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ATTACHMENT THEORY IN CLINICAL PRACTICE: A PERSONAL ACCOUNT

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Attachment theory was built by Bowlby as an attempt to link psychoanalysis with the wider world of ethology, cybernetics and evolutionary theory. Initially rejected by the psychoanalytic establishment there has been a gradual rapprochement. This paper attempts to accelerate this process by laying out the points of overlap and distinction between the attachment and psychoanalytic perspectives on clinical treatment. It summarizes the main tenets of attachment theory and then looks in detail at the therapeutic alliance, classification, transference/countertransference, and interpretation and mentalizing from an attachment perspective. A clinical example illustrates how insecure and secure attachment play out in the consulting room, and the paper ends by suggesting that attachment provides a suitable evidence base for the relational/Independent psychoanalytic approach.

KEY WORDS: ATTACHMENT, PSYCHOANALYSIS, MENTALZING, CHILD DEVELOPMENT

INTRODUCTION

Let's begin with some disclaimers and caveats. Although I hugely admire Bowlby, the man and his work, and have devoted a good chunk of my professional life to reading, thinking, talking and writing about both (Holmes, 1993/2013; Holmes, 1997, 2001, 2010; Slade & Holmes, 2014), I doubt whether my therapeutic practice could be usefully described as a 'Bowlbian'. Bowlby himself eschewed establishing any school of attachment-based therapy, and his voluminous writings barely refer to his own clinical work. I would, if pressed, describe myself as an attachment-informed psychodynamic psychotherapist with relational tendencies! But I am unconvinced that a fly-on-the-consulting-room-wall test (Holmes, 2010) could differentiate the practice, as opposed to overt belief systems, of Lacanian, Winnicottian, Kleinian, relational – or attachment-minded – therapists. Therapists vary in their effectiveness, but this is mainly a manifestation of personal qualities, rather than their espoused theoretical models (Norcross, 2011).

Another preliminary point concerns the life stage of a therapist. Four stages in the development of a therapist can be delineated, from 'natural listener', through model-absorbing student, newly qualified clinician, to mature practitioner (Holmes, 2012).

Gabbard and Ogden (2009) see the developmental challenge of the third stage as requiring therapists both to 'honour one's ancestors', but also to 'kill the father'. Negotiating that process leads, with luck, to mature clinician-hood: therapists who have found their unique voice, knowing which theories to endorse, which to jettison, when to adhere to standard technique, and when to depart from it. I like to think that in the latter stages of my career I arrived somewhere near that position. Now, approaching stage five – sans couch, sans BPC, sans BPF, sans MD, sans RCPsych, sans everything! – I feel relatively immune from disapproval and disqualification.

Finally, in ways that I hope attachment perspectives will illuminate, I believe that therapists' persona, style and general *modus operandi* owe as much to parents, grandparents, siblings, lovers, friends, spouse(s), colleagues and above all clients/patients,[1] as it does to any formal training they may or may not have received. It takes a village to raise a child,[2] and a comparable network of health-promoting and trauma-transcending relationships is needed to train a therapist.

In this paper I first summarize, twitter-style and with minimal referencing, the basic principles of attachment theory.[3] I then relate these to psychoanalytic theory and clinical practice. A clinical example follows, concluding with some general observations about the relationship between attachment and Independent psychoanalysis.

BASIC PRINCIPLES

Intimacy

Attachment theory is an evidence-based account of intimate relationships, charting the reciprocity upon which individuals' survival, developmental progress and emotional flourishing depend. Intimate relationships are typically those between parents and children, spouses, close siblings, sporting or military 'buddies' – and, arguably, therapists and patients.

The Attachment Dynamic

Bowlby's fundamental model describes relational protection in the face of threat, stress, exhaustion or illness. For newborn and young children, attachment is an essential guarantor of physical survival; with maturation the focus shifts from the physical to the psychological. The attachment dynamic motivates the distressed care-seeker to seek out a Secure Base, an 'older, wiser', care-giver, for support and succour, while the care-giving dynamic activates the latter to offer physical proximity (holding, hugging, rocking etc.), affect regulation and emotional availability. Once the attachment dynamic is assuaged, exploration of their inner and outer worlds (cf. Holmes, 2010) becomes possible. Here the role of the Secure Base shifts to that of companionship, encouragement, and supplier of narcissistic validation (Hoffman *et al*., 2006).

Attachment and Loss

The third volume of Bowlby's 'trilogy' (Bowlby, 1980) is devoted to loss, separation and bereavement. The mental pain associated with loss is intrinsic to the attachment dynamic. Without attachment there would be no grief; secure attachments make possible the processing and transcendence of loss. The securely attached are able to express appropriate and assuagable anger in the face of separation and loss, whereas the insecure either suppress or become locked into anger in unproductive ways.

Attachment Categories

The attachment model of child development arises out of direct observations of parents and children, rather than any putative reconstructions from the couch. Attachment theory's co-creator, Mary Ainsworth, devised the Strange Situation, a method of categorizing parent–child relationships at around 1 year as secure and insecure attachments[4]; the latter were subdivided initially into the avoidant/deactivating and hyperactivating[5] patterns. Insecure attachments can be viewed as interpersonal defence mechanisms designed to activate protection from emotionally compromised care-givers, but often at the expense of full flourishing

Sensitive Care-giving

Ainsworth and her collaborators identified different patterns of parent–child relationship that shape secure and insecurely attached developmental pathways. Parental 'sensitivity' is the key factor: the capacity to respond in a timely and appropriate way to infants' distress, to 'read and regulate' both their children's and their own emotional states, and to see each individual, including babies, as having projects, desires and minds of their own. Avoidant/deactivating children tend to have parents who find it hard to tolerate their children's negative affect, leading to affect suppression; hyperactivating childrens' parents are inconsistent – prompting their offspring to amplify and dwell in negative emotional states and relative helplessness, rather than transcending them, in the hope of securing parental attention.

Developmental Pathways

Attachment theory makes clear distinctions between healthy (secure), suboptimal ('insecure organized'), and pathogenic ('insecure disorganized', see below) developmental pathways, dating from early childhood. Although not immutable, these tend to be self-perpetuating and are reproduced in subsequent intimate relationships, including, transferentially with therapists. Moving from sub-optimal or pathogenic pathways to more healthy ones is associated with 'positive life events', but entails relinquishing tried and tested defences, often associated with periods of extreme vulnerability.

Disorganized Attachment

Mary Main, after Bowlby and Ainsworth the next key figure in the evolution of attachment theory, identified a third pattern of insecurity, 'disorganized' (Main, Kaplan & Cassidy, 1985). Here the child gets little or no protection from the Secure Base figure who is often the very source of threat. This creates an approach/avoidance dilemma in which the threatened child perforce resorts to pathological self-soothing measures such as dissociation, bizarre posturing or repetitive self-injury. These can be seen as analogues, or even precursors of 'perverse' and narcissistic personality disorders in adult life. Disorganized attachment, unlike the organized forms of insecurity, is rare in non-clinical populations, but common where there is socio-economic stress, and/or a history of physical or sexual abuse or neglect.

Attachment Across the Life Cycle

The attachment dynamic is not outgrown once adulthood is reached, but continues as 'mature dependency' throughout life. For adults, attachment figures are typically spousal/romantic relationships, but also persist in extenuated form with parents (often reversed as parents become frail or demented), and extend to pets, siblings, sporting and army 'buddies' etc.

Affect Regulation

While Bowlby originally saw the evolutionary function of attachment as protection from predation, attachment also provides a relational context for affect regulation in both children and adults. A key feature of secure relationships is the parental capacity for acceptance and non-shame-inducing processing of negative affect, whereas in insecure attachments painful feelings are either repressed or un-modulated, setting the scene for later psychological and somatic disturbance.

Positive Emotions

Security-providing parents do not merely help their offspring to withstand threat and illness, they also delight in their children's very existence, exuberance and developmental achievements. Positive emotions, whether overt or subliminal, strengthen secure attachment and lessen insecurity. Here the Secure Base becomes a Safe Haven: soothing and assuaging anxiety, but also providing positive encouragement, with an implicit or explicit 'you can do it, but I am here if you need me' message. Sensitive parents are aware of their offspring's growth points and provide the necessary holding to help them conquer new territory. Similarly, good therapists help patients both cope with the terrors associated with free association and overcoming shame, and celebrate their developmental progress and achievements.

Language and Discourse Style

Another of Main's key contributions to attachment was the development of the Adult Attachment Interview (AAI). This is an audio-recorded psychotherapy assessment

type interview in which the subject discusses childhood experiences, relationships with parents and any significant losses and traumata. The AAI classifies subjects according to their discourse style: fluid/autonomous, dismissing, preoccupied and unresolved. These correspond with the Strange Situation categories of secure, insecure-avoidant, insecure-hyperactivating and disorganized, respectively. The discovery of the relationship between discourse style and underlying relational dispositions is one of attachment theory's great contributions to psychological science.

Mind-mindedness, Reflexive Function or Mentalizing

These related terms, developed by Bateman, Fonagy, Meins, Allen, and colleagues (Allen & Fonagy, 2006; Allen, Fonagy & Bateman, 2008; Fonagy *et al*., 2002; Meins, 1999), refer to the capacity of sensitive care-givers to see their offspring as separate beings, with their own perspectives, desires and goals, and, equally, to apply this perspectivism to themselves – 'to see others from the inside and oneself from the outside' (Holmes, 2010). Mothers with mentalizing competence, even if they themselves have experienced childhood trauma, have securely attached offspring. Mentalizing is thus a resilience factor for those with developmental adversity, and its fostering an important psychotherapy outcome goal. Mentalization Based Therapy (MBT) has become an evidence-based therapy modality in its own right, primarily designed for people suffering with personality disorders (Bateman & Fonagy, 2009).

Rupture and Repair

A related theme is that of the rupture and repair cycle (Safran, 2012), an integral feature of intimate relationships. As infants develop, repeated cycles of losing and re-finding the Secure Base strengthens a sense of an independent self that can cope with and transcend life's inevitable vicissitudes.

IMPLICATIONS OF ATTACHMENT RESEARCH AND CONCEPTS FOR PSYCHODYNAMIC PRACTICE

Bowlby trained as a psychoanalyst and child psychiatrist (Holmes, 1993/2013). His avowed intention in developing attachment theory was to enrich psychoanalysis with theoretical and methodological currents in contemporary science – ethology, evolutionary biology, cybernetics and evidence-based practice. To his dismay the psychoanalytic world saw this project as traitorous, arguing – as is often the case with new paradigms – that what was true in Attachment wasn't new – for example, that children experience grief no less acutely than adults; and what was new wasn't true – Bowlby's fundamental postulate that that security is the 'glue' that binds parents and their children, not infantile sexuality (A. Freud, 1960/2014). Towards the end of his life there was a gradual softening and grudging acceptance on the part of the psychoanalytic community. In this section I shall pick out some points of overlap and difference between the attachment and the psychoanalytic weltanschauung.

The Therapeutic Alliance

All psychoanalytic schools acknowledge the importance of an initial alliance as a precondition for psychoanalytic work. Once established, however, this tends to be relegated to a rather minor role compared with importance of transference. The specific contribution of the analyst in the client's life, or the 'real relationship', can be something of an embarrassment for psychoanalysis since it is clearly a 'common factor' (Wampold, 2001) that would fail to differentiate psychoanalysis from other psychotherapeutic modalities.

From an attachment perspective, the therapist assumes the role of an attachment figure or Secure Base, *both* concretely *and* symbolically. The very presence of threat, or illness, or debility in people's lives is what motivates them to seek help. The analyst's reassuring presence, and the regularity, predictability and warmth – literal and metaphorical – of the setting, provide the necessary security that is a precondition for exploration of current fears and phantasies, triggering life events, and the developmental history that has set the scene for current problems. Throughout therapy the attachment dynamic determines how a balance is struck between assuagement of anxiety, and the gentle encouragement to use it as a stimulus, in the presence of a trusted companion, for exploration and reconciliation.

It is debatable to what extent the analyst fulfils the full criteria for a Secure Base, or remains merely a *representation* or simulacrum of one. In contrast to a 'real-life' Secure Base figure, the client would not be expected to contact their analyst between sessions, however great the anxiety or threat they are undergoing.[6] But this does not preclude the internalization of the analyst as an inner object to whom the sufferer can turn, just as children who suffer upset or hurt themselves at school will not instantly need to contact a parent, but wait until they are 'collected' (equivalent to the start of the analytic session) before the necessary tears, clinging and soothing can begin. A mark of secure attachment is the capacity to ask for help when required and to be able to make use of it. By contrast, in the face of difficulty, the insecurely attached – avoidant, hyperactivating or disorganized – may, respectively, be excessively self-reliant, excessively dependent, or rely on self-injurious self-soothing. An implicit aim of therapy, through the sensitivity and responsiveness of the analyst, is to model more healthy patterns of help-seeking.

Classification

Both psychoanalysis and attachment theories have to steer a course between validating the uniqueness of the individual, and the need for diagnostic categories with which to identify and work appropriately with the varying patterns of developmental difficulty which bring people for help. Attachment's categories of secure, insecure-organized (avoidant and hyperactivating), and insecure-disorganized map fairly easily onto traditional psychoanalytic categories. Thus extreme forms of avoidant insecurity correspond with schizoid defences, hyperactivating patterns with histrionic, and disorganized with borderline states.

The clinical relevance of these broad-brush categories is debatable. One issue is the extent to which they are mutually exclusive, as opposed to representing a range of defences in which one predominates, but which can shift according to circumstances. Attachment defences are conceptualized as *relational patterns* rather than properties of an individual – the fact that a child can be securely attached to one parent, and insecure with another was vital early evidence that attachment classification was not merely a proxy for temperament.

Clinically it may be important for clients to be helped to think about which circumstances elicit greater or lesser degrees of pathological defence. Another relevant theme is the extent to which attachment typologies are best seen as dimensional rather than as mutually exclusive categories, and whether severity, rather than category, may be the determining feature for psychological health (Maunder & Hunter, 2012).

Transference

The difference of tone, and yet essential theoretical compatibility between psychoanalytic and attachment psychology is nowhere more evident than in Bowlby's notion of internal working models. In contrast to 'object relations' or 'inner world of phantasy', Bowlby's term is practical, pragmatic and rather mechanistic. Yet both refer to a similar affective-relational 'map',[7] instantiated in childhood, underpinning subsequent intimate relationships. From an attachment perspective, transference refers to the expectations patients bring into therapy of how the analyst/Secure Base figure will respond to their distress. The psychoanalytic concept of 'projective identification' (see below) adds to this a relational model in which the analyst unconsciously enacts the patient's expected responses to their help-seeking.

From an attachment perspective, therapist–patient relational patterns can be classified as follows:

1. *Sensitive* – secure attachment, empathic, mentalizing.
2. *Over-solicitous* – hyperactivation, associated with excessive dependency.
3. *Dismissive* – avoidance, associated with imperviousness to interpretation (Talia *et al*., 2014).
4. *Self-centred* – disorganized-hostile (Lyons-Ruth & Jacobvitz, 2014), inducing 'you mean me' transference interpretations.
5. *Excessively passive* –disorganized-helpless (Lyons-Ruth & Jacobvitz, 2014), as manifest in excessive analytic passivity or silence.

Dozier, Cue and Barnett's (1994) study, much in need of replication, suggests that secure therapists tend to counteract and balance their client's attachment transferences, while insecure therapists reinforce them. The therapist's sensitivity to the attachment dynamic (felt as counter-transferential constraints, enacted through projective identification) forms the basis of her responses. Thus secure therapists foster restraint and self-monitoring in the hyperactivating pattern, actively encourage the expression of affect in the case of avoidance, and adopt a strong mentalizing stance when trying to help people suffering from disorganized attachment.

Countertransference and Projective Identification

As mentioned, a fundamental attachment principle is the reciprocal relationship between attachment and exploration. In the context of therapy, 'exploration' can be seen as a variant of 'free association' on which the participants (i.e. patient *and* analyst) allow thoughts and feelings to arise spontaneously in their minds, and to give vent to these, both verbally and via affective expressions of sadness, joy, rage, shame, exhilaration etc. The therapist needs to provide the security, and identify the insecurity, which may impede this process for the client. She also needs to feel sufficiently confident personally (via her own therapy) and professionally (via her training and supervision) to apply the same strictures to herself. Free access to one's countertransference is a key therapeutic skill for attachment-oriented therapists, no less than in conventional analysis. This capacity is an aspect of the dynamic in which an internal Other (reinforced by an external Other in the form of a supervisor) is felt to be responsive and sensitive to one's distress when needed, leaving one free to allow feelings, however threatening or 'dangerous' they might seem, spontaneously to emerge into consciousness.

Where then does attachment stand in relation to 'projective identification' (PI) (Roth, 2005)? Although PI is usually seen as a 'Kleinian' concept, there is a clear bridge to attachment, especially in Bion's formulation, in that PI is an essentially communicative, interpersonal, inter-psychic phenomenon. Its 'healthy' forms refer to the ways in which, in intimate relationships, prototypically mother and infant, affect is transmitted from baby to mother, 'metabolized' via mother's musings, and then reintrojected in such a way that the baby can begin to think thoughts, rather than be suffused with feelings. Bion's picture translates readily into an attachment-derived model of parent–infant affect regulation.

This formulation is consistent with the emerging neuroscience 'social brain' version of attachment (e.g. Coan, 2014; Schore, 2002). Via mutually resonating mirror neurones, the limbic system, and the right prefrontal cortex, intimates 'think for' one another, providing the evolution-shaped social buffering against stress and threat which Bowlby postulated in his original formulations. Insecure attachment can be seen in terms of pathological projective identification, in which the care-giver/mother, aversive to negative affect, fails to mentalize her infant's distress. Un-mentalized negativity is then enacted by the care-giver (disorganized-hostile pattern) or sequestered in the child (disorganized-helpless pattern) rather than soothingly verbalized and defused. As we shall see in the clinical example below, similar processes can characterize impasse in therapy.

What Brings about Change?

A hotly contested battle rages within the psychoanalytic movement about the 'mechanisms' (that miserable term for the mutability and flux of human experience) of psychic change. Is it brought about by accurate interpretations (Gabbard & Horowitz, 2009), non-interpretative 'moments of meeting' (Boston Change Process Study

Group, 2010), corrective emotional experience (Castonguay & Hill, 2012), all, or none of the above (Wampold, 2001)?

Attachment theory comes in on both sides of the argument. There is good evidence that psychodynamic therapy can help people move from insecure to secure patterns on the AAI (Daniel, 2014) – but the question is, how? Therapists provide clients with security-promoting attachment – sensitive, focused, empathic responsiveness – which may have been entirely absent, or substantially deficient – with previous care-givers. If good attachment experiences can be internalized, this might produce shifts in internal working models, leading to 'earned security' (but see Roisman *et al*., 2002). These in turn will promote less problematic, more satisfying external relationships, arguably the ultimate purpose of therapy. All this may operate at a contextual, non-interpretative level, a manifestation of the ambiance of therapy and the personal qualities of the therapist. Recent research has established that such subliminal messages can indeed impact on attachment dispositions (Mikulincer & Shaver, 2007).

However, through AAI research we also know that narrative competence (Holmes, 2014b) is a mark of secure attachment, and therapy can help clients construct more coherent, affect-laden, nuanced, discourse patterns (Avdi, 2008). So language, which presumably includes interpretations, matters too. Two of the basic attachment themes mentioned above are relevant here. The first concerns processing negative affect: insecure care-givers are particularly aversive when their care-seekers express sadness, misery and/or anger and rage. Much of the work of therapy concerns revealing and reversing this. Therapists typically are at home with, and home in on such emotions and help their clients think, like Shakespeare's Macduff, about 'the grief that does not speak' and 'give sorrow [as well as envy, hatred and despair] words'. Second, mentalizing matters, since to mentalize is to stand back from emotion, reflect upon it, and to translate that process into words – to find the imagery and its depiction with which to move the private inner world of sensation into the shared, inter-subjective realm of language. Thus MBT (Bateman & Fonagy, 2009) blends psychoanalytic and attachment ingredients into an evidence-based treatment for borderline personality disorder.

TECHNIQUE

As I have implied it would be a mistake to try to define specific attachment techniques that make it different in kind from other psychodynamic modalities. Attachment ideas are however relevant to the recently identified notion of *meta-competency* (Lemma, Roth & Pilling, 2014) which refers to the ways in which therapists deploy their thoughts and theories in the real world of dynamic interaction with clients. In this section I pick out a number of attachment-informed themes relevant to the structure and ambiance, rather than the specific content, of therapeutic conversations.

Marked Mirroring

In studying mother–infant communication in the first year of life, Gergeley and Watson (Fonagy *et al*., 2002) identified a pattern of care-giver–infant interaction

characterized by intense mutual eye contact. The mother responds to the child's proffered facial/vocal gesture, in a '*contingent*' (i.e. waiting for the child to make the first move before responding), but '*marked*' (i.e. exaggerated or emphasized) way. This, they suggest, represents evolution's means of instantiating self-knowledge, in that the child sees herself and her emotions reflected in the mirror of mother's facial expression: 'ah, that's *my* sadness/joy/discomfort/fear etc. I see in my mother's face'.

A homologous dynamic applies to psychotherapy sessions. The meta-competent therapist, especially at the beginning of sessions, waits for the client to start, and then verbally 'underlines' what she perceives to be the client's' state of mind: for example, '*Goodness* that sounds difficult!', '*Wowee*, some row!', 'Oh *dear*! That sounds really difficult'.

This immediately suggests an active, engaged therapeutic stance, possibly more so than in 'standard' technique. For marked mirroring (MM) to be effective, the care-giver needs to be able to bracket off her own states of mind, and provide an inner 'space' receptive to, and mentalizing of the care-seeker's emotional self-states. Where this does not happen – through maternal post-partum depression, or in therapeutic impasse – then the infant/client's pathway to this interpersonally facilitated affective self-awareness will be impaired.

Partially Contingent Mirroring

MM is only part of the story. As infants build up a secure sense of self, they are increasingly ready for playful interaction with others. Beebe *et al*.'s (2010) studies of mother–infant mutual vocalizing and gesture suggest that secure attachment in infants is associated with a particular relational 'dance', characterized by mid-range coordination – contingency – between mother and infant. This 'partially contingent mirroring' (PCM) (cf. Fonagy *et al*., 2002) refers to a pattern of relating in which the care-giver is responsive to, but does not exactly match, the infant's communications. By contrast, Beebe *et al*. (2010) found that both highly ('over-') contingent and low-range mirroring are associated with insecure attachment.

The bounded spontaneity of the partially contingently mirroring mother is homologous with 'good' psychodynamic practice. The mother responds to, but does not exactly reproduce her infant's sounds and gestures. Similarly, the therapist empathically resonates with the affective connotations of her patient's words and actions, but then builds on and elaborates their possible meanings. Partial contingency is by definition 'inexact' (cf. Glover, 1954). PCM therefore creates space for disagreement or correction by the patient. 'Good' interventions are inherently dialogic and relational rather than ex-cathedra or theory heavy, typically offered in an tentative, or conditional way, often including the 'we[8] word': for example, 'Perhaps we could think about what your saying in this way . . .'; 'I wonder if we're getting a bit lost here . . .' etc. (cf. Hobson, 1985). Thus the analyst is continuously responding to the client's conversational patterns with provisional hypotheses for them to consider, embrace, reject or modify.

Working with Defences: Discourse Style

The mirroring metaphor can be extended to encompass *discourse style*, the client's unique dialogic thumbprint (Talia *et al*., 2014). Sensitized to these attachment-shaped linguistic patterns, the therapist mirrors, and at first willingly enters, the clients' particular conversational style. Sensitive therapists intuitively adapt to, and mirror, the specific tone, timbre, volume and affective range of their clients' speech patterns. With avoidant people their intervention may be somewhat 'cognitive'; with hyperactivating patients they may allow themselves to be swept along by strong if confused emotions; with unresolved clients the therapist will tolerate sudden breaks in narrative continuity, while noting them for later exploration.

Gradually, though, the therapist will try to 'pull' the client towards more secure, more coherent and wider-ranging narratives. She is likely here to meet with resistance (cf. Slade, 2014), especially in insecurely attached people. The client unconsciously expects the therapist to conform to prior experience, and strives to maintain the status quo, and avoid the pain of change, especially if there is a feeling that there will be no-one 'there' to accompany him on the journey into unknown territory. The technical task is to maintain the therapeutic relationship – neither colluding nor rejecting – while disconfirming these expectations, and instilling more secure, coherent, interactive patterns of discourse and relating.

In pursuit of this, the secure therapist will home in on the hidden affect which lies beneath the avoidant client's dismissive verbal style; attempt to interrupt the hyperactivating person's string of words with a summarizing point; explore ruptures in the unresolved client's narrative, tapping into what is not being said as well as what is. Finding this middle meeting point allows for the emergence of a 'third' – a co-created set of meanings to which both client and therapist contribute (cf. Stern, 2010).

Positive Comments

As mentioned, secure children have parents who instil healthy narcissism, and give a 'you can do it – but I'm here if you need me' message. I suspect that many therapists subtly or at times explicitly encourage and praise their clients: 'well done', 'that sounds brilliant', 'that's quite an achievement' etc. However, many also feel coy about admitting this since it violates the principle of therapeutic neutrality, may encourage compliance, gloss over negative feelings, and move the therapist's role from expert interpreter to life coach. An attachment perspective provides a developmental justification for therapeutic styles that are active, positive, humorous, and as interested in what's going on in the client's life outside the consulting room as inside. All this must be tempered by the 'middle ground', mentalizing position that characterizes the provider of secure attachment. Thus the therapist might say something like: 'getting that job sounds excellent, they must really believe in you . . . but I suppose we need to consider whether you're not just doing all this to please me or your mum!'.

Creativity and Imagination

To repeat, a fundamental attachment principle is the reciprocal relationship between attachment and exploration (Holmes, 2010). Secure children feel safe to playfully explore the world. When threatened, ill, exhausted or demoralized they know their Secure Base is there to help experience, explore and resolve the problem. By contrast, insecure children tend to have care-givers who either fail to give them that facilitating ambiance, or who inappropriately intrude into the child's imaginative world.

The attachment-informed therapist, sensitive to the ways in which fear can both be a spur to psychological growth, but more often inhibit it, tries to help the client tackle deep-rooted anxieties, while holding back when the client is following their own imaginative path. Silence in sessions is a case in point. Therapists need the tact: to know when to let silence prevail, implicitly communicating respect for the client's unassailable privacy; to be able to hear when silence manifests terror and provide the verbal soothing needed before difficult feelings – often in relation to the therapist – can be faced; finally to identify and challenge silence as a perverse protest, a nihilistic attack on the therapeutic values of value of communication and connection.

Mentalizing

Mentalizing implies the ability to act, speak, engage with the world, and *at the same time* to stand back from one's engagement and to subject it to scrutiny. Attachment research reveals robust links between reflective function (aka mentalizing), sensitive parenting and secure attachment in infants (e.g. Stacks *et al*., 2014). Enhanced mentalizing can therefore be seen as a therapeutic goal. But how is this to be achieved? There are various tactics which help towards this overall strategic aim. The therapist may 'think aloud': 'as you were talking I found myself thinking about what you said last week . . .'. She may encourage the client to reflect on his own thoughts: for example after the patient has recounted a dream by asking 'what do you make of all that . . . ?'. Another technique is 'circular thinking' (Hoffman, 1981) in which one person imagines what another might be thinking: 'I wonder how you imagine I might be reacting to what you are telling me right now?'

Opening up the process of mentalizing conveys the message that there is a therapeutic mind listening and reacting to the patient's mind. This therapeutic 'mind', an embodied, other-connected 'social brain' has its own thoughts and feelings which may be very different from the client's. Learning to tolerate and differentiate these differences, and to see that one's view of the world is only *one* view amongst myriad others is an integral component of successful therapy. Through mentalizing one comes to see that one's thoughts and feelings, while valid in themselves, are inevitably coloured by position and role, may well be mistaken, and that it is only though perspectival dialogue that a 'fusion of horizons' with the Other becomes possible (Holmes, 2014b; Stern, 2010). Fonagy and colleagues (2002) identify a number of 'pre-mentalizing' modes, often seen in clinical practice: 'teleological thinking' ('if this, then that': e.g. in deliberate self-harm, 'if rejected then cut self', without an intervening mind or

affect), 'equivalence mode' ('what I think, *is*', e.g. 'my boyfriend didn't turn up, that *proves* he hates me'), and 'pretend mode' (a world of fantasy, unchecked against reality). Therapy aims to identify, examine and move on from these to a mentalizing stance towards oneself and others.

Rupture/Repair

As in all intimate relationships, therapists regularly get things wrong, in minor and major ways. An important part of attachment-informed technique is the capacity to acknowledge one's faults and failings, to apologize when appropriate, and to learn lessons from them, both for oneself and, more importantly, for the sake of the patient. MBT (Allen, Fonagy & Bateman, 2008) makes a point of encouraging therapists to say things like 'I think I got all that completely wrong . . .' or 'Can you help me, I assumed you were thinking X, but it now looks like it was Y' (note the 'I think' construction which is inherently mentalizing). None of this is to deny the role of projective identification and the ways in which therapists' 'mistakes' may represent not just their own faults and failings, but also be induced by transferential processes in the patient. But a defensive rushing to point out the patient's contribution, without acknowledging one's own, is like to be counter-productive and persecutory.

The Therapist's Secure Base

Ultimately, therapeutic 'technique' flows from therapists' access to their own inner world. I have suggested that this process entails five sequential stages: *attachment*, *reverie*, *logos*, *action, reflection* (Holmes, 2014a). In the context of an attachment relationship, the therapist needs to be secure enough to follow her own reverie, attending to bodily sensations, and snatches of feelings and images. She then plays with them in her mind, until ready to convey them in words ('logos') to the client in the form of 'interpretations'. The training, supervisory and theoretical framework within which the therapist operates provides the Secure Base which facilitates this playfulness, and which triggers the self-reflexive component of the sequence. As the example which follows illustrates, the need for that framework is especially salient when confronting the inevitable 'difficulty' and occasional impasse that psychodynamic work entails.

CLINICAL EXAMPLE

Let's now see how some of these techniques, or the lack of them, play out in the real world of clinical practice. The 'case' I've devised (imaginary, but based on real experiences) illustrates how an attachment approach values the therapist's psychic freedom and capacity to mentalize, and how anxiety-in-search-of-a-Secure-Base can inhibit this process.[9]

> Tom, 28, handsome, sporting and clever, had left a promising academic career and, wanting to 'do something practical' had become a jewelry-maker and dealer.

He was in twice-weekly sitting-up psychoanalytic psychotherapy. Presenting with 'depression' it soon emerged that he had from an early age 'known' that he was imprisoned in the wrong gender, and that, despite having exclusively heterosexual rather than homosexual interests, his 'real' identity was female. He had toyed with going for sex-change surgery, but whenever he approached the reality of doing so, drew back. He was stricken with envy: for young girls and their 'perfect' breasts, and his fellow-sufferers who had braved the gender-changing knife.

After year and a half of therapy, there were significant improvements in the quality of Tom's life and in the severity of the depression which had brought him for therapy. In particular, he had worked through and expressed much previously avoided grief about the death of his mother during his teens. But there remained a sticking point: his gender dysphoria. I had tried 'manfully', one might say, to understand Tom's conviction that he was 'really' female in many ways. Drawing on Bion's concept of the necessary 'contact barrier' (Bion, 1970) between fantasy and reality, I suggested that in his imagination Tom could be as 'feminine' – receptive, yielding, vulnerable, emotional – as he liked, while remaining 'masculine' in his appearance, hormonal makeup, sexual orientation and competitive drive.

I wondered out loud if Tom's longed-for femaleness represented a way of holding onto the mother whom he had lost after a long illness of depression and alcoholism. By 'becoming' female, I mused, perhaps his fantasy was that he could mitigate the pain of loss and 'be' with her forever. I also suggested that Tom's adherence to an idea of himself as fundamentally female represented rebellion against a father who barely noticed him or only did so perfunctorily to praise some highly 'masculine' sporting or academic achievement. But none of this attempt at 'mutual mentalization' cut ice with Tom. He maintained that I 'just didn't understand', and, like all 'alpha males' was constitutionally incapable of imaginative identification with someone with gender dysphoria.

I replied: 'Of the two of us in this room, I would have thought you were by far the most "alpha" '. (Objectively Tom was younger, cleverer, better educated, more athletic, and wealthier than me).

'Oh, that's all a front, to cover my intrinsic femaleness. Why don't you read up about gender dysphoria? You probably don't even believe in it. It's a condition laid down in the womb, you know'.

Towards the end of the same session, Tom began talking about valuing a Victorian necklace which he suspected was a fake. Trying perhaps to retrieve some genuine authority, and to move the conversation in a less literal, more psychodynamic direction, I said, 'of course authenticity is something that is hugely important to you . . .'.

At an intellectual level, Tom seemed to understand this cryptic comment immediately, since he frequently accused himself of 'living a lie' as a man, bemoaning the fact that almost nobody (including me with my gendered-fixed prejudice) 'knew' his true self. Nevertheless at an emotional level this comment fell horribly flat, producing an all-too-familiar tactical defensive response: 'I'll have to think about that' – best translated as 'You think you're so clever? So what? Where does that get us, even if it is true?'.

I was left feeling that my attempts at understanding were little more than intellectual manipulation, aimed at making myself, rather than Tom, feel better; after all 'making an interpretation' is what therapists are supposed to do, how they earn their living. But however benign its intent, I sensed that my comment had been wrong. In the heat of the session Tom felt reified, rather than responded to with compassionate resonance. One could no doubt attribute this example of failed meta-competence to Tom's psychopathology. His refusal to admit that I might have hit the spot could have a dog-in-the-manger aspect: 'If I can't be what I want – i.e. a women – I'm damned if I'll let you have what you desire – to be a good and helpful therapist, making apposite interpretations'. But I was undoubtedly at fault too: offering an attempted 'clever-clever' interpretation rather than being sensitive to Tom's anguish.

At this point my seemingly innocent, but perhaps disingenuous intervention had proved counter-therapeutic, an example of responses typical of insensitive, insecure-making care-givers. The 'mirroring' between the patient's account of inauthentic antiques, and my drawing attention to his gender 'inauthenticity' was forced, and clearly felt *non-contingent* rather than partially contingent. I was foisting my ideas on Tom, rather than facilitating an unconscious dialogic flow between us, akin to Beebe *et al*.'s (2010) mothers who were 'tone deaf' to their infants' babblings.

Reflecting, I tried to understand this mini-impasse as follows. My comment manifested a failure of empathy and identification with Tom's plight, as well as resistance to the idea that gender dysphoria could be concretely helped by surgery rather than psychoanalysis. His competitiveness – masking perhaps a fear of the vulnerability associated in his mind with femininity – had rendered me anxious and hostile; I fell back on an 'interpretation' in an attempt to bolster my waning sense of therapeutic potency. There was 'hate' in the air – mine and his. His 'hatred' of a dying and insensitive mother attached itself to me and shaped my stigmatizing comment. I failed to mentalize this process; our communication was amygdala-to-amygdala (Schore, 2002), by-passing both of our prefrontal cortexes!

But, reassuringly, the rupture/repair literature suggests that mistakes and miscommunications do not always have adverse consequences. The subsequent session perhaps justified my clumsy intervention. Tom arrived with a dream, a relatively rare occurrence.

> *I was changing, and naked to the waist. My father was there. Embarrassed I turned away from him, lest he see my chest. He gently said 'ah, I see you want to have breasts, like your mother'.*

Discussing the dream, the focus was first on the surprising fact of Tom's father's loving and accepting, rather than critical tone; second, together, Tom (who prided himself on the excellence of his use of language) and I looked at the syntax of his dream narrative, and in particular the presence or absence of a meaning-structuring comma. Was his father saying: 'Ah, I see you want to have breasts like your mother ['s breasts]', or 'Ah, I see you want to have breasts, like your mother [has breasts]'?

At this point, in contrast to the previous session, psychoanalytic theory became my Secure Base. I saw that the first parsing could be seen as a statement of concreteness or *symbolic equivalence* (Segal, 1957). Tom's happiness was contingent on his appropriating his mother's *actual* 'voluptuous' (as he described them) breasts, and this could only happen if he went through the hazardous procedures of sex-change operations and hormonal treatment.

In the second parsing, however, the emphasis was on the *desire* rather than the outcome – here the *wish* for breasts became, in Segal's terms, *truly symbolic* rather than 'equivalent'. The dream seemed to say that his 'father' (real and, transferentially, me) understood what he so desperately wanted – 'you *want to be a woman*, like your mother was a woman'. This is a mentalizing statement (cf. Allen & Fonagy, 2006), and so admits of a psychological approach. Psychoanalytic therapy could never *physically* give him what he wanted (any more than surgery could psychically give him what he wanted, i.e. eternal fusion with his lost mother). On the other hand, it *could* help him live with the gap between desire and reality, to understand that desire in a wider context of his maternal bereavement and paternal neglect. The dream acknowledged that 'changing' *was* possible in the psychological sense, if only he could accept the loss inherent in *not* changing in the concrete way that he consciously wanted.

An attachment approach can help conceptualize the contrast between the two interventions. In the first I felt anxious, subtly undermined by the patient. I was imposing rather than facilitating; I was alleviating my own, rather than my patient's insecurity, and ridding myself of my 'hatred' (cf. Winnicott, 1971) of the patient. I persuaded myself that I was doing my job by giving interpretations and trying to make sense of the patient's material, but my intervention was insufficiently mirroring, in that I failed to be sensitive to the extent to which Tom felt that he really 'was' a woman. As with insecure attachment, control took precedence over sensitivity. I wanted Tom to feel that I, the analyst, really 'knew' what was the matter. The intervention was constraining rather than liberating.

In the second session, like the secure child playing 'alone in the presence of the mother' (Winnicott, 1971), analytic theory was 'there' just when the situation needed it. Given that language is a surface marker of underlying attachment disposition, my attention to the syntax of Tom's dream was also attachment informed. To decipher the content, Segal's distinction between symbolic equivalence and true symbol helped

clarify the difference between the two ways of reading Tom's dream. My response fulfilled the criterion for PCM. The dream sentence was 'played back', twice, each with a different emphasis, and contrasting connotation. Analytic theory here played the part of a security-providing care-giver, both for me and the patient: present in the background, ready to facilitate further exploration, indispensable but non-intrusive, a happy marriage of analytic competence and attachment-informed meta-competency.

CONCLUSION: INDEPENDENT ANALYSIS IN SEARCH OF A THEORY

Let's agree with the first half of Anna Freud's riposte to Bowlby: much of what is true in attachment-informed technique is not new. Attachment approaches are not antithetical to standard theory and technique, but go beyond them in important ways. They theorize analytic 'meta-competence' – describing not so much *what* therapists think and say and do, but *how* they do so, in ways that foster secure attachment.

Thus the latter half of Anna Freud's syllogism is wrong: what's new in attachment *is* true in the sense that it is evidence based, and not dependent on mere authority or uncorroborated experience. A recent paper from a leading Independent, Michael Parsons (2009), illustrates the point. The key figures in Independent thought, ancient and modern – Ferenczi, Michael and Enid Balint, Winnicott, Bollas, Millner, Stewart, Rycroft, Kohon, and Symington, as well as Parsons himself are all duly referenced – but Bowlby is conspicuous by his absence. Parsons' paper lays out the quintessential features of 'Independent technique': tact, active listening, restraint, playfulness, valuation of the creative imagination, flexibility, use of vernacular, and an interest in what is going on in the analysand's life outside the consulting room.

But Parsons' manifesto for Independent analysis cries out for an attachment perspective. Every one of his 'Independent' hallmarks describe the relational configurations associated with secure attachment (Cassidy, 2014). Mothers of secure infants are *tactful* in that they adjust their responses to the specific needs of the child. Unlike mothers of hyperactivating children, they *hold back* if the child is happily playing. Securely attached children grow up in an environment that fosters *imaginative competence*. Care-givers of securely attached children are *in touch with both fantasy and reality*, with the inner world of the child and the potential dangers and potentialities of the external environment. All this could readily be incorporated to a robust developmental model for Independent psychoanalysis that would underpin what otherwise might seem little more than motherhood-and-apple-pie psychoanalysis far removed from the alluring obscurities of Kleinian and Lacanian thought.

To conclude, this invited paper represents an example of the increasing rapprochement between attachment and psychoanalysis (e.g. Safran, 2012). Attachment has the potential to infuse (to use Parsons' word) psychoanalysis with scientific rigour, while a Century of psychoanalytic expertise can bring experiential richness to attachment's schematic models of intimate relationships.

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NOTES

1. I use these terms interchangeably throughout.
2. In contrast to Bowlby's original view that the mother–child attachment bond was 'monotropic'.
3. Comprehensive recent texts include Daniel (2014), Danquah and Berry (2014), Mikulincer and Shaver (2007), Slade (2014), Slade and Holmes (2014).
4. Note that Ainsworth's attachment categories were originally devised to apply to relationships, not individuals.
5. I use this term (Mikulincer & Shaver, 2007) rather than Ainsworth's original 'resistant' or 'ambivalent'.
6. Although the ease of email contact means that this increasingly is a feature of ongoing therapy.
7. Compare the Interpersonal Affective Focus (IPAF), a key concept in dynamic interpersonal therapy (Lemma, Target & Fonagy, 2011), an evidence-based brief therapy model which draws on both psychoanalytic and attachment ideas.
8. Compare the 'we-go' as opposed to the 'ego'.
9. How illustrative cases are 'chosen' is an interesting topic in its own right. Perhaps I have unconsciously selected a 'difficult' and trans-gender related case because it resonates with the overall theme of the paper – miscegenation between two seemingly irreconcilable models, the psychoanalytic and attachment.

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