Bonding psychotherapy, an effective group therapy for attachment problems

Martien Kooyman, psychiatrist and psychotherapist with a private practice in Rotterdam. (martienkooyman@planet.nl).
Rob Olij, mental health care clinical psychologist, and works at PsyQ in Den Haag. (r.olij@psyq.nl).
Rob Storm, HRM adviser, trainer and career coach with a private practice in Hoofddorp. (info@stormhrmconsult.nl).

Summary
Bonding psychotherapy is an intensive form of group therapy with the goal of overcoming the fear of intimacy and rejection.
The theory, method and the research results of the bonding psychotherapy are described in this article. The ultimate aim of the bonding psychotherapy is to increase the ability to fulfil the bio-psycho- social basic needs, to be able to enter into positive relationships and to enjoy life.
Bonding is the process of becoming emotionally open and physically close to another person. Exercises with other group members help to experience and fulfil the need for bonding.
During these exercises intense emotions often surface that are linked to past painful experiences. With the described method, trust in others is increased and negative attitudes concerning oneself in relation to others become more positive. These are emotionally corrective experiences. An overview of the research results is given and these are surprisingly good

Introduction
Every human being has a natural need for intimacy and emotional contact with others. Experiencing emotional openness together with physical closeness is called bonding. This is an important condition for the development of a safe attachment in young children. When there is a lack of bonding and confirmation in childhood, we can develop destructive attitudes such as “I am not good enough”, or “I do not need anyone” and even “I have no right to exist”. This can lead to amongst others: relationship problems, depression, physical problems and compensatory behaviour such as alcohol and drug abuse.

Bonding psychotherapy is not only aimed at symptoms, for example by prescribing medication or by teaching techniques to cope with problems, but bonding psychotherapy addresses the root cause of the problem. Many people have a fear of emotional and physical closeness, a fear of rejection and abandonment, or a fear of both. This results from a lack of secure attachment and bonding in childhood.
Bonding psychotherapy provides an improvement in self-image, increases trust in others, improves relationship building and enables people to enjoy life.

Bonding
The American psychiatrist and psychoanalyst Daniel Casriel called the emotional openness and physical closeness of another person “bonding” and classified this together with other basic biological needs such as eating and drinking (Casriel, 1972). In an infant, bonding is necessary for staying alive according to Casriel. In his opinion the “need for bonding “is an important psycho-biological motive that can be compared to the need for attachment, as was described by (Bowlby, 1969).

Emotions and primary basic needs
When a basic biological need is not satisfied, this can give rise to painful emotions such as sorrow, fear or anger. If a need is fulfilled then pleasure, love and affection develop for the (other) person who has satisfied this need. According to Casriel, there are five basic emotions:

fear, anger, pleasure, sadness and love (de Klerk-Roscam Abbing, 1994). These emotions are necessary for staying alive and are already present at birth. Through experiences from the past, an emotion such as pleasure and love can be felt at the mere thought that the need will be fulfilled. Fear, anger and pain can develop with the thought that the need will not be fulfilled. Casriel called this “the logic of emotions”.

Fear, anger and pain, like pleasure and love are linked to biochemical changes in the body. When a mother breast feeds her baby we see for example, that the concentration of the attachment hormone oxytocin rises in the blood in both. Feelings such as hate and loathing are derived emotions and are reactions to fear, pain and anger. Guilt is a painful thought rather than an emotion.

While growing up, small children learn to take care of the fulfilment of their basic needs themselves. For the need of bonding another person is required. If the need for bonding is not met adequately, this can lead to a disturbance in the equilibrium of the psycho-biological basic needs. The individual is able to survive but in practice however, we see that this shortage is often compensated for, for example, by excessive use of medicines, alcohol or drugs (Kooyman, 1990, Kooyman, 1992, Höfler- Zimmer & Kooyman, 1996, Martens, 2000). This lack of bonding can also be compensated for by gambling, sex, working hard or other means.

Bonding can be perceived as threatening in persons with an insecure attachment. Emotions such as fear, sadness and anger can occur as a result of this and can lead to the defence mechanisms, fight, flight, control or freeze. In the latter case, emotions are no longer felt and a lack of bonding can manifest itself in physical symptoms such as stress, hypertension, gastrointestinal problems and psychosomatic illnesses.

The development of the method

Casriel discovered in his group therapy that the participants tended to hold each other when they became upset. The physical contact with a fellow group member was initially experienced as pleasant but consequently brought about painful feelings of loss, often originating from early childhood. Casriel let the participants practice physical closeness. When doing this, they held each other close in pairs. Intense emotional reactions are often aroused by the intimate closeness of another person. These exercises became known as bonding exercises and will be described later in this article.

Emotions, thoughts and behaviour

In a healthy individual, thoughts, emotions and behaviour influence each other to such an extent that pleasure and well-being are at a maximum and pain and discomfort at a minimum. The bonding psychotherapy groups not only work on their emotions, but their behaviour with its underlying attitude, is also addressed. Behaviour where emotions are suppressed is not tolerated in the group. Examples of this are: use of alcohol and drugs, isolating oneself, using violence or threatening with violence and other destructive behaviour

Negative attitudes

When the need for a secure bonding and attachment is not sufficiently satisfied, an attitude such as: ”I do not exist”,” I do not deserve to be loved”, “I am not good enough”, “I do not need anything” and “I am not entitled to anything”, will develop early on in childhood. These attitudes can be seen as defence mechanisms. They serve the function of justifying confusing and painful messages and to understand for oneself the reason why certain needs are not being fulfilled. That is why a small child who did not receive any loving attention can develop an attitude such as: “I do not deserve to be loved” (Kooyman, 1990). These are persistent beliefs that usually

develop before a child is able to speak and are consequently stored in the implicit memory (Stauss, 2005, 2007). In verbal therapy these negative attitudes can easily be recognised but not very often changed.

Background of the theory

Konrad Stauss, head of a psychosomatic clinic in Germany, linked the insights of Casriel with the attachment theories (Stauss, 2005, Stauss & Ellis, 2007). At the same time that Casriel developed his theory for the bonding groups, Bowlby wrote about his attachment theory (Bowlby, 1988). Bowlby stated that an inadequate fulfilment of the need for attachment is the cause of many psycho- social disorders. Grawe (2004) indicated that psychological processes are directed at the simultaneous fulfilling of bio-psycho-social basic needs. In the Netherlands, de Ruiter and Van IJzendoorn (1992) described the connection between psychological dysfunction and the lack of a secure attachment. Van Oudenhoven indicates the relationship between a secure attachment style and cohesive behaviour later on, such as social participation, bonding and involvement (Van Oudenhoven e.a.2004).Young (2005) assumes that a psychologically healthy individual is able to satisfy his/her basic needs.

Stauss (2007) described how positive experiences in fulfilling the basic bio-psycho-social needs are recorded in neuronal networks. Stauss called the psychological representation of this interaction with these basic needs “a functional emotional schema” The subjective feeling of pleasure and physical well-being can be experienced when the basic bio-psycho-social needs are satisfied and this gives a feeling of mental calm. According to Strauss this is an expression of the optimum functioning of the brain and is called consistency. If this feeling is threatened then an unpleasant, uneasy feeling (stress) develops. Restoring consistency forms a priority in bonding psychotherapy in order for the neuropsychological process in the brain to be stabilised; therefore an optimum psychological functioning becomes possible (Stauss, 2007).

Stauss states, following the humanistic psychology, that there are seven basic bio- psychosocial needs. These needs are universal and are expressed differently according to culture. According to Stauss, it is necessary that the following bio-psychosocial basic needs are fulfilled for a person’s emotional well-being:

- experiencing bonding (physical closeness and emotional openness) in relationships
- feeling secure attachment with another person
- experiencing physical well-being
- being autonomous
- experiencing self-respect
- having an own identity
- leading a meaningful life

In the development there is hierarchy similar to the stages in the psychosocial development described by Erikson (1971).

Bonding is the most basic of these needs and is a condition for fulfilling the need for attachment. The two together, form the basis for being able to fulfil the different needs and are a prerequisite for experiencing life-long pleasure and emotional well-being. Casriel described two prototypes of adults who are unable to fulfil the need for bonding adequately: the “acceptor”, who does everything to receive affection and will even suffer pain and not express anger for fear of rejection. The “rejector”, who does not wish to be dependent, does not trust others, does not ask for help and has difficulty accepting sadness.

Disorder as a symptom of a deficiency
According to Stauss most people who suffer from psychological problems are not ill; they suffer rather from symptoms that result from chronic deprivation of bio-psychosocial needs. In the therapy the participants learn how they can take care of these needs themselves. Passively allowing the needs to be fulfilled by another person is not sufficient; the person then remains unnecessarily dependent and lacking in independence.
In childhood, the development of non-effective emotional schemas (e.g. if I become too close to someone, I will get hurt) has an adaptive function. They are functional for survival in dysfunctional relationships and develop through repeated violations of a person's basic needs. By using these schemas the painful experiences are avoided. Bonding psychotherapy is aimed at changing these dysfunctional schemas, which prevent the formation of positive relationships with others, by means of exercises.

Attachment styles
Mary Ainsworth et.al. (1978) describes various forms of attachment in children. The styles of attachment are a reflection of the original attachment to the primary attachment figure and his/her response to the needs of the child. She makes a distinction between a secure style of attachment and three insecure styles of attachment, namely, an avoidant, an ambivalent and a disorganized attachment form.

Bartolomew en Horowitz, (1991) also described four forms of attachment, but in adults. Like Bolwby, they state that children internalise their early attachment experiences in the form of an internal working model. A person with a secure attachment style developed this because he/she had experienced sufficient support and protection from another person. The internal working models of the self and the other person, (positive or negative) can be combined into the four forms of attachment (see figure 1).
These four forms of attachment are:
- Secure: feels comfortable with regard to autonomy and intimacy
- Preoccupied: feels comfortable with intimacy but has a fear of autonomy
- Fearful avoidant: has a fear of intimacy as well as autonomy
- Avoidant: has a fear of intimacy but feels comfortable with autonomy

Figure 1.

Goal of the therapy
The first goal of the therapy is the emotional processing of past painful experiences, whereby the old emotions no longer recur in similar situations in the 'here and now'.
Because of this the person will no longer react in an intense and excessively emotional manner in the present, or may even not react at all.
The ultimate goal of bonding therapy is to increase the ability to fulfil the bio-social basic needs, to enter into positive relationships and to enjoy life. In order to maintain valuable relationships, a secure form of attachment is needed. This can be achieved by learning to experience closeness in the group as safe and to change negative beliefs about one self in relation to others into positive beliefs.

Bonding psychotherapy in practice
A weekly group consists of 10 to 16 participants under guidance of two therapists; preferably one male and one female. The group meetings take place at a fixed time and last approximately 3 hours. Weekend groups take place 9 to 10 times a year with 4 to 5 sessions taking place during each weekend. The number of participants in the weekend groups can reach thirty to forty under the supervision of multiple therapists.
The therapy groups are continuous, open groups. New participants regularly join the group, preferably with two or more at the same time. An intake procedure will take place prior to the client joining the group.

The intake procedure consists of several individual interviews and the filling in of a number of questionnaires (see below). A case history of the client is taken and a diagnosis is made. In addition to this, the participant receives an explanation concerning the practical issues and the group rules and a treatment program is then drawn up. In a small group of new participants an explanation is given of a number of simple exercises, these include making eye contact and subsequently touching one another. These exercises are the first step towards experiencing the closeness of another person and to share first impressions with one another.
The development of a group meeting can be seen as follows: the group therapy takes place in a soundproof room. The session begins with the participants succinctly answering in turn the question: 'How do I feel at this moment and what do I want to work on?' In the group, the participants mainly work on two techniques; learning to experience and enjoy physical closeness (the bonding technique) and working on negative attitudes (the attitude technique).

The bonding technique
For working on the physical closeness of another person, each group member chooses a partner. The bonding exercise is carried out simultaneously by all participants in pairs under supervision of two therapists. The therapists keep a careful watch to ensure that participants do not exceed their boundaries; for example, that a female participant with an incest experience does not decide impulsively to work with a male participant as a result of social pressure. It is preferable for her, for example, to work with a female partner.
In the bonding technique it is important to be able to express suppressed emotions that are connected to unprocessed experiences from the past. Emotionally working through these experiences makes it possible to experience the physical closeness of another person as pleasurable.

The partners of the pairs work in turn. The person whose turn it is (and, is working"), puts his/her arms around the partner. This can take place standing, sitting or lying down. This usually arouses deep emotions. By strengthening these feelings by screaming, contact can be made with the repressed emotions from the past (Geerlings P. & De Klerk-Roscam Abbing, 1985).Another method which is used to come into contact with suppressed emotions, is the use of short effective statements. These are generally positive versions of negative attitudes, for example, "I do deserve to be loved!". When there is an intense emotional release, the words usually fall away and all that remains is screaming out an angry, frightened or painful 'Aaah!' as pre-verbal expression.

Lying close together on a mattress with physical contact but without any eye contact stimulates the regression. The technique allows negative emotions to be expressed in a safe environment. Being allowed to, and being able to express the intense emotion (s) in a safe environment provides a corrective, emotional experience. After the emotional release has taken place, the participant experiences a feeling of calm. The positive closeness of the other (bonding) partner is experienced in silence during this period of calm. The consistency is high in this phase. Consistency is a conception that indicates that the brain function is optimum and this gives a

feeling of well-being (Grawe, 1998). This phase should last the same amount of time as the catharsis phase. Intense anger can be experienced during the catharsis phase and the closeness of the other person can then no longer be tolerated. This can then be channelled by the therapist by allowing the participant to hit against a pillow.

Contrary to popular belief, physical violence never takes place in these groups. This is probably due to the fact that primary emotions are expressed by screaming. Psychotic reactions do not take place either, but dissociation does sometimes occur. The therapist can resolve this by bringing the group member back into the 'here and now' by making eye contact, by giving encouragement and offering reassurance. With this eye contact the participant is then still able to release the deeper emotions.
Due to the fact that a great deal of physical contact takes place during bonding psychotherapy, the therapist must be aware of the risks on an ethical level. Crossing boundaries and confusion between bonding and sexuality are obvious (Martens, 2001). A bonding therapist is bound to an code of ethics that was drawn up by the Association for Bonding psychotherapy. The group rules and the climate of sincerity in the group ensure that sexual acting-out does not take place.

The attitude technique
The aforementioned negative attitudes hinder the development of satisfactory relationships. Attitudes or behaviour are also called convictions or schemas (Young, 2005) A negative conviction is, for example, " I am not allowed to make mistakes". The person in question is usually unaware of these underlying attitudes. This negative attitude can be discussed in the group and a new positive attitude can be worked on.
The participant learns how to express painful emotions from the middle of a circle of group members. This is less protective and therefore more difficult for the participant than during the bonding exercise.

In the attitude technique one of the participants stands in the middle of a circle of other group members. The participant envisages a relevant reference figure (for example, one of his/her parents), makes eye contact one for one with each group member in the circle , and says aloud the attitude that he/she does not believe such as, " I do exist", "I do have rights", " I can make mistakes"," I do deserve to be loved ",etc. During the exercise, different emotions usually follow each other: the fear and pain of the disbelief, the anger towards the person who initially gave the negative message and the pain and sorrow caused by this, and finally the pleasure as the positive attitude is experienced as the truth (van der Kar, 2004).

The support and encouragement of the therapists and group members and also their confirmation help the participant to express painful emotions. Maintaining eye contact with the other group members during the exercise is paramount. This exercise is more than a cognitive restructuring, (van der Kar, 2008, ter Haar, 2010), the participant learns how to make the positive attitudes his/her own on an emotional level. The strength of the bonding psychotherapy is that the negative attitudes that developed during the preverbal period are now corrected emotionally in the (eye) contact with the other participants.

During the work in the circle, the participant's intense feelings can also be aimed at one of the therapists or participants, for example, if one of the therapists has a negative association with an authoritarian person from the past of the participant. The second therapist will then guide the participant to express his/her frustration and aggression. An "empty chair" can also be used to clarify the transference of feelings from the past. (Struijk, 1997).
The two therapists facilitate the group process and the individual work during the various episodes of the group session (s). Learning from one another as group members within the

bonding psychotherapy is very powerful and very few words are used. A new participant in the group is able to see that expressing emotions fiercely does not have devastating consequences, but leads to relaxation and calmness. The other participants have not become "paralysed" by the pain or become "crazy".
The group session concludes with a final round where everyone can tell the group how they feel; what they have worked on and how this can be applied in everyday life. Afterwards the group members each make a report of the group meeting and also send a copy to the therapists.

In addition to the group sessions, each participant also has individual consultations with one of the therapists on a regular basis. The purpose of the consultations is to reflect on and gain insight into the experiences from the group session(s). The individual therapy process is supported by this. The participants conclude the therapy with a personal evaluation and feedback from the group.

Indications within the bonding psychotherapy

In bonding psychotherapy, disorders are seen as a symptom of attachment problems. Attachment problems cause dysfunctional interaction patterns with other individuals. This leads to a person being insufficiently capable of meeting his/her bio-psychosocial needs. Symptoms of this shortage can develop as psychological problems. In the bonding psychotherapy we therefore find people with very diverse problems such as, depression, anxiety disorders, somatoform disorders as well as personality disorders and combinations of these.

Contra-indications for bonding psychotherapy are:

Physical:
- A poorly functioning cardio-vascular condition (such as pain in the heart region on exertion). The exercises can be psychologically as well as physically strenuous.
  Hypertension without vascular disorders or a faster heart action (heartbeat) without somatic causes (such as an anxiety disorder or a panic attack) is not a contra-indication.
- An existing or a restored retinal detachment.
  When screaming out emotions, increased pressure can occur in the head along with increased pressure in the eyeball. Particularly when the emotions are partly withheld, the pressure increases.
- A pregnancy. Intense emotions, which are expressed loudly, also by the other participants, may cause stress to the mother as well as the child and can be best avoided in this period.

Psychological:
A psychotic disorder: for example, schizophrenia, a paranoid disorder, a severe borderline personality disorder, a manic phase of a bipolar disorder, and an addiction if the use of addictive substances has not been stopped for a long period of time (Kooyman 2003, Kats 2004).

Test diagnostic in bonding psychotherapy
Bonding therapy aims to improve on three levels: symptom level, interpersonal level, and intrapersonal level. In order to get an impression of these three levels at the intake interview three tests are carried out: the SCL-90 for the level of symptoms, the RSQ (Relationship Style Questionnaire) for the attachment style and the interpersonal functioning (Griffin & Bartholomew, 1994), SASB (Structural Assessment of Social Functioning) for the interpersonal functioning. In addition to the use of these instruments during the intake interview, they can also be used to determine the progress and the effect of the therapy process. This test battery can be expanded to include the IIP-C (Inventory Interpersonal Problems) (Zevalkink, & Berghout,

2005), the BDI-II (Becks Depression Inventory), the Schema questionnaire of Young and the Stressful Events Questionnaire (VBG) for determining the severity of post-traumatic symptoms.

Scientific Research on bonding psychotherapy

The first research in the Netherlands into the effectiveness of bonding psychotherapy was carried out by Kats (2004). This was a pilot study where she carried out research on 52 participants who were divided into three heterogeneous, open bonding psychotherapy groups. At a given moment all the participants in the three groups were assessed. This assessment was repeated six months later in the same group of participants. Kats found a significant reduction in the symptoms measured with the SCL-90. The reduction was strongest on the scales of anxiety, depression somatisation, insufficiency in thoughts and actions and distrust. On the RSQ, a significant reduction was seen on the distrust scale. The sub-scales separation anxiety and fear of commitment did decrease, but not significantly. Perhaps the decrease in these scales could also have been significant if the assessments had taken place over a longer period of time.

In research carried out by Maertens (2006) in Belgium in 2004-2005, the above-mentioned results were confirmed. The study involved weekly outpatient bonding psychotherapy groups in which 46 participants took part. The assessment period was one year. From figure 2., a strong increase can be seen in the group of secure attachment. A decrease can be seen in the insecure attachment styles (dismissive, preoccupied, anxious-avoidant). After one year it appeared that the secure attachment styles in the study population were more prevalent than in a healthy, normal population (See figure 2.).

Figure 2:

Maertens's research also shows that bonding psychotherapy is effective on the level of symptoms. The effect could be called spectacular (see figure 3). Three assessments were carried out during the year, (at the beginning, after 6 months, after one year). Figure 3 shows that all the symptoms which were measured with the SCL-90, reduced significantly. The difference between T1 and T2 as well as the difference between T2 and T3 were spectacular (both $p<.01$). After a year the symptoms appeared to have reduced to almost the same level as that of the normal population.

Figure 3:

Evaluation research was also carried out in the psychosomatic clinic in Germany in the period 1998-2006. The findings were comparable to those in Maertens's research. The number of persons who took part in the research was 6814 and the average admission period was 61 days. Before and after assessments were carried out on an individual level. After an average of 61 days admission, the attachment style of the group had increased by 45%. Moreover, in the assessments carried out afterwards, 5% were more securely attached than the normal population (Stauss, 2007, Fisseni & Mestel, 2009, Mestel & von Wahlert, 2009).

Spectacular results were also found in Germany on the SCL-90. The average effect size was 0.85, with insufficiency 0.82 and for depression even 0.92. From this research, it can be concluded that on an interpersonal level measured with the IIP-C, there is a highly significant effect (effect size of 0.85). On an interpersonal level measured with an abridged version of the RSQ the effects were reasonable with regard to fear of abandonment (effect size 0.75), and a small effect with regard to fear of closeness (effect size 0.38).

The conclusion of this research is: A small shift towards a secure attachment style has a significant effect on interpersonal functioning and a reasonable effect on intra-psychological functioning (Fisseni e.a.,2008).

Müller (2010) carried out further research into the effect of bonding psychotherapy on the oxytocin levels in the blood. The hormone oxytocin is regarded as a parameter for the level of attachment. Müller took a blood sample from the participants prior to the bonding exercise and the level of oxytocin was measured. He found a low concentration of oxytocin in the participants with a fear avoidant attachment style and a dismissive attachment style. By doing the bonding exercises, the rate of release of oxytocin was shown to increase. This is an indication that a bio-chemical change occurs by becoming comfortable with closeness in the bonding techniques.

The Organization for Bonding Psychotherapy

In Europe, the Netherlands, Belgium, France, Germany, Italy, Portugal, Slovenia, Sweden, and Switzerland work with bonding psychotherapy. Each country has its own organization. Only the Netherlands and Belgium form together the Association for Bonding Psychotherapy. The European Society for Bonding Psychotherapy (ESBP) is a member of the European Association for psychotherapy (EAP).The (ESBP), together with the American and Argentinean association of bonding psychotherapy form the International Society for Bonding Psychotherapy (ISBP). Every two years the ISBP organizes an international conference.
Each year, the Association for Bonding Psychotherapy organizes a conference (Kooyman, 2003, ter Haar, 2010). You can find more information on the websites
http://www.bondingpsychotherapie.nl and http://www.bondingpsychotherapy.com

Conclusion

Bonding psychotherapy is an intensive and effective group therapy. The bonding psychotherapy is based on a consistent theory and delivers the desired results.
The result of the therapy process is that the participants have dealt with the pain of previous experiences. As a result, these experiences have much less influence on emotions, behaviour and attitudes towards others. The symptoms are reduced; the attachment style, self-image and trust in others are improved considerably. The participants are able to take care of their bio-psycho-social basic needs themselves and subsequently, are able to enjoy life. The results of the therapy are spectacular and this has been confirmed by research.

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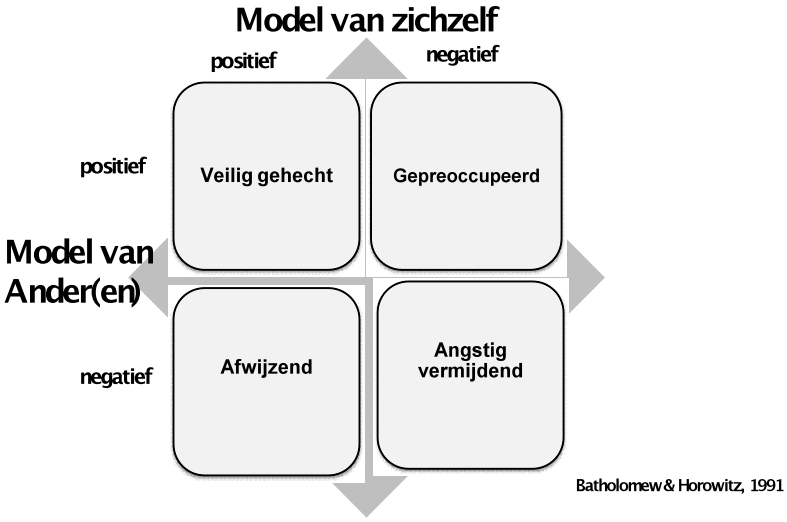
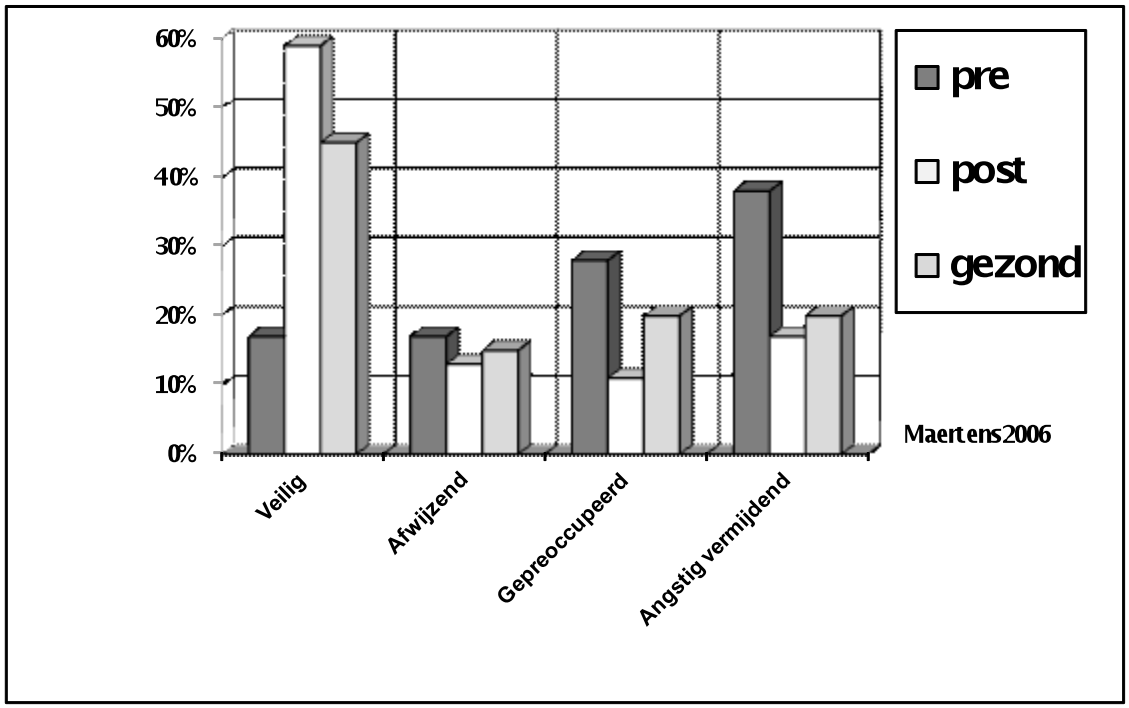
Figuur 1: De hechtingstijlen



Figuur 2: Verandering van hechtingsstijl. (1 jaar wekelijks bondingpsychotherapiegroep, ambulant, Maertens, 2006)



Figuur 3: De resultaten gemeten met de SCL 90. (1 jaar wekelijks bondingpsychotherapiegroep, ambulant, Maertens, 2006)