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REVIEW

Attachment-based compassion therapy

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Abstract Compassion therapy is a third-generation psychotherapy that has been used in association with mindfulness in recent years. Similar to mindfulness protocols, a number of compassion protocols have been developed in the United States and Britain. As these countries have cultural characteristics and health systems that differ greatly from those of Spain, it was necessary to develop compassion protocols which were more suited to the Spanish situation and which could be administered to both general population and to medical and psychiatric patients. This model is based on attachment styles, a psychoanalytical concept which describes the relationship children develop with their parents, and which will influence the interpersonal relationships and self-image they will eventually develop. This paper describes the scientific basis for this model, the structure of the protocol, the scientific evidence and the training programme for this model, which is the first such programme specifically developed for Spanish-speaking countries.
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PALABRAS CLAVE
Compasión;
Estilos de apego;
Protocolo;
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Terapia de compasión

Resumen La terapia de compasión es una psicoterapia de tercera generación que se está utilizando en los últimos años de forma asociada al mindfulness. Existen varios protocolos de entrenamiento en compasión que, al igual que los protocolos de mindfulness, han surgido en países anglosajones con entornos culturales y sistemas sanitarios muy diferentes al nuestro. En este contexto consideramos que era necesario desarrollar un modelo de terapia de compasión más cercano a nuestra cultura, más adaptado a nuestro entorno sanitario y que pudiese ser aplicable no solo a la población general, sino también a pacientes con enfermedades psicológicas y somáticas. Este modelo está centrado en los estilos de apego, un concepto psicoanalítico que describe el tipo de relación que el niño desarrolla con sus padres y que influirá de forma decisiva

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en el tipo de relación interpersonal que mantendrá de adulto con otras personas, así como en la imagen que desarrollará sobre sí mismo. En el artículo se describen las bases científicas del modelo, la estructura del programa, los datos de evidencia y el proceso de formación en este protocolo, el primero autóctono desarrollado en países de habla hispana.
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A compilation of the first articles published in Spain on the subject of mindfulness appeared in the *Revista de Psicoterapia* (Journal of Psychotherapy) in 2006 (see Cebolla & Miró, 2006; García, 2006; Miró, 2006; Pérez & Botella, 2006; Santamaría, Cebolla, Rodríguez, & Miró, 2006; Simón, 2006). Mindfulness began to be used in the Spanish health system in 2008 (García Campayo, 2008). It was found at the time that many of the protocols we were using, both for mindfulness and compassion, were not well suited to the Spanish population (García Campayo et al., 2014). The reason for this was partly due to transcultural differences, which included aspects such as expressing emotions, the relationship with the body and the relationship between healthcare professionals and patients (García Campayo, Díez, & Sanmartín, 2005) and partly because the Spanish system is very different from that found in the US, which is where most of the protocols were created. Healthcare in Spain is mostly public and free of charge, with a well-developed primary care system, while both aspects are of marginal importance in the US. Lastly, with the exception of the Gilbert model, existing compassion protocols are not considered as therapies for the treatment of psychiatric illnesses and were not designed for use with patients.

These reasons, and our experience as psychotherapists, convinced us of the need to develop structured protocols suited to our cultural environment and out health system that could be used as psychotherapy. Moreover, we decided to emphasize an aspect that we and many mental health professionals have considered to be key to the therapeutic efficacy and which is clearly related to compassion: the individual attachment style. This is the reason for naming our model *attachment-based compassion therapy.* Although a number of aspects of attachment theory (particularly secure attachment as a base for compassion) already appear in the theoretical foundations for other compassion models (Gilbert, 2015; Neff, 2012), this is the first time that a programme based on compassion makes profound use of it at the core of the therapeutic process and as the base of the programme. The theoretical foundations on which this model is structured are the following.

1. *Attachment theory*: Emotions are the main mental phenomena associated with chronic stress. Emotions such as guilt, shame and hatred are considered particularly destructive and are demonstrated to facilitate the onset of different medical and psychiatric illnesses, as explained by the Neuroinflammatory Theory (Akiyama et al., 2000). By definition, emotions tend to arise in interpersonal contexts. Attachment theory is one of the theoretical constructs that best explains our way of relating with other people and, therefore, how emotions (positive and negative) arise in our relationships throughout our lives. Knowing our attachment style and modifying the aspects that cause distress will be associated with reducing psychological distress. Our protocol aims to modify those styles by structuring a secure attachment style, one that is associated with reducing criticism and anger towards ourselves and others, and which increases compassion.
2. *Contributions from other models of compassion and other therapies*: No knowledge comes from nothing. Our model includes ideas from other compassion protocols (the structure of Paul Gilbert's three brain circuits and a number of practices that most protocols previously took from tradition). It also includes techniques from other cognitive and third-generation therapies (aspects of mindfulness taken from mindfulness-based interventions (García Campayo & Demarzo, 2015a), values that comprise an essential technique of Acceptance and Commitment Therapy and radical acceptance from Dialectical Behaviour Therapy).
3. *Contributions from tradition*: As with other compassion protocols, we have incorporated a number of practices and theoretical foundations from tradition, such as Tibetan Buddhism, but also from other religions, such as Native American beliefs in which compassion plays a part, given that it is the common denominator in all of them. Logically, as is habitual in mindfulness and compassion therapy, any religious or cultural connotation has been removed from these techniques and their efficacy has been evaluated from a scientific perspective.

Attachment theory

From an evolutionary perspective, it is accepted that compassion (Goetz, Keltner, & Simon-Thomas, 2010) is key to the care of offspring in species such as ours (and in mammals in general) in which young are very vulnerable at birth and require the intensive care of adults for a long time in order to survive. The concept of attachment, the capacity for affection and trust we feel for ourselves and other people, arises in those first years of life.

The term attachment is a classic psychoanalytical concept developed by Bowlby (1969). This author asserted that when a child feels threatened, their attachment system is activated and they instinctively seek out the protection of their parents. When the child habitually finds this protection, they are said to develop a ''secure attachment''.

However, if this protection fails, the child develops a profound insecurity in the relationship they have with their parents (''insecure attachment''), which determines that all their interpersonal adult relationships are based on mistrust. This will also impact on the self-image that child will develop. At such an age, a child cannot assimilate the idea that their parents do not love them. What they think is that they are doing something wrong, and that when they stop doing it, they will be loved again. Unfortunately, their entire childhood is spent trying to understand why their parents do not love them without success.

Although some of Bowlby's contributions are considered outdated from different perspectives, the Attachment Theory he described continues to be considered the model to best describe the long-term dynamic of relationships between humans. In summarized form, what it asserts is that a child needs to develop a satisfactory stable and lasting relationship during their early years with at least one carer in order for their psychological and emotional development to be adequate. When the child begins to crawl and walk away from their parents, they need the secure base of their known carers in order to explore their surroundings and return.

The multiple facets of attachment and care

Care and attachment, both in primates and human beings, has become more complex throughout the course of evolution. In our experience, care and the attachment style include the four following aspects that may or may not appear independently.

- *Protection and safety*: This involves keeping children protected from danger in order that they will feel safe and out of danger (which is the basis for survival of the species). It includes an aspect as important as comfort, i.e. calming the anguish of the child as it cries by means of an embrace. If a person has not had this feeling of protection and safety during their childhood, the feeling of continuing alert to an undefined danger will predominate (a symptom common to any type of anxiety). Compassion cannot be possible if there is no basic notion of security. The insecure individual has to devote all their energy to their survival (because they feel they are in danger), and will have no energy left to feel sympathy for others.
- *Provision*: This involves the offering of food, clothing, refuge and other material requirements for survival. If this has not been received in childhood, the individual will have difficulties in managing their primary needs. Consequently, they can be particularly thrifty and with a tendency to hoard (as was common in people whose childhood coincided with an immediate post-war period) or unable to save and plan for the future, spending immediately and inappropriately any income they have (as has been described in the children of poor African-American minorities in large US cities).
- *Expression of affection and validation of feelings*: This involves having received affection in a manner that is explicit, identifiable and clearly expressed. If this is the case, affection can be received and given spontaneously and trustingly. Otherwise, the expression and reception of affection will be clearly limited by fear of being hurt (as occurs with certain types of neurosis) or by a total disconnect with our feelings (as occurs in certain people who display obsessive or alexithymic traits). A key aspect of the expression of affection with which it is commonly associated is the validation of our feelings. This consists of making a child aware that their feelings are valid, although they may be different (and not accepted or criticized by others). This will allow them to feel adequate and tranquil, despite feeling themselves to be different from their social setting. Where parents have not offered the individual validation of their feelings, they will systematically avoid conflict, will need continuous social approval and will self-criticize themselves systematically and destructively. We should always accept and validate our feelings.
- *Socialization and mentalization*: Socialization involves teaching a child the rules of the world and society in which they are going to live, and existing boundaries in order to minimize conflict with others and with the law. Overly permissive parents who are unable to set boundaries facilitate the development of children with personality disorders. Mentalization refers to assisting a child to understand the feelings of others, which is associated with better interpersonal relationships.

These four aspects are independent from each other, i.e. they can develop adequately or inadequately, producing multiple combinations. It is common for all four domains to fail at the same time (for instance, inadequate parents do not offer their child security, do not express affection to them and invalidate them constantly, do not provide them with adequate food and clothing, and are unable to properly socialize them or mentalize them). However, it is also common for parents to offer some of these aspects: a single mother may offer affection and validations, but may be unable to provide for them or offer safety owing to the unfavourable economic situation, and may be unable to set boundaries. A single father may offer safety and provide for the child, but may be unable to offer affection or validation, and may not be a suitable model for socialization. For this reason, each of these domains should be dealt with independently.

Attachment styles

Bartholomew and Horowitz (1991) developed a classification system for attachment styles in adulthood divided into four main categories. It is thought that these styles, based on our biographical experiences, define the way in which we relate to other people. There is one secure attachment style and three insecure attachment styles with different characteristics.

- *Secure attachment style*: These are individuals who experienced adequate, consistent and continuous care in their childhood. For this reason they developed great trust in themselves and in others. The consequence is that they feel good about themselves and feel worthy of receiving affection. They also feel comfortable about depending on other people, which allows them to ask others for held

and to receive it trustingly whenever they need it. There is a balance between needs for affection and personal autonomy.

- *Preoccupied attachment style*: This includes subjects whose childhood experience is that of systematically variable care, between an adequate response and a non-existent response (although there has never been abuse), with different intermediate levels of care. In other words, care has been erratic and unstable, and may or may not have been received at random, generally depending on the levels of medical or psychiatric conditions or adverse circumstances affecting the carer at any time. For example, this model has been described in the children of parents suffering from bipolar disorder, with frequent bouts of depression or debilitating illnesses that appear with great intensity in cyclical periods (e.g. migraine, rheumatic diseases, etc.). The consequence is that individuals with this attachment style are overly responsive to the opinion of others on whom they depend (given that they present a positive view of others), to the point of finding themselves trapped by the response of others. As they have a negative view of themselves, they renounce any of their desires or initiatives where these may enter into conflict with the approval of others. They have very low self-esteem, great dependence on others, high levels of subjective stress, and they focus on their negative thoughts and feelings. The continued preoccupation with being abandoned may trigger obsessional jealousy in sentimental relationships.
- *Dismissive attachment style*: This is presented by individuals who have experienced childhood care in which the carer's response has systematically been inadequate or non-existent. There were never periods of the adequate care found in the preoccupied style. This style frequently occurs when parents suffer from addictions, personality disorders or psychosomatic illnesses, such as hypochondria or acute somatization, which cause them to focus all of their attention on themselves, leaving no room for the care of their children. Consequently, this group of individuals develop total distrust in others and compensate by means of compulsive strategies through which they have had to place all their trust exclusively in themselves. Although their view of others is negative as a result of their childhood experiences, their image of themselves is exaggeratedly positive as a result of their compulsive self-reliant strategies. In their relationships with others, they show little understanding of the need for affection of others (which they consider unhealthy or a sign of weakness) because they learned to survive affectively on their own and with help from nobody. This is one of the groups of people who feel the greatest rejection for compassion. They are clearly ambitious for achievement, with little need for affection and few significant interpersonal relationships, but with great emotional self-sufficiency, which means they suffer little for this reason.
- *Fearful attachment style*: These are individuals who have received cold or violent care, based on rejection or punishment. It is common when their parents are abusive, alcoholic or substance-dependent, or present with acute personality disorders. These individuals develop a very negative view both of others and of themselves. Abused children cannot understand that their parents have a disorder; they only think that they are doing something wrong which merits punishment. The consequence of this is that they spend their entire childhood trying to understand what it is that they are doing wrong and try to change so that they will no longer be punished, although they never succeed. As with the preoccupied style, these individuals present with low self-esteem and negative affect. Although they desire social contact, they inhibit this desire because of their terrible fear of rejection. Their interpersonal adult relationships are characterized by flight once they have reached a certain level of intimacy. Personal relationships are always considered secondary to their work or professional goals.

The first descriptions of these classifications (Bartholomew & Horowitz, 1991; Bowlby, 1969) led to the hypothesis that they would be very closely associated with the type of interpersonal relationship and communication with others. For instance, individuals with a negative view of others (dismissive and fearful attachment styles) have learned that people will tend to ignore or reject their attempts to find support from others. Therefore, in comparison with people with a positive view of others (secure and preoccupied attachment styles), they seek less support from others, which means that they tend not to reveal their feelings and their relationships are less intimate. If the individual holds a negative self-opinion and considers social relationships to be very important (preoccupied), they will tend to do anything for their loved one, renouncing everything of their own, including health or money.

Importance of attachment styles

It is thought that 65 per cent of children present a secure attachment style; the other 35 per cent present one of the insecure styles we have described (Prior & Glaser, 2006). The attachment style of parents predicts 75 per cent of their children's attachment style (Steele, Steele, & Fonagy, 1996). Although there are other influences apart from attachment, children with a secure attachment style are more likely to be socially competent that their insecure counterparts. They also have greater ease in acquiring social skills, intellectual development and formation of a social identity. On the whole, they tend to be more successful on all levels than children with insecure attachment styles.

In short, attachment styles modulate the image we have of ourselves and of others, and are therefore key to the relationship we have with ourselves and with others. Attachment style predicts feelings of guilt and shame towards ourselves and feelings of anger and mistrust towards others. Mindfulness and compassion therapy is key to clarifying and modifying the relationship we have with ourselves and others, and therefore is closely related to attachment styles.

Protocol for attachment-based compassion therapy

As with other compassion protocols, our model is structured into eight weekly sessions with a duration of approximately two hours. We have described our programme in greater

detail in the book *Mindfulness y Compasión: La Nueva Revolución* [Mindfulness and Compassion: The New Revolution] (García Campayo & Demarzo, 2015b). It describes the theoretical foundations for the model, the structure in sessions, and practices used in each session. Appendix I summarizes the structure of the programme in sessions.

The efficacy of this programme has already been assessed in the general population and in healthcare professionals, and two studies have already been conducted on them with favourable results that are due to be published in 2016. It has also been evaluated in patients with different medical and psychiatric conditions. A randomized controlled trial (RCT) has recently been completed on patients suffering from fibromyalgia in primary care (NCT02454244; Ethics Committee: 15/0049) the result of which were also satisfactory and will be published in 2016. Another RCT will soon be conducted on patients with depression in primary care and is currently in the design stage. The preliminary data from all of these studies are very promising and confirm the efficacy of the protocol both on final clinical results (pain, quality of life and function), in measures of psychological well-being, and in intermediate variables (compassion, positive affect, etc.).

Training in attachment-based compassion therapy is being structured in the same way as other similar protocols. After a basic training programme, personal practice is recommended for a period of time. A training programme is then given for application of the therapy (equivalent to the teacher training of other protocols) and, finally, the supervision of the first two groups to which this therapy is applied is recommended using trainers experienced in the use of the programme.

Training is systematically included in the Master's degree in Mindfulness programme offered by the University of Zaragoza, whose third edition is being completed this year (www.masterenmindfulness.com). This training can also be received independently of the master's programme through specific courses that we hold every three months, both in a weekly format and an intensive weekend course, taking place at both at the University of Zaragoza and in cities where there is demand (mindfulnessycompasiongarciacampayo.com).

Conclusions

Attachment-based compassion therapy is a compassion protocol that can also be used in both the general population and with medical and psychiatric conditions, and is adapted to the cultural setting and health systems of Latin countries (Iberia and Latin America). It is based on one of the fundamental psychological constructs that explains the interpersonal relationships of individuals: attachment styles. The preliminary results of this intervention are very promising and levels of acceptance and adherence of users is high. Unexpected effects are very few and of minor relevance. The versatility of the model, which can be used on both populations with very acute depression and healthy individuals, and the transdiagnostic component – given that it appears to be effective for depression, chronic pain and anxiety – may facilitate its widespread use in the health systems of Spain and Latin American countries.

Conflict of interest

The authors declare no conflict of interest.

Appendix I. Structure of the University of Zaragoza compassion protocol attachment-based compassion therapy

A.1. Week 1

A.1.1. Preparing ourselves for compassion. Kind attention.

Theory:

- The workings of our brain
- The reality of suffering: primary and secondary suffering
- What is and isn't compassion?

Formal practice:

- Compassionate breathing and compassionate body scan
- Compassionate coping with difficulties

Informal practice:

- 3-min compassionate practice
- Self-compassion diary
- Savouring and giving thanks

A.2. Week 2

A.2.1. Discovering our compassionate world

Theory:

- Compassion and mindfulness
- Self-esteem and compassion
- Fear of compassion

Formal practice:

- The figure of affect: connecting with basic affection
- Developing a safe place
- The compassionate action
- Identifying the figure of secure attachment

Informal practice:

- The object that joins us to the world
- Diary of compassion practice
- What are we good at?

A.3. Week 3

A.3.1. Developing our compassionate world

Theory:

- How compassion acts
- Effectiveness of compassion
- Self-criticism

Formal practice:

- Developing the figure of secure attachment
- Developing the compassionate voice

Informal practice:

- Writing a letter to a compassionate friend

A.4. Week 4

A.4.1. Understanding our relationship with compassion

Theory:

- Attachment styles
- Importance of these styles in everyday life

Formal practice:

- Becoming aware of our attachment style
- Ability to receive affection: friend, indifferent person, enemy

Informal practice:

- Letter to your parents

A.5. Week 5

A.5.1. Working on ourselves

Theory:

- Importance of affection towards ourselves and others

Formal practice:

- Showing affection to friends and indifferent people
- Showing affection to ourselves
- Reconciliation with our parents
- Three positive aspects and three negative aspects of our parents

Informal practice:

- The greatest display of affection (in general and from our parents)
- The illusion of labels

A.6. Week 6

A.6.1. Advanced compassion (I): forgiveness

Theory:

- Guilt and the importance of forgiveness

Formal practice:

- Forgiving yourself
- Asking others for forgiveness
- Forgiving others and showing compassion to enemies
- Showing forgiveness for the hurt caused by loved ones (only for people with this experience)
- Recapitulation

Informal practice:

- Compassion in everyday life
- Interdependence

A.7. Week 7

A.7.1. Advanced compassion (II): becoming your own attachment figure and handling difficult relationships

Theory:

- Working in three periods
- Envy
- Usefulness of being our attachment figure
- Difficult people

Formal practice:

- Working with envy
- Becoming our own attachment figure
- Handling difficult relationships

Informal practice:

- Not taking anything personally
- Looking others in the eye and connecting with their suffering

A.8. Week 8

A.8.1. Beyond compassion: equanimity

Theory:

- Equanimity
- How to keep up the practice of compassion for a lifetime

Formal practice:

- Equanimity (I): We are all equal.
- Equanimity (II): The illusion of categories.
- Equanimity (III): Showing the world the gratitude we have not been able to give back.

Informal practice:

- Our values and their relation with compassion
- The cosmic attachment figure
- The tantric embrace

References

Akiyama, H., Barger, S., Barnum, S., Bradt, B., Bauer, J., & Cole, G. M. (2000). Inflammation and Alzheimer's disease. *Neurobiology of Aging*, *21*(3), 383–421.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, *61*(2), 226.

Bowlby, J. (1969). *Attachment and loss, vol. 1: Attachment*. London: Hogarth Press.

Cebolla, A., & Miró, M. T. (2006). Eficacia de la terapia cognitiva basada en la atención plena en el tratamiento de la depresión. *Revista de Psicoterapia*, *66/67*, 133–156. http://revistadepsicoterapia.com/eficacia-de-la- terapia-cognitiva-basada-en-la-atencion-plena-en-el-tratamiento-de-la-depresion.html

García, A. (2006). Mindfulness en la terapia dialéctico-comportamental. *Revista de Psicoterapia*, *66/67*, 121–132. http://revistadepsicoterapia.com/mindfulness-en-la-terapia-dialectico-comportamental.html

García Campayo, J. (2008). La práctica del ''estar atento'' (*mindfulness*) en medicina. Impacto en pacientes y profesionales. *Atención Primaria*, *40*(7), 363–366.

García Campayo, J., & Demarzo, M. (2015a). *Manual de mindfulness. Curiosidad y aceptación*. Barcelona: Siglantana.

García Campayo, J., & Demarzo, M. (2015b). *Mindfulness y compasión. La nueva revolución*. Barcelona: Siglantana.

García Campayo, J., Díez, M. A., & Sanmartín, A. O. (2005). *Salud mental e inmigración en atención primaria*. Madrid: Edikamed.

García Campayo, J., Navarro-Gil, M., Andrés, E., Montero-Marín, J., López-Artal, L., & Demarzo, M. M. P. (2014). Validation of the Spanish versions of the long (26 items) and short (12 items) forms of the Self- Compassion Scale (SCS). *Health and Quality of Life Outcomes*, *12*(4), 1–9.

Gilbert, P. (2015). *Terapia centrada en compasión*. Bilbao: Desclée de Brouwer.

Goetz, J. L., Keltner, D., & Simon-Thomas, E. (2010). Compassion: An evolutionary analysis and empirical review. *Psychological Bulletin*, *136*(3), 351–355.

Miró, M. T. (2006). La atención plena (*mindfulness*) como intervención clínica para aliviar el sufrimiento y mejorar la convivencia. *Revista de Psicoterapia*, *66/67*, 31–76. http://revistadepsicoterapia.com/la-atencion-plena- mindfulness-como-intervencion-clinica-para-aliviar-el-sufrimiento-y-mejorar-la-convivencia.html

Neff, K. (2012). *Sé amable contigo mismo: El arte de la compasión hacia uno mismo*. Barcelona: ONIRO.

Pérez, M. A., & Botella, L. (2006). Conciencia plena (*mindfulness*) y psicoterapia: Concepto, evaluación y aplicaciones clínicas. *Revista de Psicoterapia*, *66/67*, 77–120. http://revistadepsicoterapia.com/conciencia- plena-mindfulness-y-psicoterapia-concepto-evaluacion-y-aplicaciones-clinicas.html

Prior, V., & Glaser, D. (2006). *Understanding attachment and attachment disorders: Theory, evidence and practice*. Jessica Kingsley Publishers.

Santamaría, M. T., Cebolla, A., Rodríguez, P. J., & Miró, M. T. (2006). La práctica de la meditación y la atención plena: Técnicas milenarias para padres del siglo XXI. *Revista de Psicoterapia*, *66/67*, 157–175. http://revistadepsicoterapia.com/la-practica-de-la-meditacion-y-la-atencion-plena-tecnicas-milenarias-para-pa- dres-del-siglo-xxi.html

Simón, V. (2006). *Mindfulness* y neurobiología. *Revista de Psicoterapia*, *66/67*, 5–30. http://revistadepsicoterapia.com/mindfulness-y-neurobiologia.html

Steele, H., Steele, M., & Fonagy, P. (1996). Associations among attachment classifications of mothers, fathers, and their infants. *Child Development*, *67*(2), 541–555.