Attachment Theory and Research

Implications for the Theory and Practice of Individual Psychotherapy with Adults

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ATTACHMENT THEORY AND PSYCHOANALYSIS: THE BREACH AND THE RAPPROCHEMENT

Attachment theory began with John Bowlby’s (1969/1982, 1973, 1980) elegant and parsimonious descriptions of his ideas about the nature and function of human attachments. These formulations inspired the interest of his colleague Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978), whose pioneering research was to provide empirical validation of many of Bowlby’s basic principles and establish a foundation for the thousands of research investigations that evolved from her original research findings (see Belsky & Cassidy, 1994; Bretherton, 1995; Karen, 1998). However, despite the fact that Bowlby was a psychiatrist and psychoanalyst who spent the bulk of his time working as a therapist and analyst, and whose theory evolved directly from his clinical work with delinquent children, the relation between attachment theory and individual psychotherapy has received relatively little attention from clinicians or attachment researchers until recently. In fact, Bowlby himself noted:

"It is a little unexpected that, whereas attachment theory was formulated by a clinician for use in the diagnosis and treatment of emotionally disturbed patients and families, its usage hitherto has been mainly to promote research in developmental psychology. Whilst I welcome the findings of this research as enormously extending our understanding of personality development and psychopathology, and thus as of the greatest clinical relevance, it has not the less been disappointing that clinicians have been so slow to test the theory's uses." (1988, pp. ix-x)

Bowlby was right: Attachment theory has had a dramatic impact on developmental psychology; until recent years, however, it had little palpable impact on clinical theory and practice.

The reasons underlying the fact that Bowlby’s work was marginalized, derided, or simply ignored by psychoanalysts, psychiatrists, and clinical psychologists for over 30 years are complex, but of course have much to do with the core elements of attachment theory. Today, given the past two decades’ remarkable advances in infancy research (Beebe & Lachmann, 1988; Beebe & Stern, 1977; Mahler, Pine, & Bergman, 1975; Stern, 1985; Tronick, 1989), and the evolution of psychoanalysis into a relational and interpersonal theory (Aron, 1995; Mitchell, 1988), Bowlby’s ideas no longer seem revolutionary and indeed have much in common with current developmental and psychoanalytic theory. In the 1940s and 1950s, however, his ideas were seen as radical and heretical. (See Cassidy, Chapter 1, this volume, for a review of Bowlby’s theory.)
Bowlby's considerable theoretical opus emphasized several key notions: (1) A child is born with a predisposition to become attached to his or her caregivers; (2) the child will organize his or her behavior and thinking in order to maintain these attachment relationships, which are key to his or her psychological and physical survival; (3) the child will often maintain such relationships at great cost to his or her own functioning; and (4) the distortions in feeling and thinking that stem from early disturbances in attachment occur most often in response to the parents' inability to meet the child's needs for comfort, security, and emotional reassurance. Environmental failure—be it in the overt trauma of abandonment or loss, of abuse, or the more covert trauma of parental neglect, rejection, and emotional unavailability—often leads to the distortions in thinking and feeling that are at the root of much psychopathology, and that typically underlie the need for psychiatric intervention.

These ideas, and specifically Bowlby's rejection of drive theory, were to lead to his dramatic breach with the psychoanalytic establishment. Despite the fact that he has been described by Storr (1992) as one of the "three or four finest psychiatrists of the twentieth century," Bowlby's theory and its tremendous ramifications for clinical work were for decades "virtually airbrushed out of the psychoanalytic record—rather like some dissident in Stalinist times" (Holmes, 1995, p. 20). Grofstein (1990) has called Bowlby's extrusion "one of the most dreadful, shameful and regrettable chapters in the history of psychoanalysis" (p. 62). Space limitations preclude a fuller discussion of the theoretical, historical, and political reasons underlying the breach; however, these have been fully described by Fonagy (Chapter 26, this volume), Holmes (1993b, 1995), Karen (1998), and van Dijken (1996). In any case, the principal effects of the events of this period were straightforward: From the standpoint of psychoanalysis, psychiatry, and clinical psychology, Bowlby all but ceased to exist for at least three decades. It was not until nearly 40 years after he published his first clinical and theoretical papers, and over a decade after he published the first volume of his attachment trilogy (Bowlby, 1969), that clinicians began to consider some of the ways attachment theory might be applicable to clinical work.

It is easy to assign all the blame for Bowlby's extrusion and subsequent exclusion from the clinical literature upon the psychoanalytic establishment; however, it is important to note that Bowlby himself played a significant role in the standoff that was to have such unfortunate consequences for the field as well as for Bowlby personally. Bowlby was incensed and indignat at his psychoanalytic colleagues' unwillingness to consider the effects of real experience. In an interview in 1991 (Hunter, 1991), he noted that although he and the reigning psychoanalytic giants of the day—Donald Winnicott and Anna Freud—saw the essentials of healthy development in much the same light, they could not agree upon theory. Speaking of Anna Freud, he noted: "It was rather strange because in all matters practical—home, young, small children, we were in complete agreement, and all the work on separation she valued very highly. But when we came to talking theory, she had no use for my ideas at all" (Hunter, 1991, p. 170).

As the split widened, Bowlby increasingly took a position that discounted the role of internal experience—fantasies, urges, and impulses—in shaping psychological life. The rigidity of his position was probably influenced by the tenor of what became a bitter and political dispute. Whatever the cause, Bowlby maintained that psychological life is determined by the response of the environment to the child's earliest feelings and needs. He rejected the notion that an aspect of the individual's response to the world emerges sui generis; as a consequence, his position left little room for the distortings effects of wish and impulse on the development of an inner life, or for the notion that an individual's own idiosyncratic wishes and personal desires may interfere with the capacity to become attached. The result was a relatively underdeveloped view of the nature of subjective experience.

The failure of clinical psychiatry, psychology, and psychoanalysis to embrace Bowlby's ideas must also be seen as a function of the relative limitations of his clinical writings. Bowlby saw himself as a scientist who especially valued the domains of hypothesis and proof. And while he recognized and valued the "artistic" dimensions of psychoanalysis, he wrote little about the specific application of his theory to clinical process, and some of what he did write seems—relative to the richness and complexity of his developmental and theoretical writings—less evolved and dimensional. For instance, Bowlby appears in some of his writings (e.g., Bowlby, 1988) to imply that once patients are faced with the irrationality of their internal working models, or learn that the "reality" of such models is no longer applicable, they will abandon lifelong be-
liefs and expectations. As much as he speaks to the difficulty of such work, his clinical publications for the most part give relatively short shrift to the examination of such complexities. Bowlby (1988) himself remarked that he was a much better scientist and theoretician than he was a therapist, and there can be little doubt that his overarching views of the role and function of attachment in the development of personality and psychopathology have had a far greater impact than his clinical writings.

At present, there is a small but steadily growing literature on the relation between attachment theory and clinical process, spurred largely by developments in the assessment of adult attachment (Main, Kaplan, & Cassidy, 1985). For the most part, the current literature has focused on three separate domains: (1) the relation between attachment theory and psychoanalysis (Diamond & Bliatt, 1994; Eagile, 1995, 1997; Fonagy, Chapter 26, this volume; Fonagy et al., 1995; Fonagy & Target, 1998; Marrone, 1984; Osofsky, 1995; Silverman, 1991; Slade, 1996; Slade & Aber, 1992; Zelick & Buchholz, 1990), (2) the relevance of attachment theory to the treatment of infants and their parents (Lieberman, 1992; Lieberman & Pawl, 1993; Lieberman & Zeanah, Chapter 24, this volume; Minde & Hesse, 1996; Zeanah, Mannen, & Lieberman, 1993); and (3) the application of attachment research to the theory and practice of psychotherapy (Biringen, 1994; Byng-Hall, 1991; Gunderson, 1996; Hamilton, 1987; Holmes, 1993a, 1993b, 1995, 1996; Mackie, 1981; Rutter, 1995; Sable, 1983, 1989, 1992, 1994; Sperling & Lyons, 1994; Sheldon & West, 1989; West & Keller, 1994; West, Sheldon, & Reifler, 1989). A number of self and relational psychoanalysts have also included Bowlby in their revisions of psychoanalytic metapsychology (Lichtenberg, 1989; Mitchell, 1988), although it must be noted that these authors consider Bowlby's theory to be largely consistent with the basic principles of the British object relations school, which in certain subtle ways it is not. The issue of the relation between object relations theory and attachment theory is addressed by Fonagy in Chapter 26 of this volume. Various writers have addressed the relation between attachment disruption and the development of specific clinical syndromes; for instance, Coates and Wolfe (1997) have linked childhood gender identity disorder to attachment derailment in the first 2 years of life, and have suggested specific treatment strategies in relation to derailed attachment between mother and child.

The implications of attachment theory and research for the theory and practice of individual, psychoanalytically oriented adult psychotherapy constitute the focus for this chapter. I wish to make explicit that I am not making a case for a specific "type" of therapy—specifically, "attachment therapy" (Biringen, 1994). Instead, I suggest, in keeping with many colleagues (Fonagy et al., 1995; Fonagy & Target, 1996; Holmes, 1993b, 1995, 1996; Pine, 1990; Silverman, 1991; Target & Fonagy, 1996), that an understanding of the nature and dynamics of attachment informs rather than defines intervention and clinical thinking. Attachment theory offers a broad and far-reaching view of human functioning that has the potential to change the way clinicians think about and respond to their patients, and the way they understand the dynamics of the therapeutic relationship. At the same time, an understanding of attachment organization does not define all aspects of human experience. Nor does it substitute for other, equally important, and equally valid kinds of clinical understanding.

In discussing how attention to attachment processes affects clinical thinking, it is useful to distinguish between the implications of attachment theory for psychotherapy, and the implications of attachment research and specifically attachment classification for psychotherapy. Given the interrelation between attachment theory and research, this distinction may seem problematic; however, for the sake of clarity, it is useful to separate them. To date, most of the literature in this area has addressed the implications of attachment theory for clinical work. Bowlby (1988) himself devoted a number of publications to this subject, and a number of primarily British or European authors—many of whom either worked with or were indirectly influenced by Bowlby and his work at the Tavistock Clinic in London—followed suit (Byng-Hall, 1991; Hamilton, 1987; Heard & Lake, 1986; Holmes, 1993a, 1993b, 1995, 1996, in press; Liotti, 1993, 1995; Mackie, 1981; Marrone, 1984). These writings make it evident that Bowlby's unique view of the role of early relationships in the development of the mind, along with his theory of the infant's inborn motivation to establish and maintain attachment relationships, has the potential to shift the therapist's understanding of various dimensions of the therapeutic situation. Relational theorists have described a similar (but in some critical respects distinct) paradigm shift stemming from developments within object relations theory and infant research (Mitchell, 1988).
What have received considerably less attention in the literature, and therefore serve as the focus of this chapter, are the implications of recent developments in attachment research and classification for the clinical process. Although clinical psychiatry, psychoanalysis, and psychology remained relatively closed to Bowlby’s ideas for decades (and to a large extent still remain so), these same ideas have been widely embraced by a number of developmental and academic psychologists, largely as a function of the pioneering efforts of Mary Ainsworth. Her development of a system for the classification of attachment was to make Bowlby’s fundamental hypotheses open to empirical investigation, and was to move attachment theory out of the domain of psychoanalysis and into the domain of developmental study. As a consequence, attachment theory was to develop along a completely different trajectory than it might have if it had remained essentially a clinical theory about early development. Today, the notion that attachment quality can be classified is at the heart of attachment research; especially relevant to this chapter are recent developments in the classification of adult attachment, much of which has been pioneered by Mary Main and her colleagues (Main et al., 1985).

In this chapter, I address the implications of adult attachment research for clinical listening and clinical process. I then consider the implications of attachment classification for the process and aims of psychotherapy. I begin with a brief history of attachment classification and related research, and then turn to a discussion of each of the issues mentioned above. Questions of the relation between diagnosis, severity of psychopathology, and attachment classification are addressed in other chapters if this volume (Dozier, Stovall, & Albus, Chapter 22; Greenberg, Chapter 21).

A BRIEF HISTORY OF ATTACHMENT CLASSIFICATION AND RELATED RESEARCH

Bowlby believed that parental behavior leads to the development of established and predictable modes of response in the infant, and to the development of patterns of attachment. These behavioral patterns are the first manifestations of what will become “internal working models” or representations of attachment, and that will guide the individual’s feelings, thoughts, and expectations in later relationships (see Bretherton, 1985; Bretherton & Munholland, Chapter 5, this volume; Main et al., 1985). Bowlby was powerfully influenced by cognitive psychology, and particularly by the information-processing model of neural and cognitive functioning. Just as cognitive psychologists defined representational models in terms of access to particular kinds of information and data, Bowlby suggested that different patterns of attachment reflect differences in an individual’s degree of access to certain kinds of thoughts, feelings, and memories. Certain types of insecure models permit only limited access to attachment-related thoughts, feelings, and memories, whereas others provide exaggerated or distorted access to attachment-relevant information. Thus, Bowlby suggested, cognitive as well as emotional access to attachment-relevant information emerges as a function of the history of the mother–child relationship; in essence, the structure and functioning of the child’s mind are determined by the types of feelings that are recognized and allowed expression within the dyad. These ideas were to be developed first by Mary Ainsworth and later by Mary Main. Their work gave rise to an extraordinarily rich and complex body of developmental research, and was to change the course of attachment research and indeed developmental theory in profound ways.

Mary Ainsworth and the Study of Mother–Infant Attachment

Mary Ainsworth was, without question, the individual single-handedly responsible for the dramatic impact attachment theory was to have upon developmental and academic psychology. Her research paved the way for what is now a vast collection of empirical studies of the antecedents and sequelae of children’s attachment to their caregivers (for reviews, see Belsky & Cassidy, 1994; Cassidy, Chapter 1, this volume; Karen, 1998). Most relevant to this chapter is Ainsworth et al.’s (1978) discovery that variations in the quality of maternal responsiveness and sensitivity during the first year of life lead to demonstrable differences in infants’ patterns of seeking comfort from their mothers. These empirical findings confirmed Bowlby’s central hypothesis: that patterns of seeking care and nurture and of expressing affect emerge as a function of the mother’s response to them. A child learns, from an early age, which responses will elicit care from the mother and which will not. Those that elicit or assure at least limited se-
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curiosity become preferred and safe ways of interacting with those who care for the child.

Central to Ainsworth's thinking was the notion that the quality of maternal responsiveness is directly tied to patterns of infantile behavior, particularly comfort seeking and contact maintenance. On the basis of her observations of infantile patterns of separation and reunion in the laboratory separation procedure known as the strange situation, Ainsworth was able to distinguish three primary attachment classifications: "secure," "avoidant," and "resistant." These patterns were linked to mothers' success or failure in responding to and meeting infant needs. Infants whose mothers had responded to them in a sensitive fashion during the first year of life were likely to seek the mothers' comfort following separation; these children were classified as secure. Mothers who were rejecting or inconsistent in their responsiveness during the first year were likely to have children who either avoided their mothers or could not be comforted or contained by them upon reunion; these infants were classified as avoidant or resistant, respectively. In later research, Main and Solomon (1986, 1990) described a third insecure category, the "disorganized/disoriented" category. This pattern of attachment, in which infants showed evidence of disorganization and dissociation upon reunion, was also linked to maternal behavior—specifically, disorganization and dissociation in the discussion of early trauma and loss (Main & Hesse, 1990). For Ainsworth, then, and for a subsequent generation of attachment researchers, infantile behavior in relationships is predictably and lawfully related to maternal behavior during the first year of life. That is, patterns of behavior in attachment-relevant situations emerge as a direct function of the mother–infant relationship.

Mary Main and the Study of Adult Attachment

Mary Main's studies of adult attachment have proven to be as significant within attachment research as those of Bowlby and Ainsworth; these contributions have also been instrumental in bringing the study of attachment to the attention of psychoanalysts and psychotherapists. In the remainder of this chapter, I consider the relevance of research on adult attachment to the therapeutic process. Main and her colleagues (George, Kaplan, & Main, 1985; Main et al., 1985) set out to examine the relations between a parent's early relationship experiences and his or her infant's attachment status: How might patterns in the parent's early attachment experiences be linked to patterns in their infant's behavior? Along with colleagues Carol George and Nancy Kaplan, Main developed a deceptively simple semistructured interview known as the Adult Attachment Interview (AAI), in which adults are asked to describe childhood attachment relationships, as well as experiences of loss, rejection, and separation (George et al., 1985). From her analysis of AAI transcripts (Main & Goldwyn, 1984, 1998), Main discovered patterns of representation that were analogous to infantile patterns of behavior in the strange situation. These patterns were manifested not in adults' descriptions of the events of their lives, but in the way such events were remembered and organized. Indeed, Main found that adults who had had especially difficult childhoods were not necessarily insecure; what distinguished them from their insecure counterparts was the quality of their representations of attachment.

Main and her colleagues originally described three patterns of adult attachment: the "autonomous," "dismissing," and "preoccupied" patterns of attachment. Autonomous adults, like secure infants (who express distress and need in clear and communicative ways), had ready and coherent access to a range of positive and negative feelings about their early attachment experiences. Their representations of early attachment experiences were coherent and flexible. Insecure adults, by contrast, described such experiences in incoherent, contradictory ways. Dismissing adults idealized early relationship experiences and described painful events in a detached, often contradictory way, whereas preoccupied adults seemed overwhelmed and flooded by the affect associated with early attachment experiences. Dismissing adults, like avoidant infants, minimized and overregulated affects that would disrupt their functioning, whereas preoccupied adults, like resistant children, were unable to contain and regulate memories and affects associated with early attachment. Some time after the publication of her original findings, Main suggested that subjects whose interviews revealed disorganization and other indices of disordered thinking in the discussion of mourning or trauma could be classified as "unresolved/disorganized with respect to mourning or trauma" (Main & Hesse, 1990); these subjects manifested the effects of trauma in cognitive or affective disorientation and confusion, dissociation, lapses in consciousness, and the like. Recently a fifth
classification, “cannot classify,” has been described (Hesse, 1996). This category is used when “no single state of mind with respect to attachment is prominent” (Main & Goldwyn, 1998); typically, this classification is used when the subject fluctuates between dismissing and preoccupied states of mind, although it can also be used when the subject fails to rely upon any “single strategy for organizing information relevant to attachment; that is, there appears to be a breakdown of strategy at a global level” (Minde & Hesse, 1996, p. 119). (Both infant and adult classifications are described more fully in Belsky & Cassidy, 1994; Main, 1999b; and Slade & Aber, 1992. See also Crowell, Fraley, & Shaver, Chapter 20, Hesse, Chapter 19, and Solomon & George, Chapter 14, this volume.)

Main and her colleagues found that parents who were autonomous in their representation of attachment had children who were secure in the strange situation (Main et al., 1985). Those who were dismissing of attachment had avoidant children, and those who were preoccupied had resistant children. Parents who were unresolved/disorganized in relation to loss and trauma had children who were disorganized in relation to attachment. These relationships were especially strong for mothers. Meta-analyses of the 14 studies replicating these findings have confirmed the strength of the association between infant and adult security (van Ijzendoorn, 1995; van Ijzendoorn & Bakermans-Kranenburg, 1996), although complex and important issues of discordance and discontinuity have yet to be resolved (Slade et al., 1995; Zeanah, Benoit, et al., 1993).

**Metacognitive Monitoring, Reflective Functioning, and Affect Regulation: Theoretical Contributions of Main, Fonagy, and Others**

Main’s description of specific categories for the classification of adult attachment was to change the course of attachment research. At the same time, it was to give rise to a theoretical revolution in the understanding of representational processes—specifically narrative coherence, metacognitive monitoring, and reflective functioning. Although these constructs are intimately tied to the notion of attachment security, Main’s groundbreaking work on representation led to a number of theoretical and clinical inquiries separate from her original work on the classification of adult attachment. These developments have been particularly relevant to the clinical enterprise.

For Main, the capacity to represent past experiences in a coherent and collaborative fashion is certainly the most significant and compelling aspect of adult security, and is clearly the most predictive of infant security. A coherent interview is one that seems both believable and “true” to the listener; in a coherent interview, the events and affects intrinsic to early relationships are conveyed without distortion, contradiction, or derailment of discourse. The subject collaborates with the interviewer, clarifying his or her meanings, and working to make sure he or she is understood. Such a subject is thinking as the interview proceeds, and is aware of thinking with and communicating to another; thus coherence and collaboration are inherently intertwined and intertwined. Life events and early relationships are examined afresh as the subject strives to make sense of his or her experience for the listener; pain and discomfort are managed with insight and humor. Main (1990, 1991, 1993a) views this critical aspect of narrative process as a manifestation of what she refers to as “metacognitive monitoring”—the adult’s capacity to “step back and consider his or her own cognitive processes as objects of thought or reflection” (1991, p. 135). Coherence reflects an active, “constructivist” process at work; the subject is reevaluating the story while telling it. Descriptions are given in the first person, in narratives that are succinct, believable, and clear, even when traumatic memories and experiences are described.

Main suggests that coherence and the capacity to collaborate with the listener are the sequels of the adult’s having formed a single, internally consistent working model of attachment; such a model allows for the integration of all attachment-relevant information and memories. All aspects of experience are allowed access to consciousness, without distortion or contradiction. Multiple models of attachment are formed when the acknowledgment of disturbing feelings or memories threatens the self or current relationships; distortion and incoherence are the cognitive and linguistic manifestations of multiple contradictory models. For Main, coherence is also a critical element in the intergenerational transmission of attachment: The mother who is able to openly acknowledge, access, and evaluate her own attachment experiences will be able to respond to her child’s attachment needs in a sensitive and nurturing way.
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Peter Fonagy and his colleagues (Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Fonagy et al., 1995; Fonagy, Steele, & Target, 1997; Fonagy & Target, 1996; Target & Fonagy, 1996) have extended Main's work on metacognitive monitoring in ways that are particularly relevant to understanding both the action of therapy and the dynamics of the therapeutic relationship. Fonagy and his colleagues suggest that coherence and other manifestations of metacognitive monitoring signal the capacity to reflect upon internal affective experience in a complex and dynamic fashion. The "reflective function refers to the psychological processes underlying the capacity to mentalize... mentalizing refers to the capacity to perceive and understand oneself and others' behavior in terms of mental states, i.e., reflection" (Fonagy et al., 1997, p. 5). The reflective function is what allows the individual to make sense of his or her own and others' psychological experience, to enter into another's experience, to "read" another's mind. The development of the reflective function allows the child to make others' behavior meaningful and predictable, and permits him or her to respond adaptively in a range of interpersonal situations. It permits a more developed, complex, and affective representation of the self, inner experience, and intimate relationships. Above all, it may provide protection against the damaging effects of abuse and trauma (Fonagy et al., 1995).

The mother's capacity to understand her child's mental states, and her "readiness to contemplate these in a coherent manner" (Fonagy et al., 1995, p. 255), are what create the context for a secure attachment relationship. The mother who is able to reflect upon her own as well as her infant's inner experience forms a representation of her infant as intentional— that is, as "mentalizing, desiring, believing." The image of the intentional infant is internalized by the child, and "constitutes the core of [his or her] mentalizing self" (Fonagy et al., 1995, p. 257). Because it gives the child a sense of his or her inner life and affective experience, the mother's capacity to enter her child's mind and give reality to the child's internal experience is probably a vital aspect of empathic and sensitive mothering. The experience of the self as real, known, and intentional is central to the experience of security.

A vital aspect of security (and a direct outgrowth of the reflective capacity) is the ability to regulate and thus fully experience a range of affects, specifically distress and pleasure (Slade, in press). With understanding comes the capacity to regulate and contain mental states. Presumably this capacity too has its roots in the mother–child relationship. The mother who is able to reflect upon and thus modulate and integrate her own affective experience will not be dysregulated by her infant or toddler's aggression or other negative affects, because the vagaries of emotion are familiar to her. And because she is sensitive to the meaning of emotion, she will respond to her infant's signals as if they are patterned, sequential, bounded, and meaningful. Infant signals are perceived by the mother as coherent, organized communications that— like all interpersonal dialogue— have a function and a message. The mother's capacity to give voice to her own experiences, to describe them meaningfully and coherently, allows her to understand the meaningfulness of her infant's affective communications and to represent them within the context of their ongoing dialogue. Thus they become known, familiar, and communicable to the child.

There are various ways to consider the clinical relevance of this body of work. In the following sections, I first consider the relevance of such general constructs as coherence, metacognitive monitoring, and reflective functioning for the clinical process. I then consider how notions of attachment classification may inform and guide the clinician's thinking regarding clinical formulation, the aims of psychotherapy, and the dynamics of processes of transference and countertransference.

THE RELEVANCE OF COHERENCE, REFLECTIVE FUNCTIONING, AND METACOGNITIVE MONITORING FOR CLINICAL LISTENING

Main's work on metacognitive monitoring and Fonagy's subsequent work on reflective functioning were to change the course of attachment theory in dramatic ways. At the same time, this work was to add to the extant literature on clinical process in both direct and indirect ways. Main's initial emphasis in her work on narrative was on the particular significance and meaning of narrative coherence. Rather than attend specifically to the content of an individual's story, Main focuses upon the structure of the story. For Main, the critical issue is not what kind of story the person tells, but where, when, and how this
story breaks down. How is the story told, and what can the subject (or patient) allow himself or herself to know, feel, and remember in telling the story, particularly as such knowing occurs in the presence of and in collaboration with the interviewer? Main suggests that experiences that cannot be known or spoken about are at the root of incoherence in discourse. Incoherence is manifested in a number of ways—in breaks and disruptions in the story, inconsistencies, contradictions, lapses, irrelevancies, and shifts in person. These are linguistic efforts to manage what cannot be integrated or regulated in experience or memory. Fonagy has elaborated this work by focusing specifically on what he terms the capacity to “mentalize” affective experience—to reflect upon and contemplate the complexity and diversity of one’s internal, mental states.

In many ways, this attention to narrative process operationalizes what has always been intrinsic to good clinical listening: listening for changes in voice; for contradictions, lapses, irrelevancies, and breakdowns in meaning; and for the subtle, ongoing disruptions and fluctuations in the structure and organization of discourse. Indeed, these ways of listening for moments when experience cannot be contemplated or mentalized offer the therapist a view of how the patient defends himself or herself against the intrusion of unacceptable feelings or memories into conscious thought. They offer a means to understanding how an individual lives in the world and in relation to others, what the individual can tolerate feeling, and what he or she needs to make others feel in order to feel personally safe. It tells the therapist what can be known, what can be felt, what can be spoken, and what cannot be contained.

Attending to what can and cannot be told, and to how it is told, also helps the therapist to imagine patients’ early experience in powerful and direct ways. It helps him or her to imagine the dynamic patterns that evolved in early childhood, to understand early empathic breaks with caregivers, and to identify islands of dissociated, un-integrated affective experience. It makes it possible to think much more closely about how early interactive experiences may be affecting responses to emotional upheaval and conflict, and may be affecting the way a patient thinks or does not think about emotion. It allows the therapist to understand the function of particular patterns of thought and feeling, as they protect the patient from intolerable experiences, and as they are designed to elicit ways of thinking and behaving in others (in both real and transference aspects of such relationships). In essence, this way of hearing language and understanding the organization of thought implies that experiences of seeking comfort and care constitute nodal, organizing events in the development of the mind.

In my own clinical work, for instance, if a patient disavows an emotional experience in the course of an hour, I may wonder whether this was an emotion the patient’s mother could imagine and embrace, or whether she subtly abandoned the patient when he or she expressed it. Or when a patient continually conveys a sense of chaos and helplessness, I may wonder whether this is the patient’s way of communicating a need for structure and containment. What was the nature of emotional exchanges between the child and each parent, and at what cost to the child (now an adult) was regulation achieved? Were the mother’s ministrations organizing and containing? Were they disorganizing and fragmenting? Or did they subtly encourage the child to disappear? How do the organizational qualities of the patient’s narrative convey his or her needs and expectations in relationship to primary caregivers? What does it tell me about what the patient believes can be responded to and heard in his or her story? When does language convey a sense of agency and personal ownership, and when does it convey a sense of being lost and helpless in the face of affective upheaval?

One of the primary aspects of coherence, in Main’s view, is the capacity to integrate semantic generalizations and episodic memories; in other words, the adult is able to provide specific memories as evidence supporting the general descriptions of his or her primary relationships. Certainly clinicians are well aware of the fact that the organization of memory is central to their work, and many therapists work directly with early memories and fantasies. However, what Main’s work suggests is that it may sometimes be useful to ask for specific memories, and to ask patients to describe their early interactions and relationships in some detail. A patient’s remembering (or imagining) what it was like to be with his or her mother and father offers the therapist a means of listening for covert abandonments, as well as the more overt disruptions of early loss, abandonment, separation, and trauma. Although these constructions may have little relation to what “actually” happened, they are nevertheless meaningful stories, and they will become more coherent, organized, and vital over the course of treatment.
ATTACHMENT CLASSIFICATION AND CLINICAL FORMULATION

Main's approach to language is not only aimed at discerning islands of coherence and incoherence; it is also aimed at uncovering patterns of representation—specifically the dismissing, preoccupied, and unresolved/disorganized patterns of attachment. What relevance do these constructs have for the clinical enterprise? Certainly the notion of insecurity has clinical utility. Many of the patients seen in psychotherapy today would be classified as insecure, by virtue of the nonautonomous or insecure nature of their internal working models of attachment; in other words, they would be classified (to a greater, lesser, or overlapping extent) as dismissing, preoccupied, or unresolved/disorganized in relation to attachment. In a review of research examining the links between attachment processes and adult psychopathology, Dozier et al. (Chapter 22, this volume) note that "psychiatric disorders are nearly always associated with nonautonomous states of mind." (p. 515). This is not to say that insecurity is synonymous with psychopathology (Cassidy, 1997; Cicchetti, 1989; Sroufe, 1989). Many complex factors lead to psychopathology; nevertheless, insecurity may be considered a significant, but not determining, risk factor. Furthermore, it is not necessarily the case that all patients seeking psychotherapy are insecure, nor does the designation of insecurity describe the breadth or complexity of any clinical picture. However, thinking about a patient's attachment classification is useful in much the same way that thinking about a patient's diagnosis is—that is, as a guide to understanding and making sense of the patient's experience.

But what of the categories themselves? Is attachment classification useful clinically? Thinking about attachment in terms of patterns overlaps in certain ways with more traditional ways of thinking about diagnosis; and, like diagnosis, it has both advantages and disadvantages in the clinical situation. I discuss some of these issues below. I begin with a description of the attachment classification system from a clinical perspective.

Attachment classification offers a distinct way of thinking about psychological structure along what is essentially a continuum of affect regulation and structure. At one end of the continuum is the avoidant/dismissing category, where free expression of (particularly negative) affect is minimal, and the structures for regulating, containing, and suppressing affect are rigid and highly organized. Affects, memories, and cognitions relevant to attachment are overregulated. Attachment researchers have suggested that such affect regulation strategies serve to "deactivate" (Kobak & Scerri, 1988; Main, 1990) or "minimize" (Cassidy, 1994) affects that would disrupt attachment relationships. Although the dismissing classification does not in and of itself reflect psychopathology, certain individuals who fall into this category might also be described as obsessional, schizoid, or narcissistic.

At the other end of the continuum is the resistant/preoccupied category. The polar opposite of the avoidant/dismissing category, the resistant/preoccupied category is characterized by the relative absence of structures for regulating affect. Feelings, memories, and cognitions relevant to attachment are underregulated. Here structures do not suppress affect; rather, affect routinely dissolves or overwhelms structures, rendering them useless or only transiently organizing. These strategies are understood as "hyperactivating" or "heightening" affective cues to caregivers, thus assuring continuing comfort and care (Cassidy, 1994; Cassidy & Berlin, 1994; Main & Solomon, 1986). Some (although again not all) individuals falling into this category might well be described diagnostically as hysterical or borderl in their personality organization.

The secure/autonomous category falls at the midpoint of this continuum. Here structure and affect exist in a balance. Affects, including a range of negative affects, can be represented and acknowledged in a flexible and coherent way. Affective experience is neither constricted nor overwhelming, indicating the presence of well-functioning capacities for affect regulation and modulation. This balance is reflected in the coherence and "truth" of narrative, and in the flexibility and cohesiveness of representational structures. Although these individuals may certainly demonstrate neurotic pathology, such as anxiety or depression, they are unlikely to receive diagnoses indicative of more severe character disturbance.

The fourth attachment category, unresolved/disorganized, cannot easily be placed along this continuum. It is in some sense an extreme form of the resistant/preoccupied category, in that it is typified by incoherence and disorganization not unlike that seen in the resistant/preoccupied category. Further confirmation of the similarity between these two categories is provided by the fact that clinical researchers find that individuals
with borderline personality disorder are most often classified as either resistant/preoccupied or disorganized/unresolved, or both (Adam, Sheldon-Keller, & West, 1995; Ainsworth & Eichberg, 1991; Allen, Hauser, & Borman-Spurrell, 1996; Fonagy et al., 1995). This category, along with the resistant/preoccupied category, has also been linked to childhood trauma or loss (Adam et al., 1995; Allen et al., 1996; Fonagy et al., 1995) and to dissociative disorders (Liothi, 1993, 1995). The fifth category, cannot classify, similarly cannot be easily placed along this continuum, for it often contains elements of both types of insecure organizations; and, like the unresolved/disorganized classification, it has been linked with indices of psychopathology (Hesse, 1996 and Chapter 19, this volume).

From the perspective of psychoanalytic theory, there are two major problems with the notion of attachment classification: It is ase development and mutually exclusive. I begin with the issue of development. In one way, the notion of attachment classification is indeed ase development; that is, the notion of attachment type is not explicitly wedded to developmental success or failure. Psychoanalysts of course assume that lower levels of functioning and failures in differentiation are associated with more primitive defenses and modes of regulating affect, whereas higher levels of functioning and success in the realms of differentiation and autonomy are associated with higher-level defenses and modes of regulating affect (Freud, 1965). Attachment theorists suggest instead that the dynamics of a secure relationship predispose a child toward more differentiated, coherent, and flexible functioning (Diamond & Blatt, 1994). Thus early patterns of defense, as manifested in the secure, avoidant, and resistant patterns, emerge not as a function of developmental progression, but as a function of the child's orientation to affect as it arises in his or her earliest relationships.

Although these ways of thinking about structural differences do not specifically include consideration of the different tasks inherent in stages of development, they map easily onto psychoanalytic developmental theory. For instance, an avoidant child's move through separation and individuation (Mahler et al., 1975) will necessarily be different from a resistant child's experience of autonomy and exploration. Similarly, an avoidant child's ways of managing the complexities of Oedipal love will differ greatly from those of a resistant child. Each of the "affectively charged moments" (Pine, 1985) that define infancy, childhood, and adulthood will be navigated in a way consistent with attachment organization.

In other words, although attachment theory is not a stage theory, there is certainly reason to think that attachment quality significantly affects a child's capacity to move through and resolve developmental challenges throughout the life-span. Notions of type, however, are less easily reconciled with psychoanalytic theory. In fact, notions of classification and type have provided the biggest impediment to psychoanalytic clinicians' acceptance of attachment research.

Some attachment researchers have avoided the problem of type by suggesting that attachment be considered in terms of two overlapping dimensions: the secure/insecure dimension and the dismissing/preoccupied dimension (Kobak & Sceery, 1988; Shaver & Clark, 1994; Shaver & Hazan 1993). In these schemas, an individual's classification is considered in terms of its overall security (i.e., coherence and organization) and its dominant defensive style (dismissing or preoccupied). Both Main's notion of coherence/collaboration and Fonagy's notion of reflective functioning avoid the problem of type altogether, by conceptualizing these variables along a single, unitary dimension. Nevertheless, most attachment researchers conceive of attachment in terms of categories that are more or less mutually exclusive; the individual in question either falls into one category or another. An individual is classified as having a single, primary attachment classification, although there are some instances in which individuals receive dual or mixed classifications (Hesse, 1996), suggesting a more complex view of this aspect of attachment theory.

Although the notion of distinct categories of attachment, or of "styles" of affect regulation, has recently received some support from the domain of neurobiology (Schore, 1994), the assumptions underlying the assignment of attachment type remain unacceptable to many clinicians. Just as they are leery of the problems inherent in the notion of diagnostic categories and labels, they are wary if not outright rejecting of attachment classification, and skeptical as to its clinical relevance. Given the history of psychoanalysis as the study of the complex and developing nature of the human mind, it is obvious why the notion of attachment "types" raises hackles among psychoanalytic clinicians. It simply does not make sense to think of patients in terms of a single, mutually exclusive attachment classifications that presumably remain stable.
within the clinical situation. It is too often the case that patients fluctuate among modes of defense, particularly when they have been in treatment for some time and their defenses necessarily become more fluid.

Nevertheless, thinking about structure and representation in this way does indeed provide clinicians with a way to listen to and think about clinical material in working with adults. Using attachment classifications as metaphors or guides in clinical listening (Blatt, 1995; Lichtenberg, 1989), rather than as singular, mutually exclusive types, offers an important means of understanding how patients live in relationships, how they organize their inner experiences and inner lives, how they manage the developmental thrusts of separation and individuation, and how they modulate desire and aggression. Most important, understanding the function of the regulatory strategies associated with specific attachment classifications allows therapists to understand the dynamic properties of patients' representational models—how the patients' ways of thinking and behaving in relationships are meant to evoke particular kinds of responses and relationships. In the same way that diagnosis serves as a guide (but not a recipe) in the treatment situation, notions of attachment organization provide a therapist with metaphors for thinking about early patterns of affect regulation and defense, and of imagining and speaking to a patient's experience.

In essence, attachment categories tell a story. They tell a story about how emotion has been regulated, what experiences have been allowed into consciousness, and to what degree an individual has been able to make meaning of his or her primary relationships. For Main and many other attachment theorists, these categories represent a way of being in the world that is set in place at an early age, as a function of early experience. Thus, these "modes of experience" or (in Main's terms) "states of mind" necessarily determine an individual's experience of development and its vicissitudes, of change, and of basic relatedness. It is also important to note, however (M. Main, personal communication, April 18, 1998), that inherent in each of the insecure categories are aspects and components of the other insecure categories. Thus, although individuals learn a specific, conscious strategy that dictates attachment behavior, there is another, unconscious representation that exists out of awareness but that may well be accessible in the clinical situation.

From this perspective, listening for the ways attachment themes and organization are both consciously and unconsciously expressed changes how therapists observe their patients and make sense of their stories; it also changes the way they respond to patient narratives, and to the particular aspects of these narratives that emerge as a function of attachment organization. Thus the nature of a therapist's efforts to transform and enter into a patient's narrative will be profoundly shaped by the individual's attachment security. How therapists talk to patients and what they endeavor to do in their talking and in their listening will vary as a function of the patients' predominant (at a given point in treatment) attachment organization.

In a recent paper, Jeremy Holmes (1998) suggests that the work of therapy involves both "story-making and story breaking," helping the patient at once to tell a coherent story and to allow this story to be told in a different, and perhaps more healing light. Holmes states: "Implicit in my argument so far is the view that psychological health (closely linked to secure attachment) depends on a dialectic between story-making and story breaking, between the capacity to form narrative, and to disperse it in light of new experience." By definition, insecure representational models either preclude story making (knitting together the events of one's life in a coherent way) or story breaking (examining the events of one's life anew in the light of new insight). Holmes (in press) defines "three prototypical pathologies of narrative capacity: clinging to rigid stories (the dismissing pattern); being overwhelmed by unstoried experience (the preoccupied pattern); or being unable to find a narrative strong enough to contain traumatic pain (the unresolved pattern)." These "pathologies of narrative capacity" have profound and distinct effects upon the clinical process.

Let me consider the clinical implications of each of the two primary insecure patterns in turn. In work with patients who seem primarily dismissing in their attachment organization, therapy revolves around finding ways of allowing affects into experience and into consciousness—that is, of allowing for "story breaking." These are individuals who construe rather than contain their emotional experience, and who are strangers to feelings, motivations, or inner life. With such patients, the import of psychological experience, intimacy (Holmes, 1996), and attachment is minimized and diminished, or at the very least seems far out of reach. Often when it is suggested to such patients that they may be feeling sad, long-
ing, or angry, or that they might have felt that way as children, their response is usually some variant of "Well, I must have, or maybe I do, but I really don't feel it right now," or "I guess so, I suppose so." They often speak in the second person: "Well, you know, when you're dealing with your child, you can feel angry and frustrated." Thus denial and avoidance appear in the form of the discourse markers described by Main as indicative of a patient's detachment.

From a therapeutic perspective, then, the therapist who recognizes a dismissing attachment organization in a patient must turn her attention to finding ways into the patient's affective experience and memory. Such avenues are often blocked by what Holmes (1998) refers to as "nodal memories," or rigid, inflexible versions of the patient's story that must be "reworked...unpacked...and then reassembled, taking on a new perspective." As the patient comes to tell his or her story in treatment, this singular view of life's events must be recast in light of new information. There are often multiple roadblocks to joining the patient in his or her pain and confusion, because the adherence to rigid stories precludes the patient's experiencing aspects of his or her life that have been long denied and forgotten.

By contrast, treatment with individuals whose attachment organization can be described as preoccupied revolves around the slow creation of structures for the modulation of affect. These patients (particularly those in Main's E2 and E3 categories; see Main & Goldwyn, 1998) often seem overwhelmed and indeed tormented by feelings, and much of treatment revolves around containing and organizing such feelings. In Holmes's (1998) terms, work with many preoccupied adults involves the therapist's finding a way "of capturing the confusion and vagaries of overwhelming feelings." Thus, whereas the absence of affect typifies individuals who are dismissing of attachment, the relative absence of structures to contain an abundance of emotion is typical of many preoccupied individuals. Indeed, the major challenge of working with these patients is to find ways to help them manage and contain affect; often the development of real, internalized structures seems virtually impossible. They often seem to derive very little from therapeutic attempts to organize their experience. Structures seem to evaporate readily and are replaced with raw affect. Their general understanding of relationships seems superficial and hackneyed, and not at all deeply related to internal consolidation (Main, 1995b). Therapeutic insights, instead of paving the way toward the development of real structure, take on a hollow, un-integrated feel. Within the session, these patients are so "driven" by feeling that they jump from one issue to the next, without any sense of a focus or inner purpose. Fonagy et al. (1996) have noted that these patients are especially difficult to treat, and have the least success in outcome studies.

Work with patients who are unresolved/disorganized with respect to mourning or trauma poses a different set of issues, primarily because much of the affect underlying the lack of resolution has been dissociated and profoundly distorted. Here there is often a slow and painstaking recreation of what might have happened; this process often involves working from the barest of clues, and at the same time engenders terror and further dissociation in the patient (Liotti, 1993, 1995).

ATTACHMENT ORGANIZATION AND THE THERAPEUTIC RELATIONSHIP

Therapeutic work takes place within a therapeutic relationship. As all important relationships are affected to a greater or lesser extent by the dynamics of attachment processes, so will the therapeutic relationship be affected by these same dynamics. On the one hand, attachment organization and attachment history will have a profound effect upon the patient's feelings about as well as conscious and unconscious expectations of the therapist. And attachment dynamics will also influence the therapist's feelings about and responses to the patient, although these effects are more subtle and (ideally) more acknowledged.

From an attachment perspective, the model of a successful or helpful treatment involves a patient's capacity to make use of therapy and of a therapist in a "secure" way—namely, to be able to reflect upon his or her life story together with the therapist, and then to bring that shared understanding and meaning into everyday life in a way that is transforming and healing. In other words, treatment provides the patient a means to contemplate and indeed reexperience his or her life story within a safe and healing context, with an emotionally available and sensitive other who "marks" (Gergely & Watson, 1996), and thus gives new meaning and shape to, life events and the patient's sense of self and relationships. But
the degree to which a patient is able to involve himself or herself in treatment, to join with the therapist in the task of mutual understanding, is very much a function of the patient's attachment security. Even when the therapist provides a "secure base," serving as an emotionally available, responsive, and empathic "companion" to the patient (Bowlby, 1988), patients whose attachment organization is insecure are likely to respond to the therapist in ways that are consistent with their lifelong patterns of defense, affect regulation, and security operations.

Reliance upon a therapist need not necessarily be seen as a manifestation of transference. Indeed, turning to a therapist for help and guidance at a time of emotional distress and turmoil derives from a "universal human need to feel protected and comforted" when alarmed or frightened (M. Cortina, personal communication, January 4, 1997). Thus the impulse to seek therapy may well derive from a healthy sense that one can be helped by someone "stronger and wiser" (Bowlby, 1988; Farber, Lippert, & Nevas, 1995), and from a view of others as capable of providing care and comfort. However, for individuals with insecure attachment histories, such normal human processes often become distorted and transformed by what are rightly called "transferential expectations" that the therapist will not understand, will not be available, or will in some way violate the patient's sense of (albeit shaky) safety and security. And, as might be expected, the "shape" of such responses to treatment will emerge as a function the individual's attachment organization.

Individuals with a dismissing organization will typically find the treatment process emotionally challenging and difficult. These individuals often seem cool and somewhat remote, and tend to dismiss the importance of relationships as well as feelings. They often describe difficulty in maintaining relationships. Difficulties in these relationships are minimized, even though it may be evident from the patients' life circumstances that their distance has caused them a great deal of pain. "There may be a smooth, seemingly friendly exterior that appears self-assured and less afraid than others might be. But the apparent good adaptation is superficial and underneath the springs of love are frozen and independence is hollow" (Bowlby, 1960)" (Sable, 1983, p. 378). Psychotherapy poses explicit challenges to such patients' defensive strategies. Mary Dozier and her colleagues have carried out a series of studies investigating the impact of attachment organization on the treatment process. With respect to dismissing adults, Dozier and her colleagues (Dozier, 1990; Dozier, Lomax, & Tyrrell, 1996) have noted that such individuals often seem quite resistant to treatment. Dozier (1990) reports that within the context of therapy, they deny their need for help so as to protect themselves from the possibility that the caregiver will be unavailable. Often they are rejecting of treatment, rarely asking for help and pulling back from help that is offered. In other work, Dozier et al. (1996) report that when individuals with dismissing attachment organizations do confront emotional issues, they often try to divert the clinician's attention. They may become somewhat disorganized in discussing emotional issues.

Dozier's findings are entirely consistent with my own experience as a therapist. I too have found such individuals to be rejecting of help, unmoved by my references to their hurt or fear, and likely to experience my efforts to imagine their feelings as intrusive or overly emotional. They rarely acknowledge the effects or distress of separation; appointments may be missed, rescheduled, or forgotten with apparent equanimity. They are able to acknowledge their dependency upon me in only the most oblique ways. It is only after a reasonable length of time that such patients are able to acknowledge feelings of loss, sadness, need, and rejection, and often such revelations are followed by periods of scaling over and denial. Emotional outbursts are often brief, intense, and contained, and efforts at minimization quickly become apparent.

Adults who are preoccupied in relation to attachment pose very different challenges to the treatment process and to the formation and maintenance of a treatment alliance. The inability to collaborate with and thus take in the therapist's words and support is what makes therapy with such individuals so difficult. Preoccupied adults are thought to heighten or maximize their expression of attachment needs and feelings, in order to ensure their caregivers' care and availability (Cassidy, 1994; Main & Solomon, 1986). Indeed, these individuals "present themselves (in treatment) as needy and dependent, and demand much of their attachment figures" (Dozier, 1990, p. 57). They are far more likely to call therapists between sessions, to demand extra appointments, to become extremely dependent upon their therapists, and to demand advice and support. In other words, these patients are far more likely than dismissing individuals to challenge the parameters of psychotherapy and endeavor to turn the treat-
ment situation into a relationship more reminiscent of a parent–child relationship. On the one hand, such ways of being in relationship to the therapist are not transference manifestations in the classical sense, but manifestations of the patients’ primary mode of relatedness. Need and distress presumably function to keep the therapist involved. What is transferential, however, is the experience of the therapist as insufficiently helpful and available; this may well result in a great deal of hostility toward the therapist as the rage and chaos of primary relationships is elicited in the transference. Gunderson (1996) notes that these patients cannot tolerate being alone; thus, specific technical interventions are required to manage both resulting transference and countertransference manifestations.

ATTACHMENT ORGANIZATION AND COUNTERTRANSFERENCE

I have described some of the ways dismissing and preoccupied individuals may respond to the treatment process. But what of the feelings these individuals evoke in the therapist? Clearly, given that attachment patterns function to evoke feelings in others, they will function to evoke feelings in the therapist (see also Strore & Fleeson, 1988). Insecure adults—namely, those who have suffered some early assault on their capacity to develop relationships—bring their insecure representational models into the therapeutic relationship in vivid and immediate ways, and these form the basis for a range of countertransferrential reactions in the therapist. Deadlocked in their rigid representations, dismissing patients lock the therapist out as they themselves were locked out by their attachment figures. Faced with the impermeability of such a patient’s narratives, the therapist experiences himself or herself as caught in the same barren landscape as the patient; however, the therapist experiences what the patient cannot—the hopelessness of change and of attaining intimacy. And the therapist is left feeling much as the patient once felt as a child: angry, unacknowledged, silly, and inept.

As Dozier (1990) has pointed out, these patients often do succeed in driving clinicians away, and thus lose the help they need. Countertransference reactions can be quite intense, and therapists treating such patients often feel intrusive, melodramatic, helpless, ridiculous, and excluded. Such patients can be very rejecting and hurtful; it is natural to withdraw in response to these kinds of rejections. Often, a therapist’s unconscious response to such rejections manifests itself in “forgetting” to bring things to a patient’s attention and failing to address critical transferrence issues. These are vivid examples of how the therapist unwittingly colludes with the patient’s inability to grapple with the exigencies of his or her emotional life. A different and somewhat more sadistic variation of possible countertransference reactions to such a patient is the attempt to force them to acknowledge disturbing feelings. This reaction, like withdrawal, stems from the frustration of being utterly shut out, as well as from the projection of the patient’s unmetabolized feelings (especially rage) onto the therapist.

The emotional “feel” of working with a preoccupied patient is of course quite different from that of working with a dismissing one. Patients who are primarily preoccupied with respect to attachment are trying very hard to get the therapist to lessen their sense of confusion and take care of them, and yet collaboration with the therapist is all but impossible for these patients. And the therapist feels much the way the patients once did as a child: swamped, angry, helpless, confused, and dysregulated. As a consequence, countertransference reactions to such patients can be quite powerful—feelings of being devoured and overwhelmed, as well as annoyed and confused. And, in natural response to becoming mired in such feelings, a therapist will often try to organize and structure a preoccupied patient; in effect, the therapist may start trying too hard to (in Holmes’s terms) “make” stories for the patient. These efforts are sometimes not helpful and may in fact increase the patient’s feeling of chaos and confusion. Progress in work with patients who are primarily preoccupied in relation to attachment is hard-won. It seems to follow not from words or interpretation, but from the therapist’s long-term emotional availability and tolerance for fragmentation and chaos. Such flexibility and emotional availability provide the structure that is most likely to lead to internal consolidation and genuine structural change.

Dozier (1990) and Fonagy et al. (1996) have noted that these individuals are not necessarily more compliant in treatment, nor are they more likely to be helped by treatment. In fact, in the only large-scale outcome study of attachment classification and therapy outcome, Fonagy et al. (1996) reported that dismissing adults were far more likely to improve in psychotherapy than
preoccupied individuals. Interestingly, Horowitz, Rosenberg, and Bartholomew (1996) reported that dismissing adults do not do well in brief psychotherapy; in line with Fonagy et al.'s findings, as well as the clinical writings of Liotti (1993, 1995), they suggested instead that "long-term dynamic psychotherapy, cognitive therapy, or pharmacotherapy may be more appropriate" (p. 558). For preoccupied patients, however, the capacity to reflect upon emotions in self and others rather than respond to them is notably absent. This is undoubtedly a factor in the finding that such individuals seem not to do well in psychotherapy (see also Korfmacher, Adam, Ogawa & Egeland, 1997, for a discussion of therapeutic process and outcome in a home visitation intervention).

Thus far, I have addressed the question of therapist response from the vantage point of the patient's attachment classification. But what aspects of therapist response, and specifically of negative countertransferential responses, evolve from the therapist's own history and attachment classification? Bowlby (1988) viewed the therapist's emotional availability as central to healing in psychotherapy, because only when the therapist behaves in a sensitive, empathic (i.e., secure) way is the patient able to separate childhood projections from his or her real experience in psychotherapy. In fact, Bowlby implied that for some patients therapeutic neutrality may well trigger experiences of rejection, neglect, and abandonment, whereas for others the therapist's overinvolvement and intrusiveness may well trigger fears of engulfment or enhance dependency. But to what extent is a therapist's sensitivity and emotional availability contingent upon his or her own attachment history and attachment classification?

Therapy concerns itself over and over again with loss, separation, and reunion—both in its consideration of such events in patients' lives, and in the constant separations and reunions that are intrinsic to the therapeutic process. And just as losses, separations, and reunions have meaning for patients, so do they have meaning for therapists. Similarly, just as being cared for may be quite evocative for patients, so may the experience of caring be evocative for therapists. Many therapists have suffered early loss and abandonment; naturally, they will vary in the degree to which they have reconciled and come to terms with these experiences. And, regardless of the degree to which a therapist has come to terms with his or her own early experience, different patients will engage the therapist's attachment dramas in different ways.

From an attachment perspective, the readiness to care for patients is as normal in therapists as it is normal for patients to turn to them for care. Indeed, it may be seen as a corollary to the parental "caregiving system" (Bowlby, 1980; Solomon & George, 1996; see George & Solomon, Chapter 28, this volume). "Care" within the therapeutic context can be defined in myriad ways (providing a secure base, reflecting upon and entering into the patient's experience, etc.); in any case, it implies an emotional connection that flows from therapist to patient as well as from patient to therapist. In a secure therapist, these feelings create an atmosphere of safety and connection. The therapist's feelings of connection to the patient, as well as his or her capacity to care for the patient, may well contribute to the therapist's capacity for empathy and to the resulting therapeutic success, and may well be understood in light of attachment processes. But in an insecure therapist, the predilection to care is as vulnerable to distortion as it is in the insecure patient; these are the perils of countertransference.

In one study, Dozier, Cue, and Barnett (1994) offered fascinating support for the notion that the attachment organization of the therapist may influence treatment outcome. Dozier and her colleagues reported that secure therapists were more able than insecure therapists to hear and respond to the dependency needs of their dismissing patients, and were thus less vulnerable to intense countertransference reactions toward these individuals. The overt demands and explicit dependency needs of patients who are preoccupied in relation to attachment may also be better managed by secure therapists. Insecure therapists are often most likely to become entangled with such patients, responding to their obvious needs rather than their underlying needs. By contrast, secure therapists are more likely to respond to less direct and subtle manifestations of need and dependency. These findings add an interesting dimension to considering the emerging attachment of patient to therapist. A therapist's own security, manifested in the capacity to remain open to his or her experience as well as to the patient's, is likely to be most predictive of a healthy and successful psychotherapy. Obviously, these findings raise a number of issues in the training and supervision of therapists (Main, 1995b).
CLOSING NOTES

I have outlined various implications of attachment theory and research for the theory and practice of individual psychotherapy—for clinicians’ thinking about the therapeutic relationship, development, defense, and clinical process. The understanding of defense, affect regulation, motivation, and the dynamics of relationships that is provided by latter-day attachment theory does not replace other ways of understanding developmental and relational processes. Optimally, it should add to therapists’ ways of listening to and understanding clinical material, and will be helpful with some patients and not others. As Pine (1990) has noted in introducing his view that a “multiplicity of variables” are central to human function, “The complexity of the human animal is sufficiently great such that we gain in our understanding by having multiple perspectives on it” (p. 4). Attachment and attachment processes constitute only one (admittedly very important) aspect of human functioning, and although attachment processes define an aspect of human experience, they do not define an individual in all his or her complexity. Nevertheless, an understanding of the processes so richly described by Bowlby, Ainsworth, and Main, along with a broad array of attachment theorists and researchers, can shed much light on the clinical enterprise and can serve as a valuable adjunct to good clinical work.

Today clinicians are under increasing pressure to administer short, cost-effective, problem-centered treatments. From the vantage point of attachment theory (as well as psychoanalytic theory more generally), the brief psychotherapies are unlikely to result in the “reworking” of representational models, or in changing the quality of attachment representations. They are also unlikely to allow for the development of healthy and curative attachment processes between patient and therapist. Given that issues surrounding the “making and breaking of affective bonds” (Bowlby, 1979) are so often at the center of therapeutic inquiry, we cannot ignore the fact that it takes time and a relationship to change lifelong patterns of attachment. Attachment-related issues also raise a number of questions about training: How can we sensitize upcoming generations of therapists to the vicissitudes of attachment? And, more importantly, how can we increase the likelihood that therapist trainees have examined the vagaries of their own histories? We now know that this is critical to good clinical work.

These are but a few of the matters raised by the research and theory reviewed here. Let us hope that further understanding by clinicians of the complex and rich literature on attachment will shed even more light on how the dynamics and organization of attachment affect clinical outcome and clinical process, and will pave the way toward development of even more effective ways of listening to patients and helping them to change their lives.

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NOTES

1. “Psychotherapy” is a term used to describe a wide range of therapeutic approaches that vary in duration, in intensity, and in their aims and goals, and that can be administered to families, couples, groups, and individual children or adults. A discussion of the complexity of and overlap among different forms of psychotherapy is beyond the scope of this chapter. Here I limit myself to a consideration of what is variously called “psychoanalytically oriented psychotherapy,” “insight-oriented psychotherapy,” and “dynamic psychotherapy.” All of these terms refer to the idea that there exists a dynamic relation between early childhood experience and current adaptation; the aim of treatment in this form of psychotherapy is to illuminate the emotional and structural links between past and present experience. Bowlby himself was a psychoanalytic psychotherapist; thus an emphasis on the representation of early childhood experience is intrinsic to both attachment theory and psychoanalytic psychotherapy.

2. In view of the recent developments in understanding the link between neurobiology and attachment, it should be noted that the differences inherent in working with dismissing and preoccupied patients
may involve differential involvement of left- and right-brain functioning (P. Thomas, personal communication, June 24, 1997). If therapy leads to the transformation of neurobiological structures, the nature and type of transformation sought by the therapist may well differ as a function of attachment category. Main and Hesse (M. Main, personal communication, May 27, 1998) have been using a self-report inventory to examine these phenomena, with interesting preliminary results. Notably, they have found that certain states of mind in relation to attachment are differentially related to left- and right-brain functioning.

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PART V. CLINICAL APPLICATIONS


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