Applying attachment theory to psychotherapy practice

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In contrast to attempts to blend attachment ideas into a single unified therapy, GEOFF FITZGERALD has drawn upon attachment research, theory and practice to identify four dimensions of therapeutic practice within which attachment ideas can be organised as the cornerstones of an attachment-oriented psychotherapeutic practice. While attachment theory and practice does not hold an exclusive claim on any of these dimensions, it offers a unique contribution to understanding and applying them. By holding all four dimensions in mind when working with clients, practitioners can access and implement the depth and breadth of attachment theory and practice. A case study is used to illustrate these four dimensions. Several therapy models based on attachment theory are reviewed to consider how they illustrate and express these dimensions of attachment practice; schema therapy, brief dynamic interpersonal therapy, mentalization based therapy, emotionally focused couple therapy, and attachment-based family therapy.

John Bowlby quoted the social psychologist Kurt Lewin — ‘there is nothing so practical as a good theory’ — to imply that the utility of attachment theory should be self-evident (Bowlby, 1988, p. 42). Many therapy models utilise attachment theory, but some integrate attachment ideas more fully than others, and often quite differently. An enormous body of research and literature based on attachment theory has emerged in the last three decades. In its wake is the psychotherapy practitioner with the more modest, yet more crucial, task of applying attachment theory and research to everyday psychotherapy with clients.

A growing number of therapy models claim to integrate attachment ideas into their therapeutic models and many have somewhat manualised formulations and interventions. Attachment ideas are diverse and expansive, yet some therapy models can be reductive in their application of attachment theory and limited in scope. Like the proverbial elephant that is described inadequately by examining each separate small part, attachment ideas need to be appreciated in their entirety to be implemented fully in psychotherapy practice. Rather than trying to pin attachment ideas down into a single unified therapy, we can describe the dimensions of practice within which attachment ideas can be organised, keeping our practice open to the depth and breadth of this body of knowledge and practice wisdom.

Four dimensions of therapeutic practice identified here are:
1. considering symptoms in relation to the attachment system;
2. giving primacy to emotion and its regulation;
3. making meta-cognition a means and an end in therapy, and;
4. provision of secure attachment experiences in and out of therapy.

None of these dimensions of practice are, on their own, unique to an attachment approach. However, attachment literature brings its own contribution to each, and all four dimensions together constitute a framework for organising and applying the breadth and depth of attachment theory and practice.

This paper reviews attachment research, theory and practice to identify four dimensions of practice as the cornerstones of an attachment-oriented psychotherapeutic practice. Several key therapies grounded in attachment theory will be considered for how they express these dimensions of attachment practice. Some models have attachment theory as their very basis, others see attachment theory as a crucial dimension to their model.

Case study

Alison, a 24 year-old woman, was referred to counselling by her doctor for ‘depression, anxiety, possible panic attacks, and unresolved grief over the divorce of her parents’.

When Alison was sixteen, her mother abruptly moved out of the family home, began night-clubbing, and had a string of boyfriends. Alison’s father became depressed and withdrawn. Alison’s older sister had moved out of home with her partner and her older brother was on the way to moving out also. Around this time, Alison started having what she called
Attachment ideas are diverse and expansive, yet some therapy models can be reductive in their application of attachment theory and limited in scope.

She continued to have a fractious relationship with her family. Her mother kept up her exuberant lifestyle and her father moved on to a new marriage. Both seemed preoccupied by their new lives. When she had contact with them, Alison felt pressured and used. For example, her mother kept a dubious tally of all her financial contributions to Alison's living and educational expenses since the marriage break-up and often used this as a means to leverage favours or money from Alison. Alison still lived in the family home, waiting for her parents to make a decision about property settlement.

1) Considering symptoms in relation to the attachment system

One of the iconic concepts of attachment theory is the 'internal working model' (Bowlby, 1988), which contains our expectations of how current and future relationships will unfold, and how we will experience ourselves and others in that relationship. These symbolic representations of self and other determine how we edit, interpret, and anticipate our relationship experiences. Because these expectations shape our response to others, they also shape the actual relationship dynamics, and so become self-reinforcing.

Attachment literature is replete with related concepts. Baldwin (1997) refers to 'if-then contingencies'. Stern (1985) postulated 'representations of interactions that have been generalised' (RIGS) to describe patterns of experience and behaviour that originated in early infancy and that maintain a similar morphology later in life. Rafaeli, Bernstein, and Young (2011), pioneers of the schema therapy approach, regard schema therapy as a cognitive-experiential therapy that owes its taxonomy of categories of self and other schemas — and their related coping styles and modes of behaviour — to attachment theory's concern of patterns of self-other representations that stretch from early childhood into adulthood.

The notion of intra-psychic representations of self and other overlaps with object relations theory, but without the often complex layers of object introjections and projections. The degree of overlap depends on the extent to which the therapist is analytically oriented. Fonagy and his associates, while psychoanalytically oriented, have developed the attachment-based therapies of mentalization based therapy (Fonagy, Allen, & Bateman, 2008) and brief dynamic interpersonal therapy (Lemma, Target, & Fonagy, 2011) based on more straight-forward formulations of self and other. Brickman (2009) is one of many psychoanalysts who have moved from the less accessible formulations of object relations to the more 'experience-near' language of self and other and championed in attachment literature.

In recent years, some attachment theorists have expanded the notion of the internal working model to that of an 'attachment system' (Liotti, 2004; Fonagy et al., 2008). This is in recognition that self and other exist not only as representations within the mind of the individual, but also as an actual relationship between two or more people, and that these two dimensions are recursively informed by each other.

Various therapy models with an attachment emphasis ground symptoms in the attachment system.
in their own way. But common to all is the idea that the symptom is caused, maintained, influenced or interpreted by the recursive feedback loop between the intra-psychic self-other representations of an individual and their actual self-other interactions. This consideration of symptoms in relation to the attachment system is supported by two bodies of research evidence: 1) research that correlates symptom severity and prevalence with various attachment measures, including attachment category and ‘reflective function’ (Fonagy & Target, 1997), and 2) research that demonstrates how the treatment of attachment relationships both improves and protects against symptoms (see Fitzgerald, 2011).

Consider Alison’s ‘turns’. Alison and her therapist explored antecedents, associated cognitions and the relational context of these events. What emerged was a pattern of Alison feeling under pressure to compromise her needs in the face of the expectations of others. For example, her father and his new wife demanded Alison accept a business associate of her father as a boarder while she lived in what was once the family home. They came around to talk her into the arrangement. Rather than negotiate, Alison barricaded herself in the shower while she had her ‘turn’. She reported going numb and splitting off from the cajoling voices outside the door.

Liotti (2004) is one of a number of contemporary theorists who discuss dissociative phenomena from an attachment perspective. Liotti proposes a developmental thread that runs from disorganised attachment in early development, to a vulnerability to dissociation in later life and an unresolved attachment style in adulthood. Infants with ‘disorganised attachment’ are faced with the ultimate mixed message—the person most needed for secure attachment experiences is also the one most threatening in terms of either a possible hostile response or an abject lack of responsiveness. These other-representations can be carried on into relationships in later life, along with a tendency to dissociate when these relationships begin to mimic these inner representations. Alison related a story about her boss who expected her to work back continually without overtime pay. When her boss made this request on a day she had made important plans after work, she took herself off to the toilet to have a ‘turn’.

Attachment categories have been crucial for attachment research, but in psychotherapy practice they can be blunt and un nuanced descriptors of a client’s behaviour and experience.

Lemma, Target, & Fonagy (2011), in their formulation of brief dynamic interpersonal therapy, make explicit links between presenting symptoms and the attachment system (i.e., the recursive feedback system between intra-psychic self and other representations and actual self and other dynamics). They bring their formulations back to a consideration of how the presenting symptom is either created or reinforced by their attachment system. They articulate the defensive function that symptoms serve within the person’s attachment system. For example, they might consider Alison’s turns as serving a defensive function to protect her from an experience of her attachment figure as rejecting and abandoning. Being conscious of this other-representation may be too disorganising for someone still dependant on the remote beneficence of her parents.

In schema therapy, presenting symptoms are seen as maladaptive coping styles driven by representations of self and other that endure across the lifespan (Rafaeli, Berstein, & Young, 2011). For example, a schema therapy framework might describe Alison as holding a ‘subjugation’ schema (i.e., subjugating her needs to that of others to avoid abandonment), and as oscillating between the coping styles of ‘schema surrender’ and ‘schema avoidance’.

Emotionally focused therapy for couples (EFT-C)1 relies heavily on the symptom is the secondary reactive emotion of a person and their defensive behaviour driven by underlying attachment fears. The ‘internal working model’ is implied, though not explicated, by the assumption in EFT-C that secondary reactive emotions are linked to particular attachment vulnerabilities and these can be triggered reliably by the particular defensive behaviour of their attachment figure.

Few attachment proponents are explicit with clients about their actual attachment category. Solomon and Tatkin (2011), for example, will apply the Adult Attachment Interview (Main, 1995) to couples and talk about the outcomes, but they will mostly explore the clients’ unique set of self-and-other dynamics in the past and present. Attachment categories have been crucial for attachment research, but in psychotherapy practice they can be blunt and un nuanced descriptors of a client’s behaviour and experience.

During session, Alison was asked questions to help her articulate her intra-psychic representations of self and others. For example:

- Could you finish this sentence?
  ‘When mum asked me to repay $50 it...’

1 Emotionally Focused Therapy (EFT) and Emotionally Focused Therapy for Couples (EFT-C) are derived from similar experiential, systemic and attachment underpinnings (Greenberg & Johnson, 1988), however EFT-C is more integrated and explicit about relying on and applying attachment theory in both its theoretical considerations and techniques of intervention.

2 The three main adult attachment categories conceptualised in Mary Main’s (1995) research, are described in attachment literature as ‘secure or autonomous’, ‘avoidant or dismissive’, and ‘anxious or preoccupied’.
What did her request say about you as a person?

What would you have to believe about your needs in order to shut down like that in that situation?

What would the answer be if I could speak to this ‘turn’ and ask it ‘What are you there for? What is your purpose?’ (Eliciting the defensive function of the symptom — Lemma et al., 2011).

Alison was asked to sit in the unoccupied chair in the room. From there she imagined herself in a healthy adult or observer mode, watching herself in the other chair, noticing her usual compliant surrender mode (Rafaeli, Bernstein, & Young, 2011). She imagined herself saying ‘No!’ to demands (playing with alternative, more assertive self-representations) and telling herself that she could look after herself if she was rejected. She walked the room feeling the difference in her body position, her gait, and in the level of her shoulders between these two modes.

After a while her ‘turns’ began to change in quality. Where once she would hide away or give in when faced with trading off her needs for security, she now reported being overwhelmed by a great rage that scared her and others. This rage seemed to her to be as out of control and out of the blue as her dissociative ‘turns’. These nascent expressions of the ‘angry child’ mode identified by Rafaeli et al. (2011) were employed in therapy as building blocks for asserting boundaries and defining self-hood.

While some attachment-based therapy models focus on the intra-psychic dimension of self and other representations, other therapy models emphasise the actual dimension of self-other interactions. Schema therapy, brief dynamic interpersonal therapy, and mentalization based therapy place the therapist explicitly in the attachment system but do not consider working at the level of the client’s actual relationships with others. In contrast, EFT-C (Greenberg & Johnson, 1988) works explicitly with the actual self and other relationship, but is mute to the possibilities of the therapist-client alliance.

The advent in the literature of an attachment system has brought attachment proponents closer to family therapy practitioners who have, for many decades, appreciated the notion of recursive feedback loops within and between self and other. Several theorists have made attempts to bridge attachment theory and family therapy practice (Byng-Hall, 2008; Hughes, 2009; Israel, Diamond, & Siqveland, 2010).

Attachment Based Family Therapy (ABFT) is a manualised treatment approach for adolescents who are vulnerable to suicide and depression developed by Israel et al. (2010). At the time of her family’s schism, Alison may have benefited from the ‘reattachment task’ of ABFT that aims to enhance parental responsiveness and protectiveness, and from the ‘competency promoting task’ that aims to enhance her ability to verbalise her thoughts, feelings and needs to her parents (Israel et al., 2010). These theorists make the useful point that, by altering the interactional sequences in the actual self-other dynamics, intra-psychic self-other representations can be perturbed until new internal working models are forged.

Clearly, no one attachment-based therapy model has the final word on conceptualising the relationship of the client’s symptom with their attachment system. An appreciation of a range of attachment-based approaches provides a greater scope for formulating assessment and treatment.

2) Giving primacy to emotion and its regulation

Attachment approaches afford primacy to emotional experiences and their regulation, and formulate these emotions in terms of their relevance to a person’s attachment system. Emotions are seen as either generated or influenced by a person’s attachment system.

In privileging emotional material, many attachment-oriented theorists refer to the research of Le Doux, Panksepp and Damasio (see Fonagy, Gergely, Jurist, & Target, 2004; Johnson 2009; Solomon, 2009). Le Doux (1996) found that emotions can be experienced and responded to in the absence of neocortical involvement—they are phenomena in their own right and not mere by-products of cognitive processes. Damasio (1994) showed that emotions and body experiences actually organise cognitive reasoning, decision-making, and the experience of selfhood.

For Panksepp (1998) and Damasio, emotion and cognition may not even be indistinguishable.

Schore (2009) stresses the implicit
and unconscious nature of emotional experiences in and out of therapy; that emotions can be experienced and regulated without cognitive elaboration and without even outward expression. Schore argues that arousal and tolerance of emotional states is necessary to access pre-verbal, implicit memories and to allow cognitive elaboration and meaning-making to occur in therapy. Fonagy et al. (2008) make the point that emotions are ‘intentional’—they are related to or influenced by one’s attachment system and have a meaning and purpose that can be elicited in therapy.

Mikulincer, Shaver and Pereg (2003), outline a raft of research showing that cognition is mediated by both a person’s emotional state and their attachment style. For example, ‘securely attached’ individuals are more likely to utilise positive affect and to down-regulate negative affect to allow creative and cognitive strategies to thrive. ‘Anxious-preoccupied’ individuals are more likely to have negative cognitive responses activated by both negative and positive affect induction. ‘Avoidant individuals’ are more likely to be cognitively unresponsive to either positive or negative affect induction (Mikulincer et al., 2003).

Increasingly, many attachment proponents emphasise the idea that emotion is co-regulated by the attuned responsiveness of an attachment figure throughout the lifespan. Mikulincer et al. (2003), Schore (2009), Solomon (2011), Johnson (2009) all assert that emotions are regulated both by individuals and by attachment dyads, and that adults need to access both processes to regulate emotions and their attendant cognitions.

Attachment-oriented therapies place emotions explicitly at the coalface. The goals for doing so are:

1) to explore constructs of self and other, which are seen as best accessed in the context of emotional arousal;
2) to promote opportunities for experiencing interpersonal affect regulation;
3) to promote the client’s ability to self-regulate through re-appraisal of their affective experience.

Distinctions between therapies that claim an attachment basis can be drawn from how they emphasise each of these goals.

The two major treatment approaches developed by Peter Fonagy and his associates rely heavily on attachment theory and research. The concept of mentalization is an extension from their earlier work on reflective function (Fonagy & Target, 1997). Mentalization based therapy (Fonagy et al., 2008) was developed specifically for borderline mental states but has broader implications for therapy. This approach de-emphasises insight into patterns and past relationship dynamics, but seeks to enhance the client’s ability to reflect upon their emotional state and to consider more useful representations of self and other. Of central importance is the term mentalized affectivity (Jurist, 2005), which refers not just to making cognitive sense of emotions and their relationship to their attachment system, but also to the view that cognitive reappraisal is only effective while the client is in the midst of emotion. They refer to three dimensions of mentalizing emotion: identifying, modulating and expressing emotions. MBT also emphasises the crucial role of the therapist in providing interpersonal affect regulation to facilitate this mentalizing enterprise.

Brief dynamic interpersonal therapy (DIT) incorporates these ideas from MBT but also harks back to analytic ideas and practices, most notably the role of defences. DIT promotes old fashioned ‘insight’ into the client’s emotions through the continuous explication of their ‘interpersonal-affective focus’. DIT retains notions of mentalizing interventions but has a somewhat decentralised role for the therapist in affect co-regulation.

Schema therapy locates itself in a cognitive epistemology and as such sees emotions as by-products of cognitions (Rafaeli et al., 2011). None-the-less it discusses the way affect is entwined with schemas of self and other. It has developed and borrowed a raft of experiential techniques that emphasise the working through of emotional material in the presence of the therapist. Emotionally focussed therapy for couples (EFT-C) operates on the basis that secondary reactive emotions like anger must be accessed before softer primary emotional states such as grief and sadness can emerge. For example, Alison’s nascent rage can be seen as a secondary reactive emotion sitting above a core attachment need for being recognised as a person with unique and valid needs of her own that are separate from her attachment figure.

In EFT-C, unlike other attachment approaches, working the emotional seam is not so much for the purpose of gaining insight or for committing affect to cognitive awareness, but rather to change the quality of interactions between couples or family members. The goal is to draw empathy and engagement from important others experientially by expressing their needs in a less threatening or ‘softer’ manner (Greenberg & Johnson, 1988). Interpersonal affect regulation is promoted between couples rather than with the therapist.

The alliance building task of Attachment Based Family Therapy (ABFT) seeks to enhance the capacity of parents to empathise with their adolescent, and the re-attachment task seeks to facilitate nascent attempts by parents to help their young person to articulate their feelings and co-regulate their affect (Israel et al., 2010).

During the course of therapy, Alison started a relationship with a new boyfriend, Rodney, 23 yrs old. After a few months, their relationship became more serious and they became engaged. Because her symptoms were now emerging in that relationship, it was decided to include Rodney in the therapy.

Alison related her distress at her family’s rejection of her new boyfriend, Rodney, because of his Arab ethnicity. As she spoke about her sister’s racism, Alison went quiet and looked down at the floor. She moved her hands in short, agitated movements.

Therapist: “What are you experiencing right now, Alison?”

Alison: (After a long pause). “I don’t know. I guess I feel really frustrated. How could they talk about Rodney like that?”

Therapist: “What feeling do you think you are having as we talk about this?” (mentalizing affect).

Alison: “I’m not sure. Pissed off maybe?”
Therapist: “Would it be fair to say that you are feeling anger?”

(identifying—Jurist, 2005)

Alison: “Yaah. Yes, that's right. I'm really pissed off!”

Therapist: “Where in your body do you think this feeling is strongest?” (wanting Alison to help the therapist explore and articulate this feeling further—see Jurist (2005) on 'modulating' and 'expressing' emotion).

The therapist leads Alison to scan her body and then to focus on the muscles around her throat (working 'implicitly' with feelings—see Wallin, 2007, Schore, 2008).

Therapist: “So your anger seems to be heaviest around your throat? Is that where your muscles are most tense?”

Alison: “Yes” (voice is raspy and parched).

Therapist: “I notice your voice is very strained at the moment. I'm wondering if those muscles around your throat are trying to hold back your voice? I wonder what your voice would say if those muscles just let it out without holding back?” (again see Jurist (2005) on 'modulating' and 'expressing' the affect).

Alison: “It wouldn't be very nice? I don't think people would like it.”

Therapist: “Maybe you might say something others don't want to hear?” (mentaling self and other representations in the midst of aroused emotions).

Alison: “No…they definitely wouldn’t want to hear it.”

Therapist: “What's it like to have to hold back what you are thinking and feeling because others won't like it, or even worse, not like you?” (mentalizing Alison's ‘interpersonal-affect focus’— Lemma et al., 2011).

Alison: “It feels impossible. It feels like I've got all this anger that I can't have.”

Alison is articulating the double bind of her interpersonal-affective focus (Lemma et al., 2011)—her anger is both inevitable and unacceptable and risks censuring by important others. As she discusses this with the therapist, she becomes sadder and calmer, less angry and not as tense and jumpy—interpersonal affect regulation (Schore, 2008). In this sadness, Alison is also beginning to access softer, primary emotions (Greenberg & Johnson, 1988). ABFT argues that helping young people to articulate and voice their experience is an essential ingredient of affect regulation (Israel et al., 2010).

Working with emotions requires certain precautions. By raising and ‘heightening’ attachment-related affect, the therapist engages the client’s attachment system (Greenberg & Johnson, 1988; Johnson, 2009). From an attachment perspective, this is desirable and necessary. However, as Fonagy et al., (2008) point out, there is a tightrope for the therapist to walk between useful reflection of these emotions and the client being overwhelmed by them. This tightrope is, of course, most pronounced with clients prone to borderline mental states, whereby loss of affect regulation is triggered by a perceived injury in the self-other relational field. Many cognitive therapists eschew this focus on emotions on these very grounds. However, an attachment-oriented therapist will use their skills to amplify and down-modulate the client’s affect to a kind of ‘goldilocks’ level that facilitates reflection and reappraisal of self and other constructs.

3) Making meta-cognition a means and an end in therapy

Reflecting on cognitions is the cornerstone of several therapeutic paradigms. In the attachment domain, Main (1991) first championed the term meta-cognition to refer to a person’s ability to reflect recursively upon their thoughts and feelings and view them as mental representations or constructs that are influenced by beliefs, biases, emotions and interpersonal context, and as subject to change. For Main and others, this ability is fostered by a secure attachment context. Hence meta-cognition has become a focus for research of infant attachment development, as well as a focus for possible therapeutic interventions in a client’s attachment system. Main and other attachment proponents regard meta-cognition as the pathway for improving mental health and for gaining earned security (Wallin, 2007).

Fonagy and his associates have described an extensive body of research that links meta-cognitive development in infants with the quality of responsiveness by primary attachment figures (Fonagy & Target, 1997; Fonagy et al., 2004; Fonagy et al., 2008). They and others have used this research to inform therapeutic interventions in clients’ attachment systems at various life stages. Meta-cognition has been studied empirically as reflective function (Fonagy & Target, 1997) and more recently and extensively as mentalization. The concept of mentalization is the basis for a theory of emotional-cognitive development and for mentalization based therapy (Fonagy et al., 2004, 2008). While mentalization based therapy was developed primarily to treat borderline mental states, it can serve as a meta-approach to psychotherapy in general.

Both Main and Fonagy draw from the body of research into theory of mind (Wallin, 2007)—the developmental hallmark of being able to perceive the thoughts, feelings, mental processes and intentions of another person. Mentalization refers to the ability to appreciate one's own mental state (thoughts, feelings and intentions), the mental state of another, and the recursive interconnections between the two. It elaborates on Main's (1991) notion of meta-cognitive monitoring. The capacity for mentalization4 is a more effective predictor of mental health outcomes than attachment categories (Fonagy et al., 2008), and provides a conceptual bridge between attachment theory and the actual practice of psychotherapy. There is a direct relationship between a capacity for mentalization and an ability to regulate one's affect and access representational

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3 Keeping emotions not too ‘hot’ and not too ‘cold’, by employing techniques that keep emotions from being overwhelming, yet sufficiently activated for useful reflection.

4 Daniel Siegel (2010) coined a similar term — ‘mindsight’ — to describe reflective awareness of one’s mental state. Siegel also talks about ‘me maps’, ‘you maps’ and ‘we maps’ to integrate awareness of the interrelationship of mental states. Siegel, however, emphasises mindfulness training as a means to develop this capacity. Fonagy and others who use the term mentalization, emphasise the interpersonal context for the development of mentalization: both in childhood development and the therapeutic context.
and actual proximity to attachment figures in the face of disturbance and stress.

In the therapeutic setting, the enhancement of a client’s mentalizing capacity is dependent on four factors:

1) Their level of metacognitive development will determine how able they are to engage in reflecting on mental states and how able they are to co-generate, with the therapist, multiple perspectives of self and other. Interventions should be titrated accordingly.

2) Their level of emotional arousal needs to be at a moderate, ‘goldilocks’ level—not so ‘hot’ that the client is overwhelmed by affect, yet not so cold that reflections take on a remote, inauthentic quality.

3) An experience of the therapeutic space as a secure base and safe haven so they are able to tolerate activation of attachment vulnerabilities and reflect upon them.

4) Exploring and making sense of mental states is a collaborative activity, where the therapist’s own contribution is used tentatively to help the client to forge their representational constructs. This calls on the therapist’s ability to maintain a meta-cognitive stance during the therapy process and to intervene in ways that promote the client’s ability to reflect.

There are a plethora of techniques that can be used to enhance the metacognitive capacity of an individual. Fonagy et al. (2008) make the point that mentalization based therapy is a meta-approach that can encapsulate multiple therapeutic modalities, including cognitive behavioural therapy. Schema therapy is imbued with tools for reappraisal of cognitive and behavioural patterns, and of imaginal and experiential interpersonal coaching. However, it does not address the above four concerns of promoting meta-cognition. Schema therapy interventions can read as rather didactic affairs.

EFT-C emphasises mapping out and continually re-articulating the link between reactive emotions, primary attachment fears, and their recursive link with the attachment emotions and fears of the other person. Because these explorations are tied in with the emotional arousal of the client and titrated to their capacity to reflect in the moment, this approach is closer to that of Fonagy and associates.

Family therapy approaches are generally not explicit about enhancing clients’ meta-cognitive capacity. However, family therapy does offer significant contributions to enhancing implicit mentalizing in ways not featured in the mentalizing literature. Many schools of family therapy promote the validation of different perspectives of different family members, ask family members to speculate on the intentions of others, and to consider the alternate experience that other family members have of the same events. Many family therapy schools use reframing to articulate benign interpretations of the intentions of others—bolstering the mentalizing capacity of family members both implicitly and experientially. For example, in the relational reframe task of ABFT parents are moved from negative descriptions of adolescent behaviour to a consideration of how the family dynamic has either contributed or failed to mitigate that behaviour.

Consider the following encounter with Alison in a session with her boyfriend, Rodney.

**Therapist:** “So, Alison, you say that you are finding yourself getting increasingly angry with Rodney?”

**Alison:** “Yeah. Sometimes I just go mental!” (nervous laughter—poor articulation of affect, or mentalized affectivity)

**Therapist:** “Let’s go back to a good recent example of going ‘mental’. Describe to me what was happening.”

**Alison:** “Well I was just getting ready to meet Stacey down the pub and Rodney gets home and starts getting the shits with me and starts being a real arsehole. He starts telling me I’m being selfish. And then he tells me he wants to leave the relationship. I thought I was going to have a turn but instead I just went nuts.”

Fonagy et al. (2008) describe how poor mentalization can ascribe motivations as alien and external to oneself, such as Alison’s ‘turns’. It is also the case that poor meta-cognition usually results in narratives of incidents that are heavily edited toward the others negative behaviour and assumed malicious intentions.

**Rodney:** “It was Friday afternoon! We always get together on Friday afternoon. I couldn’t believe the way she was telling me to fuck off! Like she just couldn’t give a toss!”

Rodney also displays poor meta-cognition of intentions and emotions. However, Rodney’s alternate perspective provides a useful juxtaposition with Alison’s current interpretation of Rodney. At this point Alison interrupts and they both start arguing about who started the fight:

**Therapist:** (firmly) “Whoa!” (raises his hands toward the protagonists) “I might interrupt there” (firm mentalizing hand employed to down-regulate emotions—see Fonagy et al., 2008).

“I just want to get back to what you were saying, Rodney, about coming home to find Alison stepping out. I guess you must have felt disappointed” (explicitly inviting metacognition of primary attachment emotions).

**Rodney:** “Yeah! I was really looking forward to us relaxing together.”

**Therapist:** “When you feel let down by someone as important to you as Alison is, how might that show? What might I see in your face, or hear in your voice, or notice in your behaviour … if I was a fly on the wall?” (inviting Rodney to mentalize how others might experience his behaviour).

**Alison:** “I can tell you!”

**Therapist:** “I’m sure you can, Alison. But I would like Rodney to have a go at my question.”

**Rodney:** “Well, I guess I get pissed off!” (voice rising).

**Therapist:** “So you might look angry to someone looking on?”

**Rodney:** “Yeah pissed off!”

**Therapist:** “So your voice might rise like it is right now?”

**Rodney:** “I suppose so.”

**Therapist:** “So let me get this right. You were feeling really deflated and disappointed, but what showed outwardly was anger. Have I got it right?”

**Rodney:** “Yeah that’s it. That’s how it was. But she talks as if I was some kind of monster. She kept yelling at me about stopping her from seeing her friends.”

**Therapist:** “Right. Things get pretty heated usually. Can you have a go at finishing this sentence for me? When she accused me of controlling her and stopping her from seeing her friends it felt as if she saw me as …”

This was an invitation to the client
to co-construct the narrative of self and other in an, ‘as if’ curious way (Fonagy et al. 2008).

Rodney: (after some gentle prompting) “It felt as if she thought I was some horrible person who would control her like that.”

Therapist: “It must have felt like you were being painted to be a really bad guy?”

Rodney: “Yeah.”

Therapist: (turning to Alison) “Did you realise at that time that he was feeling really disappointed and down about you going out and then he felt really alarmed that you saw him as a controlling guy?”

Alison: “I just wanted to see my friends. I tested him. It wasn’t my fault that he didn’t see it” (Alison’s emotions are aroused here and she is not mentalizing well).

Therapist: (calmly, persistently) “Alison, can I get you to consider what I am saying more closely? When he saw you were going out, he got really down and disappointed underneath. All you got to see was his anger. But beneath this he was really upset and flat about missing out on being with you. Instead of showing that, he argued with you about you going out. As a result you felt controlled. You might well have felt old feelings of having to choose what you want for yourself or having to choose your relationship with the most important person to you in the world. Normally you might shut down when you are faced with such an awful choice but sometimes inside you switched to anger and rage. Some part of you decided not to accept this awful choice.”

This is similar to the infinity cycle of EFT-C where interlinking defensive behaviour and contingent attachment vulnerabilities are articulated and co-constructed with both partners (Greenberg & Johnson, 1988). This process helps clients to mentalize both their own and the other’s intentional stance and reframe the other’s actions from malicious intention to a more benevolent intention.

Attachment researchers have linked infant attachment research to its application in psychotherapy. Tronic (1998), renowned for his ‘still-face’ experiments, argues for the importance of interactional synchrony in both parent-infant and therapeutic settings to allow individual mental states to come under the influence of the mental state of the other and to achieve greater complexity and coherence. Beebe and Lachman (2002) demonstrated the need for a ‘mid-range tracking’ of the mental state of the child/client, between the extremes of intrusive engagement and poorly timed and inaccurate attentiveness. Fonagy et al. (2004) have shown that mirroring requires a ‘marknessed’ quality—a responsiveness that reflects back to the child/client what their experience is, that their experiences is understood and matters, but that it is their experience and not the experience of the parent/therapist. Schore (2008) is well-known for writing about intersubjective affect regulation with parent/therapist through repeated cycles of attunement, misattunement, and reattunement. Wallin (2007) outlines three core attributes to the provision of safe haven responses: 1) that the cause of their distress is understood; 2) that by maintaining one’s own emotional equilibrium the parent/therapist allows the child/client to borrow functioning, and; 3) that their intentional stance or benign motivation is mirrored back to them. For Fonagy et al., (2004), this mirroring of the intentional stance of the child/client is crucial for the emergence of personal and interpersonal agency.

By working with raised emotions and attachment vulnerabilities, and providing attunement and mirroring, the therapist has not only activated the

This process helps clients to mentalize both their own and the other’s intentional stance, and reframe the other’s actions from malicious intention to a more benevolent intention.

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Therapist: “So it sounds like you felt rather hogged down with them.”

Alison: (pause) “Yeah, I mean they were nice and everything but I don’t know how much good it did. Sometimes it felt like I was just there to feel miserable.”

Therapist: “I’m wondering if it felt like you had to meet the expectations of the therapist?”

Alison: “Yes! And I feel a little that way with you as well sometimes.”

Therapist: “I’d like to understand that better. Can you give me a recent example when you felt like this with me.”

Alison: “I dunno…” (pause) “I don’t remember a recent example” (Alison raises her hands petulantly and uses her fingers as quotation marks as she says the word ‘example’).

Therapist: “Maybe you feel a little hassled by me to come up with something?”

Alison: “Sometimes you get a little pushy.”

Therapist: “Do you think that is what happened before when you shut-down and couldn’t speak?”

Alison: “Uh-buh.”

This vignette shows that Alison’s self-other representations are beginning to emerge in therapy and are playing a part in shaping the therapist’s behaviour toward her. The therapist

PSYCHOTHERAPY IN AUSTRALIA . VOL 20 NO 3 . MAY 2014
is at risk of pushing for responses from Alison in the belief that this is what she needs from him in order to articulate her thoughts and feelings. Yet he is inadvertently re-creating the conditions for dissociation in the therapy room. As the proponents of ABFT stress, allowing Alison to articulate and voice her concerns in this way is an essential part of secure base provision.

Of the attachment-oriented therapies, Fonagy and associates are most explicit about the provision of a secure attachment environment in therapy. Both their MBT and DIT emphasise the importance of working skilfully in the transference without asking the client to be acculturated to psychoanalytic dogma. Schema Therapy perhaps goes further by providing 'limited re-parenting' and 'corrective experiences' through attending to and providing the client’s attachment needs. This includes ‘guided imagery’ exercises that place the therapist as their safe and reparative attachment figure. EFT-C, deemphasises the role of therapist as an attachment figure and emphasises the role of partners as secure attachment figures. Nevertheless, the EFT-C therapist is trained to provide the kind of attunement and mirroring that is inherent in secure base provision. ABFT, in its alliance building task, recognise that therapists need to provide a safe haven for both adolescent and parents to reflect about themselves and the other party before they can facilitate parents to reclaim this role for their young person.

One of the underpinnings of an attachment approach is intersubjectivity—the process of two minds being under mutual influence (Stolorow, Atwood, & Brandschaft, 1994). Intersubjectivity refers to both a developmental capacity of an individual and an experiential process in attachment relationships. In secure attachment environments, one experiences the attachment figure as attuned, caring, positively disposed, able to perceive one’s mind with reasonable accuracy, and willing to repair when schisms occur. It is an experience of being ‘in the mind of the other’ (Wallin, 2007), with a mutual knowing that both people are aware of and want.

For Stern (2004), ‘This involves the mutual interpenetration of minds that permits us to say, “I know that you know that I know”’ or “I feel that you feel that I feel”. There is a reading of the contents of the other’s mind. Such readings can be mutual. Two people see and feel roughly the same mental landscape for a moment at least. These meetings are what psychotherapy is largely about’ (p. 75).

By holding an awareness of intersubjectivity in the therapeutic setting, several interrelated corollaries follow:

First, the therapist takes an active stance in therapy, whether they realise it or not. This stands in contrast to Freudian notions of the therapist as ‘blank screen’, and to more recent notions of the ‘scientist-practitioner’ who assesses clients lineally and then prescribes treatment regimes.

Second, the techniques championed by the therapist should be held lightly, with the therapist being able to tailor their level of involvement and techniques to the client’s needs. For example, more avoidant clients may prefer a less-involved, more outcome-focused ambience. Others will want, and require, a greater experience of being attuned to and ‘held’ in the Winnicott sense. Fonagy et al. (2008) recommend we adjust whatever approach we use to the meta-cognitive capacities of the patient. For example, more emotionally-overwhelmed clients or borderline mental states will require more emphasis on reflecting on feelings and constructs rather than insights about past events or enduring patterns.

Third, if we accept that both therapist and client are under mutual (though not equal) influence then we can appreciate how the client’s meaning system is co-constructed with the therapist in an emergent, heuristic manner. Fonagy et al. (2008) and the family therapist Harlene Anderson (1992) both refer to ‘a not knowing stance’ to describe a way to offer the therapist’s expert ideas tentatively as an emerging dialectic between therapist and client. Such an approach enhances the client’s ability to reflect upon their mental state and their therapist’s mental state—thus enhancing their meta-cognitive capacity.

Fourth, it should be remembered that intersubjectivity occurs both implicitly and explicitly (Schore, 2009). This means that one can provide a secure base in therapy and work with the transference field by discussing it explicitly with clients, by referring to it obliquely, or without even mentioning it at all. Again, a therapist’s approach should be governed at least as much by the needs and expectations of the client as their own theoretical approach.

Fifth, the notion of intersubjectivity has its own built-in caution. Intersubjectivity creates an analogue of intimacy. This requires the therapist to be good with their boundaries—able to maintain their differentiated sense of self while staying attuned to clients with aroused affect. It also requires caution when working with borderline mental states, when clients may not read the meta-messages of when this intimacy begins and ends, nor the meta-rule of therapy (Bateson, 1972) being an ‘as if’ analogue of intimacy. Of the attachment oriented therapies, mentalization based therapy has the most to say about managing these dynamics with general advice to slow down such enactments, to explore and repair schisms, and clarify antecedent behaviours and interpretations.

Conclusion

In contrast to attempts to pin attachment ideas down into a single unified therapy, attachment research, theory and practice have been drawn upon to identify four dimensions of practice within which attachment ideas can be organised as the cornerstones of an attachment-oriented psychotherapeutic practice. Attachment theory and practice does not hold an exclusive claim on any one of these dimensions. It does, however, offer its own unique contributions to understanding and applying them. By holding all four dimensions in mind when working with clients, practitioners can access and implement the depth and breadth of attachment theory and practice.

No one model of therapy captures this breadth and depth. They all have different emphases and ways of expressing these four dimensions of attachment practice. The practitioner must step beyond the confines of the formulations and interventions of single therapies if he or she wants to
put attachment theory into practice.

By doing so, our practice with clients remains open to this rich body of knowledge and practice wisdom.

References


AUTHOR NOTES

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