The Use of Attachment Theory in the Clinical Dialogue with Patients

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Abstract: Attachment theory specifically addresses the ability to use an attachment figure as a haven of safety and base of exploration. While many other relational issues are important during development, a foundation of trust based on having positive expectations that others will be available when needed is clearly relevant in the practice of psychotherapy. Yet many patients come in with histories of insecure or even disorganized attachment and have suffered different forms of maltreatment. Understanding affect-regulating strategies, defensive processes, and transference and countertransference patterns associated with insecure or disorganized patterns is enormously useful during the clinical exchange. In addition to paying attention to affect regulation strategies, it is important to note that two other motivational systems may become coopted for defensive purposes in order to cope with disorganized attachment: the caregiving system and the ranking system (the latter being the legacy of dominance hierarchies we observe in primates). The other theme in this article is the importance of paying attention to a cooperative and social engagement motivational system (sometimes referred to as a social or affiliative motive) in building a therapeutic alliance. This prosocial motive is not about safety (attachment) but about sharing and developing positive social relations with others (Cortina & Liotti, 2010). The article explores the significance of building on this cooperative and social engagement system when there is not a foundation of trust based on a secure attachment history.

Despite many excellent books and articles that explore the clinical implications of attachment theory, with the exception of Cortina and Liotti (2010, 2014), none of them touch on the relation between the attach-
ment, and what some have called the sociable, system (Cassidy, 2008) or the affiliative system (Lichtenberg, Lachmann, & Fosshage, 2011). Liotti and I have come to call this social or affiliative system the cooperative and social engagement system (Cortina & Liotti, 2014; Cortina, Liotti, & Silberman, 2013), inspired in part by the work of Steven Porges (Porges, 2011; Porges, 2005). The relationship between the attachment system and the cooperative social engagement system is important because the cooperative and social engagement system is closely linked with intersubjective abilities and intersubjective communication. As I will explain shortly, when there is a history of attachment trauma, these intersubjective abilities can collapse when attachment-related trauma is cued in psychotherapy. In this article I will also call attention to the importance of considering the caregiving and ranking system as a separate motivational system that can sometimes be co-opted in the form of controlling strategies when there is a history of disorganized attachment and trauma (Liotti, 2001).

CORE DIMENSIONS OF PSYCHOTHERAPY INFORMED BY ATTACHMENT THEORY

In clinical work we routinely focus on the following core themes:

- Patients’ intentions, that is, their conscious and unconscious motivations;
- Patients’ emotions and how they regulate them in intimate interpersonal relationships and under stressful conditions;
- The types of defensive patterns that characterize their interpersonal relations;
- How those patterns of interaction show up in the therapeutic dialogue as transference reactions or enactments; and
- Patients’ histories, how they acquired symptoms, and patterns of interaction with others during infancy and childhood and how they are perpetuated in the present.

Attachment theory makes valuable and useful contributions to each of these basic dimensions of the therapeutic dialogue. This is not to say that attachment theory is a comprehensive clinical theory that covers all the topics of motivation, emotional regulation, defense mechanisms, transference, and development. Attachment theory has never tried to be an all-encompassing theory. Rather, it is a very specific theory whose
central theme is the level of security and trust each of us has in our in-
timate relationships over the course of our lives. There are many topics
that attachment theory does not address, or addresses only indirectly.
For example, it does not address sexuality, academic and professional
ability, relationships between brothers and sisters or between peers, or
the importance of the cultural environment. There have been attempted
efforts to fill this gap by exploring the relations between attachment
and sexuality (Diamond, Blatt, & Lichtenberg, 2007), the relationship
between attachment and peer relations (Sroufe, Egeland, & Carlson,
1999), and the unfolding of attachment relations within different cul-
tures (van IJzendoorn & Sagi, 2008). This specificity of attachment the-
ory, which could be seen as a limitation, is its strength, in that it helps
us focus precisely on one of the central themes of human development:
our ability to get help and support from the people who love us and our
ability to give help and support to the people we love.

Before describing how attachment theory helps us with each of these
basic dimensions of psychotherapy, I would like to say a few words
about fantasy. In contrast to many psychoanalytic theories, attachment
theory maintains that fantasies about people with whom we have an
attachment relationship are a product of actual interpersonal experi-
ences during early development. Fantasies play a role later in develop-
ment by allowing us to imagine different ways of resolving or manag-
ing conflicts, anxieties or fears, but this vital function can be affected by
severe psychopathology that limits the capacity for perspective taking
(mentalization).

1. Conscious and Unconscious Motivations

Since Freud made his magnificent contribution about the importance
of unconscious motivations in daily life there has been a revolution in
our understanding of unconscious processes. The fundamental change
has been in thinking of unconscious processes as primarily adaptive
and only secondarily defensive. The defensive function corresponds to
Freud’s dynamic unconscious (Cortina & Liotti, 2007). Neuroscience
and contemporary cognitive science highlight various types of mem-
ory. I am going to concentrate on two major memory systems, implicit
and explicit memory (Fosshage, 2005). The great majority of implicit
memories are adaptive and cannot be consciously remembered (Wil-
son, 2002). Implicit memory is a memory of procedures and routines,
such as learning to crawl or walk or play an instrument. The expecta-
tions and attributes that we automatically (without thinking) make
of others are also part of the system of implicit memories. These non-conscious memories are the result of repeated social interactions. The secure base phenomenon is an example. The hundreds of times that infants and young children use attachment figures as a haven of safety and a base for exploration are recorded as implicit memories. Implicit memory is consolidated slowly since it is based on multiple repetitions. Once established, implicit memory is difficult to change since change implies learning new motor or interpersonal “routines.” Implicit memories become dysfunctional when, for example, there is a history of very insecure or disorganized attachment.

The second type of memory, explicit memory, is in principle accessible to conscious recollection. While implicit memories take time to become established and consolidated, explicit memories can be recorded after only a few experiences, such as when a child learns the name of an animal or a new concept. This makes explicit memories easier to change and more flexible since they are not based on motor or interpersonal routines. During the course of human evolution, with the appearance of language and imagination, there was a major development in the explicit memory system toward a type of narrative memory that enabled us to have a global perspective that can incorporate elements of the past, present, and future (Donald, 2001). This type of autobiographical memory appears relatively late in human development, generally between 4 to 5 years of age (Markowitsch & Welzer, 2010). The capacity for self-reflection depends on this type of autobiographical memory, even though it is not until adolescence that this capacity shows itself with all its complexity.

Clinical Implications

With this preface about implicit and explicit memory processes in mind, we can return to the contributions of attachment theory to the theme of motivation. The attachment system (the search for security and protection from an attachment figure) and the caregiving system (providing security and protection) are not drives or impulses that need to be discharged, as Freud believed. The attachment system and the caregiving system function as homeostatic systems. As with any homeostatic system, there is a goal or fixed point (with small variations) within which a dynamic equilibrium is maintained. This goal or fixed point in the attachment system is a sense of felt security (Sroufe, 1990). There are very specific conditions that temporarily activate and temporarily put the attachment system on a stand-by or expectant mode.
When we perceive a threat or feel stressed we feel fear or anxiety, and these feelings activate a search for physical and emotional proximity to attachment figures. The caregiving system also functions as a homeostatic system, but instead of a sense of security, the goal of the caregiving system is to provide protection and care to the people we love. When we perceive that our loved ones are in danger or are not well, we immediately try to protect and take care of them.

When there is no imminent danger, the attachment system is temporarily put on an “expectant mode” and another motivational system, the exploratory system, is automatically activated. The focus might be on the exploration of the material or the social world. In marked contrast to the feelings of anxiety that accompany activation of the attachment system, the state of mind that accompanies exploration might be variations of interest, playfulness or joy, and every shade of mood in between. Motivational systems are constantly shifting. At one moment they are in the foreground and another on the background. What is important to keep in mind is that the attachment system and the caregiving system are basic security systems, while the main function of the exploratory system is to gain competence in the material world.

There is another motivation system, an affiliative system, that like exploration is activated when there are no dangerous or alarming situations, that Cortina, Liotti, and Silberman (2013) have called the cooperative and social engagement system. The principle function of this system is to develop affiliative ties that promote collaboration between family and non-family members within social groups (Cortina & Liotti, 2014). In contrast to the attachment system that is activated in moments of danger and regulated by the fear system in the brain by the amygdala and prefrontal cortex (LeDoux, 1996), the cooperative and social engagement system is marked by emotions that range from jubilation and pleasure to affective neutrality. These prosocial feelings can be expressed toward attachment figures when we are engaged in pleasurable interactions with them, toward friends or peers, or toward strangers.

The attachment system shows up in many ways in the therapeutic process. Patients generally seek professional help because of a problem that they have not been able to resolve by themselves or with the help of friends or family. They will therefore be inclined to see the therapist as an attachment figure who might be able to provide help. This expectation may be implicit or explicit, but it is often best if the therapist does not overemphasize this point unless it becomes a problem. This point of view is similar to Freud’s recommendations in his papers on
technique of not interpreting positive transferences unless they become a resistance (Freud, 1912). As Bowlby indicated (Bowlby, 1988), one of the therapist’s fundamental tasks is to create a haven of safety and a secure base with the patient so that together conflicts and emotional problems that bring them to therapy can be explored. This is easier said than done. Sometimes establishing a relationship of security and trust with a patient becomes an end in itself and a huge challenge. This is particularly the case with patients who have histories of abandonment or profound trauma at the hands of attachment figures. Success is generally the result of a long and arduous therapeutic process.

The idea of developing a secure base from which to explore with patients is not a new idea, since other psychoanalytic and cognitive theories emphasize creating a secure environment for the patient. However, no other theory explicitly links establishing a secure base in therapy with a similar process during infancy between the infant and primary caregivers. Before there is time to establish a minimal level of trust and safety with the therapist, a premature activation of the attachment bond might produce a re-activation of the trauma in patients. The panic that accompanies the trauma can show up as fleeing from therapy, aggression, intense shame, feelings of impotence, or paranoia. All these reactions may be difficult to contain and assimilate in therapy. As Mary Main has shown in the strange situation with mother–infant dyads with a disorganized attachment, when the attachment system is activated there is a momentary collapse in the ability of infants to maintain a coherent behavioral response toward the attachment figure (Main & Hesse, 1990). Fonagy and his collaborators have also shown that the ability to maintain a perspective of self and others (mentalization) can collapse when interpersonal exchanges cue memories of traumatic or chaotic attachment relations in patients (Allen, Fonagy, & Bateman, 2008).

It is important to be aware of other prosocial motivations (other than attachment and caretaking systems) that can be mobilized in therapy. The social engagement and cooperative system can help us collaborate with patients, even when we cannot yet count on a secure base with our patients. The highly developed cooperative/altruistic system in humans (the cooperative and social engagement system) that coevolved with intersubjective abilities during the course of human development (Cortina & Liotti, 2010, 2014) is instrumental in building mutuality, trust and hope, key ingredients of the therapeutic (working) alliance, and being able to repair the inevitable disruptions that will occur in therapy. The establishment of a working alliance builds on mutuality, and provides the necessary scaffolding that will allow patients with
histories of traumatic attachment to build trust before they are able to expose deep wounds. Mutuality and trust are the *sine qua non* in the treatment of patients with histories of cumulative childhood trauma and disorganized attachment (Van der Hart, Nijenhuis, & Steele, 2006). The model of a hierarchy of evolved motivational systems helps explain the key role cooperation and intersubjective communication plays in developing the working alliance based on mutuality. A working alliance based on collaboration and mutuality, together with an empathic engagement geared to sense into the intentions, feelings, and mental states of patients, allows for a gradual modulation and mentalization of unbearable mental states linked to disorganized attachment and fight/flight/freezing defensive operations (Allen et al., 2008). It is possible to find ways to work toward therapeutic goals that do not involve activating the attachment system with the therapist before a sufficient level of trust has developed. There are many different therapeutic goals that might be less threatening to the patient, such as:

- Creating alternatives to self-harm such as cutting.
- Finding ways to identify and regulate states of panic and loneliness, and help name different emotions such as fear, anxiety or shame.
- Developing simple rules of communication, such as using “I” statements, instead of attacking others and preventing interpersonal conflicts from escalating to crisis levels.
- Minimizing blaming of self and of others with measures toward self-acceptance and using different relaxation techniques.
- Identifying persons to go to in moments of panic, as well as making ourselves available in times of crisis.
- Helping our patients develop curiosity in regard to their emotional reactions so we can begin to engage them in a spirit of inquiry (Lichtenberg, Lachmann, & Fosshage, 2002), that gradually and slowly will develop their ability and skills to see their conflicts and interpersonal difficulties from new perspectives (mentalization).
- Making an appropriate assessment or seeking consultation with a psychiatrist who is experienced in working with patients with traumatic histories to see if psychotropic medication might help with panic states, manic or hypomanic reactions, or profound depressive episodes.

These and other measures will give our patients confidence that we are listening to them, that we are not here to judge them, and that we can help to reduce their suffering. At the same time we are increasing
the patient’s ability to better self-regulate their states of panic while trying to minimize a premature reactivation of the trauma in therapy.¹

2. Emotions and Their Affective Regulation

Infants are not born with the ability to regulate their emotions by themselves. They need attachment figures to help with emotional regulation and states of high arousal. Affective regulation is one of the most important functions of attachment figures (Sroufe, 1996). Attachment theory has contributed greatly to this understanding and has great clinical utility. The different patterns of attachment discovered by Mary Ainsworth—secure, avoidant, and ambivalent—can be thought of as strategies used by infants to adapt to different affective responses for their needs for security and protection (Ainsworth, Blehar, Waters, & Wall, 1978). When there is a history of a secure attachment, strategies of affective regulation (displayed by infants that are observable in the strange situation between 12 and 18 months of age) in home settings are the most economical, simple, and direct. Based on a multitude of experiences, the infant knows that when she is alarmed or stressed her mother (in the great majority of cases mothers continue to be the main attachment figures) will respond to her quickly and effectively. Infants with a history of avoidant attachment have mothers who generally do not respond to their distress. In situations that are not excessively alarming, such as Ainsworth’s strange situation, these infants tend to minimize their expressions of stress and try to regulate/control themselves by paying attention to their toys or other distractions that can help them contain their distress (a de-activating or minimizing attachment strategy). Infants with a history of ambivalent or resistant attachment (these terms are used interchangeably in the attachment literature) have very inconsistent mothers. Sometimes these mothers respond to signals of stress and other times they ignore them, or when they do not ignore them, these mothers are not effective consoling their infants. Infants develop an emotional strategy that magnifies their stress signals

¹ Liotti, Cortina, and Farina (2008) have proposed a model of multiple integrated treatments that might combine individual and group therapy, individual and couples therapy, or two individual therapists working simultaneously with the same patient in different office settings. This team concept is not new, but what it adds is the idea that by having more than one therapist, the intense activation of the trauma with one of the therapists can be managed better. Patient and therapist alike can resort to the second member of the team to diffuse the intensity and chaotic nature of the transference or enactment in therapy and help clarify and understand it better.
with the goal of maintaining the attention and care of an inconsistent and ineffective mother (a hyperactivating or maximizing attachment strategy). Strategies that minimize or magnify distress signals are not optimal, but they are functional and adaptive because children have a way to respond to attachment figures who are insensitive to their needs for security and are not effective in comforting their children.

Disorganized attachment was discovered by Mary Main and Judith Solomon (1986) over a decade after Mary Ainsworth had discovered the three main (organized) attachment patterns. The main characteristic of a disorganized attachment is that it involves a temporary collapse of any viable behavioral strategy on the part of the infant to respond to a frightened or frightening parent. Infants are responding to signs of alarm or threatening gestures from an attachment figure, while at the same time wanting to be comforted by them. These contradictory impulses of wanting to move toward and away from their mothers is inherently disorganizing for infants. Mary Main expressed it well: this contradictory situation is one of “fear without solution” (Main & Solomon, 1986; Main & Hesse, 1990). Intense shaming of a child can produce a similar result, even though this clinical observation has not been confirmed in the developmental or attachment literature. It is not surprising that many studies investigating the consequences of different types of attachment show that children with disorganized attachment are at higher risk of developing more severe emotional and behavioral problems than children whose only risk factor is an insecure but organized and adaptive attachment pattern (Main & Hesse, 1990). However, this finding is more applicable to middle class populations than to poverty populations. With poverty, an insecure attachment in and of itself is a considerable risk factor (see for example Sroufe, Egeland, Carlson, & Collins, 2005).

3. Defensive Processes and Attachment Regulating Strategies

Sorting out whether a patient has a strategy for minimizing her expressions of attachment—which suggests a history of avoidant attachment—or of magnifying her expressions of attachment—which suggests a history of ambivalent attachment—is enormously useful in clinical settings. It is also useful to observe whether a patient suddenly enters into a panicky or confused state when attachment to the therapist is activated, because this suggests that there is a history of disorganized attachment and possibly trauma. I will explore each of these below.
Bowlby describes various types of defensive processes (Bowlby, 1980). His concept of defensive exclusion (Bowlby, 1980, pp. 44-46) fits well with the strategy of minimizing the need to be comforted in the strange situation (avoidant attachment). Suspecting that a patient resorts to a minimizing attachment strategy not only helps in developing a clinical approach, but also helps the therapist sustain an empathic approach. It is easier for a therapist to tolerate feeling ineffective with patients who remain emotionally aloof knowing that the patient probably has a history of avoidant attachment, and that the distancing is part of an unconscious strategy to avoid feeling rejected or ignored. There are several variations to this avoidant defensive strategy. One possibility is that the patient expects very little from the therapist, given his history of feeling rejected or ignored when he sought support from attachment figures. Unknowingly the patient is miscuing us as therapists. He or she wants to be helped, but has low expectations that he will be helped and/or does not know how to recognize and express desires and needs that make him feel vulnerable. Another common theme in patients with these types of history is the prevalence of intense shame. The shame is often the result of parents who become impatient or dismiss their children’s needs for comfort. The need to be comforted is seen later in adolescence and adulthood as “infantile” or a sign of weakness.

Yet another variation is that the patient may idealize attachment figures while at the same time feeling disdain for his or her own feelings of vulnerability. It is not uncommon to hear histories of maltreatment or histories in which attachment needs are ignored or met with scorn from our patients who have come to believe that this harsh treatment “made them strong.” These defensive processes, dismissive or idealizing, can be clearly seen in the Adult Attachment Interview (AAI; Main & Goldwyn, 1984/1998) in which individuals who are assessed as dismissive disdain or minimize their needs for attachment. They may use very positive adjectives to describe the types of relationships they had with attachment figures, but they cannot provide specific memories to substantiate these positive adjectives. Instead of specific memories they use clichéd expressions such as, “My mom was always present” or “My mom always loved us equally.” Another example of the use of a defensive exclusion in the AAI is frequent utterances such as “I don’t remember” and other expressions of forgetfulness.
Strategies that Magnify Expressions of Attachment

In his description of defensive processes, Bowlby (1980) did not conceive of a defensive strategy of magnifying demonstrations of attachment needs (a hyperactivating and maximizing attachment strategy). This was a discovery made by Mary Ainsworth when she developed the strange situation laboratory procedure. In the psychoanalytic literature, this hyperactivating strategy fits well with some characteristics of the “hysterical personality” described by Shapiro in his classic book on neurotic styles (Shapiro, 1965). Attachment strategies that magnify attachment needs can show up in various ways. A patient might have a constant need to be reassured. These demands can be hidden or explicit. The end result is that demands for assurance often exhaust intimate partners, who experience these demands as a bottomless pit of needs. When this defensive pattern appears in therapy, the initial response by therapists is often to try to understand and empathize with the patient’s point of view. Sooner or later—in spite of all the sympathy a therapist might show—this magnifying strategy begins to strain the therapeutic relation with the therapist. For instance, the patient might begin to feel that the therapist has failed him and becomes disillusioned with him, while at the same time the patient might feel responsible for the failure, and attacks himself. This will confirm the belief in a basic “defect” that results in always being rejected in intimate and close relationships. There is some truth to this reproach in the sense that this patient ends up exhausting his loved ones with constant demands to be reassured, intense jealousies, and conscious or unconscious “tests” to which he subjects intimate partners, including the therapist. Without an exploration of this defensive pattern it is not possible to break out of this vicious circle. Part of the challenge of working with this type of patient is to help them learn through many episodes of disruption and repair in the therapy relation, that there are much more effective and satisfying ways to become a valued, respected, and loved partner. As confidence grows in a steady resilient relation in therapy, patients become more self-confident and have greater control over their emotional lives.
Bowlby described a defensive process that consists of a fragmentation of self that can be accompanied by dissociative states (Bowlby, 1980). This type of fragmentation can be a consequence of a history of disorganized attachment and trauma. As previously noted, when there is an attachment relationship in which there are elements of disorganization, the child cannot maintain a coherent emotional and behavioral response to frightening or frightened caregivers. This can show up in many ways, such as with fleeing behaviors when the mother appears in the strange situation, in slow movements as if the child were underwater, or in aberrant behaviors such as when a child throws herself to the floor as the mother makes her appearance in the strange situation or the infant or toddler might appear confused or disoriented or remain immobile for several seconds. Based on these behaviors Liotti (1992) predicted that these children would be at risk of showing dissociative states as adults, particularly if they were exposed to traumatic or very disruptive situations later on in childhood. On the other hand, children who do not have histories of disorganized attachment, but experienced traumatic events in later childhood, would be less likely to show dissociative symptoms as adults. Liotti’s extraordinary prediction has been confirmed by a longitudinal study by the University of Minnesota using a structured psychiatric interview and a questionnaire completed by 19-year-old adolescents (Carlson, Yates, & Sroufe, 2009).

These complex cases require a more elaborate discussion than can be provided within the scope of a short article, but I will illustrate some general observations reached by many therapists working with these challenging cases. Patients with a history of disorganized attachment and complex cumulative trauma might show (a) very pronounced changes in affect regulation strategies mixed with very controlling interpersonal attitudes and behaviors, (b) sudden changes in roles from victim, persecutor, or rescuer, and (c) fragmentation of mental states and dissociative processes.

a. Controlling-Punitive and Controlling-Rescuing Strategies. A common defense in patients with histories of disorganized attachment and with histories of maltreatment or neglect is development controlling strategies have been observed in two longitudinal studies (Main & Cassidy, 1988; Wartner, Grossmann, Gremmer-Bombik, & Suess, 1984). These controlling strategies take two forms. A controlling-punitive strategy, whereby the child takes over by directing the parent and becoming bossy (clinically some of these children become tyrannical and take con-
control of the household). This is a co-option of the ranking system we see in primates (dominance hierarchies as they are technically called). The form is a controlling-caregiving strategy in which the child becomes solicitous rather than bossy with a parent who is ineffective and helpless. This strategy is an indication of an inversion of the normal direction of attachment-caregiving interactions between parent and child (Bureau, Easterbrooks, & Lyons-Ruth, 2009). The co-option of the ranking and the caregiving motivational systems are attempts to avoid shattering dissociative feelings, the unbearable experience of fright without solution, and a helpless relational chaos (Liotti, 2011).

The relational problems that emerge from trying to regulate the dissociative experiences and controlling strategies linked to a history of disorganized attachment create formidable challenges during the clinical exchange. It is not unusual to observe during a therapeutic process that is progressing well the sudden emergence of dominant-punitive attitudes and behaviors. These sudden disruptions are difficult to understand on the basis of previous exchanges. The conflicting activation of the defense and the attachment system together with the activation of controlling strategies lies at the root of many traumatic transferences and countertransferences (Howell, 2011). Efforts to control emotional storms might be achieved by becoming a dominant partner who is bullying and coercive in intimate relations. Or conversely, some individuals might become submissive and accommodating partners, or become what Bowlby called a “compulsive caregiver” (1980) and rescuer of others. When these controlling strategies fail, the result is experienced as catastrophic and may lead to desperate efforts to stay in the relation through threats of suicide or other coercive measures. These controlling patterns can also be accompanied by the fluctuation of affect regulating strategies that minimize or magnify attachment needs. These individuals might become very possessive and clingy in one moment, only to become distant and aloof next. Given the history of emotional instability and chaos in their families, they are hypervigilant of changes in the moods or emotions of their intimate partners, while at the same time they maintain an emotional distance.

b. Sudden and Dramatic Changes from Victim, Perpetrator, and Rescuer Roles. Rapid changes in roles may be another manifestation of complex cumulative attachment trauma in which a patient feels an urgent need to save a loved one with overprotective behaviors (the rescuer role), with sudden change toward victim, to perpetrator role (Liotti, 2000). To understand these sudden role changes it is important to recognize that children assimilate the way in which they were treated, just as they learn to behave like their attachment figures. For instance, the role re-
versal in which a child or adult shifts from the victim to the rescuer role can be the result of being treated aggressively and punitively by a parent when the child does not comply or obey, only for the parent to collapse into a helpless state. The child internalizes the experience of being treated aggressively (the victim role) as well as the aggressive role by becoming controlling and punitive in turn. Or the child might respond to the helpless and ineffective parent by becoming a parentified child (the rescuer role). These examples of the internalization of relational experiences are specific instances, but the internalization of different experiences apply to all relationships and are based on relational principles that have been succinctly and elegantly conceptualized by Sroufe and Fleeson (1986):

1. Relationships are wholes. They are the more than simple combinations of the individual characteristics of people.
2. There is continuity and coherence in close relationships over time (unless of course there is serious attachment trauma, in which incoherence is to be expected).
3. The whole relationship “resides” in each individual (in the example above, the victim, persecutor, and rescuer roles).
4. Relationships are carried forward to later close relationships.

c. Fragmented Mental States and Dissociative Processes. A severe interpersonal crisis may be accompanied by various types of dissociative states. Individuals in these circumstances might feel confused, disoriented, and be unable to think. Occasionally a patient might enter into a frozen state in which she cannot articulate what she feels. Fight, flight, and freeze reactions are the norm (Liotti, 2006; Porges, 2011). Occasionally we hear reports from patients who describe how they could see what was happening to them during a traumatic event, but from the very perspective of an observer. This is a phenomenon of depersonalization. It is as if they are watching a terrifying movie of what is happening during the trauma without having any emotional reaction.

It is easy to understand why it is so difficult to contain the trauma in such moments of crisis, since patients feel overwhelmed by contradictory feelings and thoughts and are in a state of panic that seriously compromises their ability to think about what is happening and be able to put some perspective on the crises.
4. Transference, Countertransference, and Enactments

Transference can be usefully defined as a series of expectations and attributes that we automatically make toward others. As we saw earlier, these expectations are based on internalization at the implicit level of attachment relationships, which have been formed and reinforced during infancy and childhood. This definition bypasses the fruitless debate—from a patient’s perspective—whether manifestations of transference are distortions or are based on the experience of a “real” relationship with the therapist. We all have expectations and make attributions in our relationships. When a person has had the good fortune to have a history of secure attachment, positive expectations and attributes are created, and this is the foundation for the development of a positive transference. Transference reactions that incorporate defensive processes are the result of histories of very insecure or disorganized attachment that might (or might not) be accompanied by trauma. This is the basis for negative transferences. This way of understanding transference is similar to Freud’s understanding in his classic articles on psychoanalytic technique. Freud thought that positive transference was based on positive “imagos” from infancy that the patient transferred to the figure of the analyst (Freud, 1912). These positive transferences were essential to a successful therapy, and had to be in place before resistance to the process could be interpreted, an idea that he maintained to very end of his life in “Analysis Terminable and Interminable” (Freud, 1937). Unfortunately Freud complicated this account by believing that there were two types of resistance (Freud, 1912). One was based on positive transference and the other on negative transference. How could a positive transference become a source of resistance? Freud’s libidinal theory conflated attachment needs with sexual needs, and from this perspective all deep human connections were ultimately erotic. Sooner or later a positive connection would have an erotic manifestation or component that would become a source of resistance during the therapeutic process. Attachment theory is not encumbered by this confusing theory. Therefore understanding positive and negative manifestations have a more straightforward explanation.

None of the above should imply that a therapist’s attitudes and personality do not have a major impact on the quality of the therapeutic relation. The therapy relation, like any other relation, is co-constructed
and we should always be open to the likelihood that the attributions patients make of us are based on subtle (and not so subtle) cues that they pick up from us. Lichtenberg and his colleagues’ recommendation of “wearing patients’ attributions” (Lichtenberg, Lachmann, & Foss-hage, 1996) is not only good technique, it is also an acknowledgement, in the words of Harry Stack Sullivan, that we are “all much more human than otherwise” and that our strengths and weaknesses have to be openly acknowledged and used to help our patients.

To summarize:

• When there is a history of secure attachment, patients will have positive expectations that they can be helped and they will engage in therapy with the idea that the therapist will listen to and understand them. When these expectations are confirmed, the therapeutic alliance is solidified.

• When there is a history of avoidant attachment, a patient will not expect therapy to help or will have low expectations of what can be accomplished, but this deep skepticism is generally not expressed as such. Instead, this skepticism might be expressed indirectly and patients will look for therapy to be a technical process in which the therapist provides information, behavioral strategies, or illuminates cognitive distortions, all without the need of developing an emotional attachment in therapy. When there is a history of more painful rejection a patient will not trust the therapist and will avoid exposing vulnerabilities. Feelings of shame will be common. Another variation that is seen in the AAI is one in which a person idealizes his attachment figures and describes a “normal” infancy. In these interviews an individual might appear to be cooperative with the interviewer. But the cooperation is superficial, without a genuine emotional engagement. Shame, fear, and lack of trust remain hidden. When confronted with these types of patients as therapists we can feel bored without knowing why.

• Patients with a history of ambivalent attachment will likely begin therapy with a desire to be helped, and often a positive transference will develop which sometimes can be very intense. If the patient is smart and knows the psychological jargon, there may be a long honeymoon phase and a feeling that the process is going well. But after the honeymoon the patient might begin testing the relationship or become disillusioned with the process. Or the therapist might begin to realize that despite all the talk, and occasional drama, there is no change. It is in these moments that the therapy can really begin.
Patients with a history of disorganized attachment, who in addition have been physically or sexually abused or neglected by attachment figures, have the most unpredictable types of transference. There may be combinations and permutations of the patterns that I mentioned earlier that combine strategies minimizing and maximizing attachment strategies and sudden changes in victim, persecutor, or rescuer roles. There may be states of fragmentation and dissociation that are very hard to understand and contain. One of the most difficult moments in therapy happens when a patient begins to understand the magnitude and extent of his or her childhood suffering. Patients might be horrified by the intensity of their rage and their desire to do to others what was done to them. We often learn the most from our traumatized patients. From their tenacity, resilience, and persistence we learn the meaning of human dignity. Our work together can be transformative, both for the patient and for us.

5. Developmental Processes

No other clinical theory yields so much practical information about the process of human development as attachment theory. Several generations of researchers have confirmed and added to the contributions of Bowlby and Ainsworth and the body of work as a whole is magnificent (Cassidy & Shafer, 2008). A comparison between these relational and self psychological perspectives is beyond the scope of this article, but I would offer the following ideas that I think point toward an emerging common ground in our understanding of developmental processes:

Early relationships have long-term effects on later relationships, but early experiences can be modified by later positive experiences. These positive experiences do not erase the effects of difficult or traumatic early experience, but they can have a huge impact in the way we can regulate and master frightful and shameful states of mind.

During the course of development, experiences with significant others (attachment figures) are expressed as a series of implicit expectations and attributions we make of others.

We internalize the experience of how we were taken care of and treated as children by taking in and internalizing the behaviors and attitudes of the people who cared for us when we were children. We often do to others what was done to us.
There is both continuity and discontinuity in interpersonal patterns during development and nonlinear effects are the norm.

The development of interpersonal relationships is best described as routes or paths of development that are based on strategies or patterns of affective regulation between young children and their primary caretakers. These strategies of emotional regulation have important effects on other interpersonal relations, such as peer relations and relations to teachers. This model of development replaces a more static model of development based on fixed developmental phases.

There are cycles of disruption and repair in attachment relationships, but as long as these disruptions are minor and are repaired, these can enhance rather than hinder development.

An organizational model of development has been proposed by self psychologists (Attwood & Stolorow, 1984; Lichtenberg, Lachmann, & Fosshage, 1992) independently from a similar model formulated by attachment theorists (Sroufe, 1990; Sroufe, Egeland, Carlson, & Collins, 2005). These models are based on the premise that the most important function of the brain/mind is to integrate experience from perceptual, emotional, and cognitive domains into a coherent whole. Coherence allows for the development of multiple states of mind and multiple perspectives from which to understand experience. When this coherence is seriously compromised, as in the case of complex cumulative trauma, these different states of mind become fragmented and incoherent.

CONCLUSION

The strength of attachment theory is its specificity. This theory focuses on the processes that lead to the development of secure interpersonal connections that create a foundation for:

• Being able to ask for help, expect well and trust others who have shown the capacity to be responsive and caring;
• Being able to provide loving care to others;
• Exploring the material and social worlds with confidence; and
• Being able to sense into the minds of others (empathy), and what is closely related, being able to gain perspective (reflect) on self, and on relations between self and others.
Like any other theoretical framework, attachment theory should be used with care and a light touch. It is more important to understand the logic of developmental processes and affect regulation strategies that lead to different attachment patterns than to pigeonhole people into attachment categories. We need to listen from the “bottom up,” seeing how the narrative and story lines unfold, and we need to listen from the “top down,” using clinical theories that help focus and illuminate human experience. As Kurt Lewin once put it, nothing is as useful as a good theory, but even a good theory has to be used with care and with an open mind.

REFERENCES


Main, M., & Hesse, E. (1990). Parents’ unresolved traumatic experiences are related to infant disorganized attachment status. In M. T. Greenberg, D. Cicchetti, &
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E. M. Commings (Eds.), Attachment in the preschool years: Theory, research, and intervention (pp. 161-182). Chicago: University of Chicago Press.


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