that are scored on a Likert-type scale that ranges from 1 to 5. The instrument measures the five dimensions of Zimbardo's Temporal Orientation theory: Past Positive (PP), Past Negative (PN), Present Hedonist (PH), Present Fatalist (PF) and Future (F). Each item is on a five-point Likert scale ranging from 1 (very uncharacteristic) to 5 (very characteristic). Higher scores reflecting a stronger orientation toward that particular item's TP. The reliability analysis in the Chilean population shows a Cronbach's alpha of .80 for Past Negative and Future, of .79 for Present Hedonist and .74 for Present Fatalistic. The lowest indicator has been reported for Past Positive with Cronbach's alpha of .59, being at a moderate level.

Stolarski et al. (2011), provided a continuous indicator of BTP labeled Deviation from the BTP (DBTP). Furthermore, to calculate the deviation from the balanced time perspective (DBTP) (Stolarski et al., 2011; Zajenkowski et al., 2016) the formula was used which is based on ZTPI scores and serves as an indicator of BTP (Zhang et al., 2013). From a mathematical point of view, DBTP is the root of the sum of the squared deviations of a person's scores (i.e., ePN) from the optimal score on each scale (i.e. oPN) (Stolarski et al., 2011). This method is considered optimal among the existing BTP evaluation methods (Stolarski et al., 2016). The formula is as follows:

$$DPTB = \sqrt{} \; (oPN\text{-}ePN)^2 + (oPP\text{-}ePP)^2 + (oPF\text{-}ePF)^2 + (oPH\text{-}ePH)^2 + (oF\text{-}eF)^2$$

An ideal score for each TP scale was adopted on the basis of optimal ZTPI raw scores (1.95 [oPN], 4.60 [oPP], 1.50 [oPF], 3.90 [oPH] and 4.00 [oF]) (Zhang et al., 2013; Stolarski et al., 2015).

$$DPTB = \sqrt{} \; (1.95\text{-}2.64)^2 + (4.60\text{-}3.83)^2 + (1.50\text{-}2.38)^2 + (3.90\text{-}2.99)^2 + (4.00\text{-}3.73)^2$$

A low DBTP score (closer to zero) indicates a more balanced time perspective (Zhang et al., 2013), characterized by an equilibrium among temporal dimensions, which is associated with greater psychological well-being and better emotional integration (Stolarski et al., 2011). In contrast, a high score reflects a greater deviation from this balance, which may be related to difficulties in reconciling past, present, and future experiences.

Each deviation in the temporal subscales provides information about specific areas where participants exhibit significant differences from the ideal balanced time perspective. For example, a high deviation in the Past Negative subscale indicates a more critical or traumatic view of the past, while a deviation in the Present Fatalistic subscale may reflect more pessimistic attitudes toward the present. These interpretations are crucial for analyzing the differences among the study's subgroups.

Short Form 36 Health Survey (SF-36: It was designed to assess the perception of health-related quality of life in adults (Ware & Sherbourne, 1992). The instrument shows good indicators of reliability and validity in different countries as well as in Chile (Olivares, 2006). It contains 36 items that evaluate eight dimensions of health, grouped into two components: 1) Physical Health Component: a) Physical function, b) Physical role, c) Body pain, d) General health; 2) Mental Health Component: a) Vitality, b) Social function, c) Emotional role, and d) Mental health. In addition, it evaluates the evolution of health in the last year. The results of each of the dimensions are coded and transformed into a scale ranging from 0 (worst state of health) to 100 (best state of health).

Sociodemographic variables: Sex, age, educational level, current activity, whether religious (Priest, Nun, Seminarian) or layperson, were considered. These data were obtained through an ad hoc questionnaire carried out to obtain specific information of interest to our study.

Procedure

Contact was made with the representatives of the churches, specifically the respective superiors for nuns, priests, and seminarians. Face-to-face meetings were held with ecclesiastical authorities, during which they requested to review the project, psychometric instruments, sociodemographic files, and informed consent forms. Once their approval was obtained, 150 dossiers containing the instruments and their respective informed consents were delivered to the ecclesiastical authorities, who were responsible for distributing them to participants within their communities. The instruments were self-administered and returned by participants at different times.

For the laity, Catholic participants were contacted directly by the researchers. The instruments were self-administered with an average completion time of 40 minutes. Although evangelicals were initially contacted for potential participation, the final sample only included Catholics, ensuring consistency across the religious affiliation of all participants.

The sample consisted of 128 subjects, equally distributed across the four groups (n = 32 per group). Participation was voluntary and required the signing of informed consent. To maintain confidentiality, each participant was assigned a unique identification number. The data were recorded in an Excel spreadsheet and subsequently imported into SPSS for analysis.

Note on Data Collection Differences

While the data collection process involved ecclesiastical authorities for the religious groups and direct contact for the laity, this approach was chosen to respect the organizational structure of the religious institutions. These differences are acknowledged as a limitation of the study and are discussed further in the Limitations section.

Data Analysis

Descriptive analysis for sociodemographic characterization and item response was performed. The Deviation from Balanced Time Perspective (DBTP) was used as a dependent variable to examine differences among the studied groups (priests, nuns, seminarians, and laypeople) in their level of balanced time perspective.

The normality of the data was assessed using the Shapiro-Wilk test, given its higher sensitivity for small to medium-sized samples. The results indicated that the variables PN, PP, PH, PF, and F met the assumption of normality ($p > 0.05$). However, the variable PTbalanceado (DBTP) and all dimensions of the Short Form 36 Health Survey did not meet this assumption ($p < 0.05$). Consequently, one-way ANOVA tests were conducted to compare groups across the variables of the Zimbardo Time Perspective Inventory, with effect size estimated using Eta-square (η^2). For the DBTP and the SF-36 dimensions, Kruskal-Wallis tests were employed due to the violation of the normality assumption, and effect size was calculated using the epsilon-squared (ε^2) statistic to provide a measure of the magnitude of group differences. Data analyses were carried out using the SPSS statistical package (V.25.0), and the criterion used to determine statistical significance in all analyses was set at $p < 0.05$.

Results

One hundred twenty-eight persons with ages between 18 and 74 years (mean of 38.06, *SD* = 14.5) participated in the study. 18 persons (30%) are aged 60 or over. 75% of the sample corresponded to consecrated religious, and 25% were Catholic laity; 56.3% were women.

Table 1 shows the descriptions of the instruments.

The Figure 1 illustrates the BTP profile, locating "optimal" ZTPI raw scores at 1.95 for Past Negative, 4.6 for Past Positive, 1.5 for Present Fatalism, 3.9 for Present Hedonism, and 4.0 for Future. Zimbardo and Boyd (1999) propose this definition of BTP on Time Paradox webpage (www. timeparadox.com/surveys/).

ANOVA with Bonferroni posthoc tests was used to analyze differences between the four groups. Statistical significant differences were detected on Present-hedonistic ($F = 8.27$; $p < 0.001$) and Present-fatalistic ($F = 5.90$; $p < 0.001$) (See Table 2) The results of the Kruskal-Wallis test are shown in Table 3. Layperson showed scores significantly higher than priests ($p < 0.001$), nuns ($p < 0.001$), and seminarians ($p < 0.000$) in Present-hedonistic and Present-fatalistic. No differences were found between nuns, priests, and seminarians in these two variables (Figure 2).

Bonferroni post-hoc tests show that in physical function, seminarians have significantly fewer limitations to perform various physical activities than nuns ($p = 0.003$) and lay people ($p = 0.006$). No significant differences were observed between seminarians and priests on this scale. There were also no significant differences between the groups in other SF-36 scales.

Table 1
Descriptive Statistics for Major Variables

	M (SD)	*Min.*	*Max.*	*Kurtosis*	*SKEW*	*Alpha*	*(95% IC)*
ZTPI							
Past Negative	2,64(0,50)	1,31	3,85	0,208	-0,033	.72	2,56 – 2,73
Past Positive	3,83(0,47)	2,38	4,88	-0,177	-0,311	.59	3,75 – 3,92
Present Hedonist	2,99(0,54)	1,64	4,36	-0,130	-0,019	.78	2,90 – 3,09
Present Fatalist	2,38(0,55)	1,27	3,91	-0,145	0,318	.71	2,28 – 2,47
Future	3,73(0,48)	2,10	4,90	0,486	-0,106	.61	3,65 – 3,81
SF-36							
Physical function	89,5 (14,8)	35	100	2,534	-1,728	.85	86,9 – 92,1
Role physical	83,3 (18,1)	18,7	100	1,383	-1,274	.85	80,2 – 86,5
Bodily pain	47,1 (15,2)	0	74	0,042	-0,081	.72	44,5 – 49,8
General health perception	72,3 (17,6)	25	97	0,473	-0,931	.75	69,2 – 75,4
Vitality	64,3 (12,1)	25	90	0,164	-0,327	.68	62,2 – 66,5
Social functioning	84,3 (19,3)	12,5	100	1,837	-1,464	.75	80,9 – 87,7
Role emotional	82,4 (16,4)	33,3	100	-0,159	-0,758	.70	79,5 – 85,2
General mental health	70,4 (12,1)	32	88	0,909	-0,984	.81	68,3 – 72,5
Evolution of health	2,16 (0,84)	1	4	-0,774	0,149	-	2,02 – 2,31

ZTPI: Zimbardo Time Perspective Inventory; SF-36: Short Form 36 Health Survey.

Figure 1
BTP Profile and Time Perspective Profile of Sample

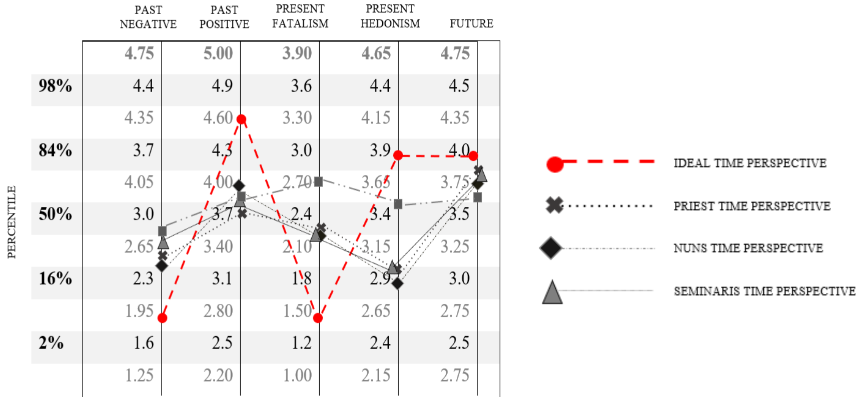


Table 2
Temporal Perspective ANOVA Results

ZTPI	Priests *M(SD)*	Nuns *M(SD)*	Seminarians *M(SD)*	Layperson *M(SD)*	*F*	*p*	η2
Past – Negative	2,62(0,52)	2,58(0,51)	2,69(0,48)	2,70(0,52)	0,439	0,725	
Past – Positive	3,74(0,39)	3,95(0,53)	3,81(0,44)	3,84(0,50)	1,146	0,333	
Present – Hedonist	2,91(0,48)	2,79(0,49)	2,91(0,53)	3,38(0,52)	8,270	0,000	0,167
Present – Fatalist	2,34(0,50)	2,22(0,51)	2,22(0,53)	2,70(0,55)	5,901	0,001	0,125
Future	3,87(0,38)	3,76(0,51)	3,63(0,47)	3,69(0,53)	1,422	0,239	

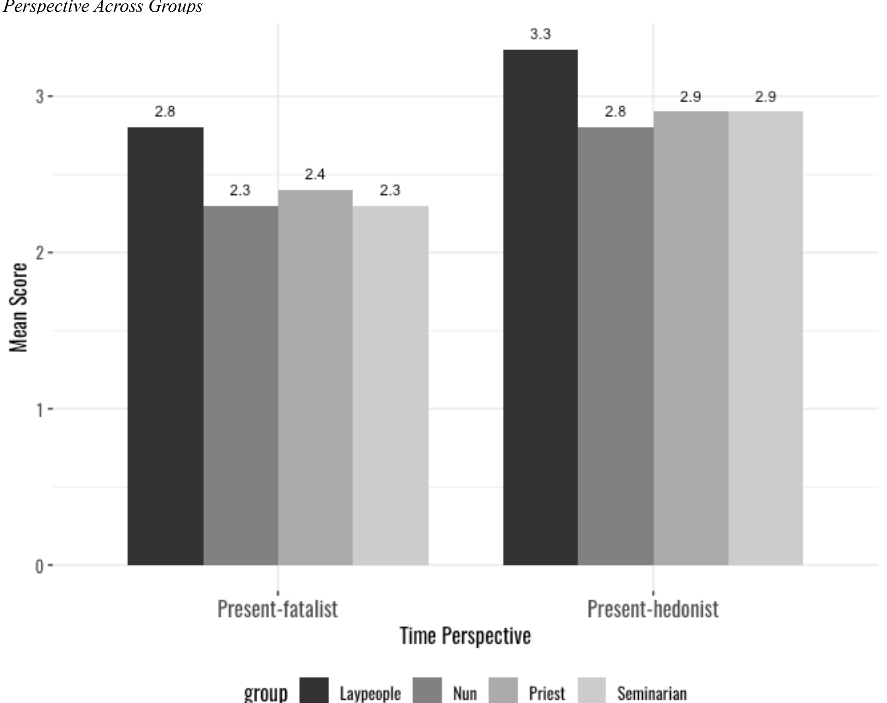
ZTPI: Zimbardo Time Perspective Inventory

Table 3
Temporal Perspective and Short Form 36 Health Survey: Kruskall Wallis Results

	Priests *Average rank*	Nuns *Average rank*	Seminarians *Average rank*	Layperson *Average rank*	*H*	*p*	*ε2*
Deviation from Balanced Time Perspective (DBTP)	61,13	69,44	57,59	69,84	2,61	0,457	
			SF-36				
Physical function	**61,36**	**57,03**	**79,94**	**59,67**	**8,41**	**0,038**	**0,066**
Role physical	61,39	66,66	73,48	56,47	3,86	0,277	
Bodily pain	60,6	65,2	56,4	73,5	3,868	0,276	
General health perception	59,6	63,8	67,9	66,7	0,958	0,812	
Vitality	56,2	72,9	63,6	65,3	3,333	0,343	
Social functioning	56,5	73,3	71,9	56,4	6,750	0,08	
Role emotional	60,5	71,1	57,5	68,9	3,09	0,377	
General mental health	65,8	69,5	65,5	57,3	1,875	0,599	
Evolution of health	60,8	65,97	84,89	46,31	19,872	0,000	0,136

SF-36: Short Form 36 Health Survey.

Figure 2
Mean Score for Present Time Perspective Across Groups



An analysis of items of the present hedonistic and present fatalistic was performed to explore specific differences between groups. Differences were found in seven items from the hedonistic perspective (See Table 4) and five from the Fatalist perspective (See Table 5).

In all the analyzes, laity shows significantly higher scores, but significant differences were also observed in some items between the groups of religious persons. Table 6 presents the results of the post hoc comparisons that show the significant differences between the groups.

Discussion

The present investigation has two particularities.

First, a sample of Catholic priests, nuns, and seminarians can be considered representative of high religiosity groups. Second, this research is the first to explore the relationship between religiosity and temporal perspective across different groups of religious consecrated to God, including priests, nuns, and seminarians, using Zimbardo's theory of temporality. Our results do not coincide with that reported by the research by Lowicki et al. (2018) between Religiosity and temporality, and it is possible that it is fundamentally due to the specific characteristics of the sample. In our research that is with religious consecrated to God (Catholic priests, nuns, and seminarians) we find significant differences in relation to the laity in the present temporal perspective only.is with religious consecrated to God (Catholic priests, nuns, and seminarians) we find significant differences in relation to the laity in the present temporal perspective only.

More specifically, results show that in the Present-hedonist the laity differs significantly from priests ($p<0.001$), from nuns ($p<0.001$) and seminarians ($p<0.000$). Likewise, the laity differ significantly from priests ($p = 0.015$), nuns ($p<0.001$) and seminarians ($p \leq 0.001$) in the Present-fatalistic temporal perspective. Laity presents significantly higher scores in both temporal perspectives when compared with the three groups of Catholic religious. It should also be noted that no significant differences were found between Catholic religious (nuns, priests, and seminarians) in both variables.

The results found are consistent with that reported by research in general on temporality and psychological functioning. A layperson with greater Present-Hedonist scores can be related to a focus on the search for enjoyment and delight. On the other hand, the fact that laypeople present a greater focus on the Present-Fatalist dimension in no case implies a negative dimension of psychological functioning. However, dissatisfaction with life, on the contrary, is known to be associated mainly with the negative perspective of the Past and the present fatalistic perspective.

Table 4
Present-Hedonist Items Differences Between Groups

Present-Hedonist items	*F*	*p*	η2
I believe that getting together with one's friends to party is one of life's important pleasures.	2.04	0.112	0,047
I do things impulsively.	2.09	0104	0,048
When listening to my favorite music, I often lose all track of time	**5.63**	**0.001**	**0,120**
I try to live my life as fully as possible, one day at a time.	**3.17**	**0.027**	**0,071**
Ideally, I would live each day as if it were my last.	2.38	0.072	0,055
I make decisions on the spur of the moment.	**5.32**	**0.002**	**0,114**
It is important to put excitement in my life.	0.96	0.414	0,023
Taking risks keeps my life from becoming boring.	1.48	0.220	0,035
It is more important for me to enjoy life's journey than to focus only on the destination.	**3.57**	**0.016**	**0,079**
I take risks to put excitement in my life	0,83	0,479	0,020
I often follow my heart more than my head.	**2.99**	**0.034**	**0,067**
I find myself getting swept up in the excitement of the moment	**5.26**	**0.002**	**0,113**
I prefer friends who are spontaneous rather than predictable.	1.70	0.170	0,040
I like my close relationships to be passionate.	**15.34**	**0.000**	**0,271**

Table 5
Present-Fatalist Items Differences Between Groups

Present-Fatalist items	*F*	*p*	η2
Fate determines much in my life.	2.16	0.095	0,050
Since whatever will be will be, it doesn't really matter what I do.	0.53	0.660	0,013
I take each day as it is rather than try to plan it out.	**2.96**	**0.035**	**0,067**
I feel that it's more important to enjoy what you're doing than to get work done on time.	**5.96**	**0.001**	**0,126**
You can't really plan for the future because things change so much.	**6.16**	**0.001**	**0,130**
My life path is controlled by forces I cannot influence.	0.14	0.933	0,003
It doesn't make sense to worry about the future, since there is nothing that I can do about it anyway.	1.92	0.130	0,044
Life today is too complicated; I would prefer the simpler life of the past.	**3.87**	**0.011**	**0,086**
Spending what I earn on pleasures today is better than saving for tomorrow's security.	1.59	0.193	0,037
Often luck pays off better than hard work	**3.73**	**0.013**	**0,083**
There will always be time to catch up on my work.	1.35	0.261	0,032

Noteworthy, both differences in present hedonistic and present fatalistic, are not indicators of dysfunctionality and our statement is based on a deviation analysis of the balanced time perspective (p = 0.801). No significant differences were found between the groups in the future temporal dimension. We hypothesize that the absence of differences in this dimension is mainly due to the fact that it evaluates an approach towards planning and the achievement of objectives.

In this context, we must highlight that when comparing the sample data with the ideal time perspective (Zimbardo & Boyd, 1999), we observe deviations, especially in the Present-Hedonist and Present-Fatalist dimensions. For example, the scores for Present-Hedonist in the laity (M = 3.38, SD = 0.52) are higher compared to the scores of priests, nuns, and seminarians, but still below the ideal score of 3.90, indicating a moderate focus on immediate enjoyment and pleasure. Similarly, in the Present-Fatalist dimension, the laity (M = 2.70, SD = 0.55) score higher than the ideal score of 1.50, which may indicate a more negative view of present events and experiences. However, it is important to note that the Deviation from Balanced Time Perspective (DBTP) values show that all subsamples (priests: 2.66, nuns: 2.71, seminarians: 2.63, laity: 2.69) exhibit a significant deviation from the ideal time perspective. The DBTP should be as close to 0 as possible to reflect an ideal balanced profile, with ideal scores set at 1.95 for Past Negative, 4.6 for Past Positive, 1.5 for Present Fatalism, 3.9 for Present Hedonism, and 4.0 for Future. These elevated DBTP scores indicate that the samples exhibit a more unbalanced temporal profile. It is also important to emphasize that the balanced time perspective profile is theoretical, and the scores obtained by the groups do not necessarily reflect a pathological imbalance. In the case of the religious groups (priests, nuns, and seminarians), this deviation could be attributed to the specific characteristics of their religious vocation and their dedication to the religious life. For instance, these groups score lower on Present-Hedonistic, which may be related to aspects of their religious activity, where immediate pleasure and the pursuit of personal gratification are not priorities, but rather a focus on transcendental and spiritual values.

Table 6
Item Comparison Between Specific Groups

Present- Hedonist items		Mean Difference	p
When listening to my favorite music, I often lose all track of time			
	Layperson – Nun	.90	.020
	Layperson – Seminarians	.87	.022
I try to live my life as fully as possible, one day at a time.			
	Layperson – Priest	.84	.031
I make decisions on the spur of the moment.			
	Layperson – Priest	.84	.005
	Layperson – Nun	.84	.005
It is more important for me to enjoy life's journey than to focus only on the destination.			
	Layperson – Priest	.78	.049
	Layperson – Nun	.84	.026
	Layperson – Seminarians	.66	.154
I often follow my heart more than my head.			
	Layperson – Priest	-.63	.045
I find myself getting swept up in the excitement of the moment			
	Layperson – Nun	.88	.001
I like my close relationships to be passionate.			
	Layperson – Priest	1.34	.000
	Layperson – Nun	1.71	.000
	Layperson – Seminarian	.97	.002
	Seminarian – Priest	.75	.340
Present- Fatalist items			
I take each day as it is rather than try to plan it out.			
	Layperson – Nun	.72	.024
I feel that it's more important to enjoy what you're doing than to get work done on time.			
	Layperson – Nun	1.03	.002
	Layperson – Seminarian	1.03	.002
You can't really plan for the future because things change so much.			
	Layperson – Priest	1.03	.001
	Layperson – Nun	.91	.006
	Layperson – Seminarian	.88	.009
Life today is too complicated; I would prefer the simpler life of the past.			
	Layperson – Seminarian	.91	.006
Often luck pays off better than hard work			
	Layperson – Nun	.69	.013

From a theoretical perspective, the deviation from the balanced time perspective can have implications for psychological well-being and emotional integration, as a more balanced profile across the temporal dimensions evaluated is associated with higher levels of well-being. However, since the ideal profile is a theoretical construct, the deviations observed in the groups do not necessarily indicate malfunction or dysfunctionality, but rather an adaptation or differentiated approach according to the specific demands and values of each group, particularly in religious individuals who may adopt a more transcendent-focused perspective than one focused on hedonism or fatalism. This could influence their scores on the evaluated dimensions.

In addition, SF-36 in its mental health component did not show significant differences between the four groups. In other words, what we find in this research is interpreted parsimoniously in the direction that lay people have a focus on earthly life and religious a horizon of consciousness with a focus on the transcendent.

This research has limitations to consider. First, the sample included only Chilean participants and, in terms of religious affiliation, these were exclusively Roman Apostolic Catholics. Therefore, although the results of this research can describe quite accurately the Chilean Catholic believers consecrated to God (Catholic Priests, nuns and seminarians), they may also not reflect as well the religious attitudes of people from different countries who are Roman Apostolic Catholics. Second, the vast majority of the sample investigated were adults and young adults and, therefore, the elderly population (60 years) was underrepresented. This is an important limitation of our research because some significant differences in time perspective profiles between age groups have already been observed (Sobol-Kwapinska & Jankowski, 2016). It should therefore be pointed out once again that our results mainly concern the population of young adults.

An important limitation of this study was the lack of explicit control over differences in the level of religious practice within the lay group. Although all participants in this group identified as Catholics, no specific information was collected on the frequency of attendance at religious services or participation in community activities. As a result, the lay group included both regular practitioners and believers with minimal religious practice. This heterogeneity could have influenced the results, as previous research suggests that non-practicing believers may differ significantly from regular practitioners in key psychosocial aspects, such as subjective well-being and temporal perspective (Braam & Koenig, 2019; Stewart-Sicking & Piedmont, 2022). Without this distinction, the findings from the lay group may reflect a general average that does not adequately capture the individual differences within the subgroup. Future research should address this limitation by more precisely selecting participants, differentiating between practitioners and non-practitioners. This would allow for a more detailed analysis and a more robust interpretation of how the level of religious practice influences the studied variables.

The data collection method differed slightly between the subsamples. For religious participants, instruments were distributed and collected by ecclesiastical authorities, while for the laity, the researchers directly contacted participants. Although this approach was necessary to respect institutional hierarchies and ensure access to the religious groups, it may have introduced subtle differences in the conditions under which the instruments were completed. Future research should aim for a more uniform data collection process to minimize potential biases.

A replication of this research with other religions and to carry out studies in different cultures will help us to consolidate present results and get a better understanding of the studied phenomenon.

Authorship Declaration

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Formal análisis: Álvaro Quiñones, Carla Ugarte e Iván Armijo
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Resources: Delia Argandoña y Camila Llínas
Supervision: Álvaro Quiñones
Validation: Álvaro Quiñones, Carla Ugarte
Visualization: Álvaro Quiñones, Carla Ugarte e Iván Armijo
Writing – original draft: Álvaro Quiñones y Carla Ugarte
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Statement

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Conflict of Interest

There is no financial interest or benefit from the direct application of this research.

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