

Attachment in Psychotherapy

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- classified reveal a “global disorganization or collapse of a singular or consistent discourse strategy that runs throughout the interview” (Main et al., 2005, p. 285). Research has shown that the cannot classify category is associated with adult lives marked by psychiatric disturbance, violence, and sexual abuse (Hesse, 1999).
4. Secure attachment is represented by the upper-left-hand quadrant as securely attached individuals are neither avoidant in their behavior nor anxious about abandonment. Ambivalent/preoccupied attachment is represented by the upper-right-hand quadrant because individuals with this pattern are anxious about abandonment yet seek closeness rather than avoiding it. Avoidant/dismissing attachment is represented by the lower-left-hand quadrant: Adults with this pattern appear to be without anxiety about abandonment, yet their behavior is avoidant. The lower-right-hand quadrant, finally, represents what social psychologists call fearful-avoidant attachment: Overlapping with Main’s disorganized and unresolved classifications, the pattern of fearful avoidance involves both avoidant behavior and abandonment anxiety.

CHAPTER 7

How Attachment Relationships Shape the Self

... one's experiences of relations with others becomes a feature of one's relations with oneself.

—PETER HOBSON (2002, p. 180)

The human infant is an extraordinarily vulnerable and dependent creature. Infants are unequipped with the advanced neural gear necessary to manage on their own the bodily, emotional, and environmental challenges of life outside the womb. To survive, they require the protection of what Bowlby (1988) called “stronger and/or wiser” others (p. 121). Beyond physical survival, infants need attachment figures to help them in forming and maintaining that stable point of reference known as the self.

The infant’s utter dependence means that adapting to attachment figures—with their idiosyncratic strengths and vulnerabilities—is mandatory. And because the infant *must* adapt, the infant *will* adapt. (Of course, good-enough attachment figures tend to return the favor, by adapting to their infants: hence, the empirical finding that relationships of attachment are co-created.) Ainsworth’s research is essentially a documentation of the variety of adaptive strategies infants develop in order to gain the protection that flows from proximity to their attachment figures.

The infant’s automatic adaptations to attachment figures clearly have roots in survival imperatives and instincts. (Recall that the newborn is preequipped at birth with brainstem-based reflexes that jump-start the attachment process.) Yet attachment is driven every bit as much by the need

for felt security. Because infants are incapable of manufacturing their own felt security, they need attachment figures to help them manage their difficult emotions.

This emotional management is called *affect regulation*. The psychological fate of the infant (in attachment terms, her security or the lack of it) depends largely on the relative success or failure with which first relationships regulate the infant's affects. From this angle, adaptive attachment strategies can also be seen as strategies of affect regulation that will shape the self in fundamental and pervasive ways.

The self of the developing child emerges as a function of these adaptive strategies and the specific feelings, thoughts, and actions for which the child's first relationships of attachment can effectively make room. The expressions of the child's self that evoke the attachment figure's attuned responsiveness can be integrated, while those that evoke dismissing, unpredictable, or frightening responses (or no responses at all) will be defensively excluded or distorted. What is integrated can then enjoy a healthy maturational trajectory; what is not tends to remain undeveloped.

Attachment relationships are crucial to the process of integration.¹ The difficulties that bring patients to treatment usually involve unintegrated and undeveloped capacities to feel, think, and relate to others (and to themselves) in ways that "work." With this in mind, Bowlby (1985) characterized the psychotherapist's task as follows: "Our role is in sanctioning the patient to think thoughts that his parents have discouraged or forbidden him to think, to experience feelings his parents have discouraged or forbidden him to experience, and to consider actions his parents have forbidden him to contemplate" (p. 198). The role of the clinician is, in short, to facilitate integration and, thus, the resumption of healthy development, starting usually with emotional development.

AFFECT REGULATION AND ATTACHMENT STRATEGIES

The quality of the caregiver's response to the infant's affects is vitally important in determining the nature of the predominant attachment strategy—secure or insecure—that the infant adopts. In the case of secure attachment, the responses of the caregiver help both to alleviate the infant's distress and to amplify her positive emotions. As a consequence, the infant experiences the attachment relationship as a context within which affects can be effectively regulated. What registers internally, then, will be a visceral sense that connection to others can be a source of relief, comfort, and pleasure. What also registers is a sense that the self—in expressing its full range of bodily and emotional experiences and needs—is good, loved, accepted, and competent.

The process of affect regulation here is one in which the infant, through a kind of "social biofeedback," comes to associate the initially involuntary expressions of her emotions with the responses of the caregiver. That is, the infant comes to "know" that her affects are responsible for evoking the caregiver's affect-mirroring responses. Thus, in the most desirable scenario, the infant is learning a number of very useful things: (1) that expressing her feelings can bring about positive outcomes—which generates positive feelings about the self and others; (2) that she can have impact on others—which generates a dawning sense of agency or self-initiative; and (3) gradually, that *particular* affects elicit particular reactions—which helps her begin to differentiate and eventually name her feelings (Fonagy et al., 2002). A relationship of secure attachment can thus be seen as a school in which we learn to effectively regulate affects not only in early childhood but throughout our lives.

The secure pattern I've just sketched reflects what Main calls the *primary attachment strategy*. A biologically preprogrammed product of evolution, it mandates the seeking of proximity to an attachment figure whose affective attunement enables the infant to experience her both as a safe haven at moments of alarm and as a secure base whose availability makes autonomous exploration possible. When, however, the infant's emotional signals evoke misattuned responses from the caregiver that discourage either proximity seeking or autonomy, then this primary attachment strategy will be rejected. More accurately, it will be modified to adapt to the particular vulnerabilities of the (insecure) caregiver: The infant will develop a *secondary attachment strategy* that reflects either a *deactivation* or a *hyperactivation* of the attachment behavioral system. These strategies of infancy can also be seen as the forerunners of psychological defenses that originate in the child's necessary, if sometimes failed, efforts to make the best of a bad situation—that is, to adapt to attachment figures whose own defenses have compromised their ability to interactively regulate the child's affects (Main, 1990, 1995; Mikulincer & Shaver, 2003).

Deactivation is seen in infants classified as avoidant and also in adults whose state of mind is described as dismissing. In contrast, hyperactivation is the adaptive strategy of infants who are ambivalent and adults whose state of mind is preoccupied. Disorganized infants as well as unresolved adults may oscillate between strategies of hyperactivation and deactivation.

As a rule, a predominantly deactivating strategy arises when the parents' responses to the child's attachment-related affects are aversive. Here the child's signals of distress and bids for proximity have evoked reactions that are rejecting and/or controlling. In rejecting her bids for proximity, the parents fail to restore the child's emotional equilibrium, while their intrusiveness can leave the child feeling emotionally overaroused (Sroufe, 1996). In neither case has she received help in managing her difficult feelings—

quite the contrary. In order to maintain the best possible attachment relationship under these circumstances, the child learns to overregulate her feelings and their expression, and to distance from her impulse to connect.

You might think here of obsessive, narcissistic, or schizoid patients whose emotional range is narrow, who can appear more or less blind to the affective signals of others, and whose flattened responsiveness can make them seem low on life—a little as if they were playing dead. Siegel (1999) has suggested that in adults, this avoidant, deactivating strategy is reflected in a bias toward left-brain and parasympathetic nervous system activation.² What remains unintegrated in patients with such a strategy are all the emotions, desires, and satisfactions associated with intimate relationships. Needless to say, the avoidance of closeness constricts the development of their capacities for deep feeling, sexual expression, healthy dependency, and trust.

By contrast, the hyperactivating strategy of ambivalent infants appears to be organized around the pursuit of closeness. Adapting to parents whose responsiveness to the infant's emotions is unpredictable and/or misattuned, the child learns that amplifying her affects increases the likelihood of engaging her parents' attention. Yet the quality and quantity of attention evoked does not usually match the child's needs. So she learns not only that her bids for support often fail to produce the desired result, but also that to gain comfort she may have to maintain her expressions of distress at a consistently high volume. In short, she learns to keep the attachment system chronically activated.

The hyperactivating strategy of patients we might see as hysteric or borderline may well reflect their preoccupation with the perceived unavailability of attachment figures (past and present) whose help they have sought to gain by maximizing their displays of distress. Unfortunately for such patients, their need to keep the attachment system chronically activated makes them hypervigilant and prone to exaggerate the presence of threats—particularly threats of abandonment. As with the deactivating strategy, the price of protection here is high. Encouraging a sense of personal helplessness, the strategy of hyperactivation precludes the integration of positive feelings about the self or others for at least two reasons. First, such feelings risk *deactivating* the attachment system upon which emotional survival has come to depend. And second, overdependency undermines self-esteem and tends to provoke the very abandonment it is unconsciously intended to avert. Hyperactivating defenses also undermine the development of mutuality in relationships, autonomy in thought or action, and, of course, affect regulation. Relatedly, habitual resort to hyperactivation may lower the threshold for triggering the sympathetic nervous system and diminish the capacity to exert cortical control over emotional reactions. The implication is that our preoccupied patients may need us to help them modulate their emotional reactivity and strengthen their capacity to manage their emotions by making sense of them.

Disorganized attachment is generally seen to reflect the breakdown of an adaptive strategy on the part of a frightened infant instinctively driven to seek proximity to a frightening parent. Yet Main (1995) also notes as evidence of disorganization the sequential or simultaneous display of contradictory behavior patterns:

An example observed in a maltreated infant consisted of a strong display of attachment behavior (running crying to parent with arms outstretched, followed inexplicably by avoidance (infant suddenly stops, turns her back to the parent, silent). (p. 423)

Correspondingly, it has been suggested that unresolved adults have learned to resort to both deactivating *and* hyperactivating strategies. Such adults frequently have a history of trauma in relation to attachment figures that evoked both an avoidance of closeness and a terror of abandonment (Mikulincer & Shaver, 2003). Patients like these are torn by conflicting impulses (to avoid others out of fear of attack, to turn desperately to others out of a fear of being alone) and often experience their feelings as overpowering and chaotic. As therapists, it can be very helpful to realize that the apparently self-destructive behavior of such patients represents their past and present attempts to contend as self-protectively as possible with these contradictory impulses and overwhelming feelings. The integration we are called on to facilitate here has multiple dimensions, including (but not limited to) the integration of traumatic experience and dissociated affects, as well as the mending of splits in these patients' images of self and others. Making this integration possible depends upon our ability to generate an increasingly secure attachment—a haven of safety and secure base—that can itself become the primary source of the patient's ability to tolerate, modulate, and communicate feelings that were previously unbearable.

In summing up the influence of attachment figures on the development of their offspring (and, by extension, the influence of therapists on their patients' development) it may be useful to recall the perspectives of Fonagy and Main. Per Fonagy, the parents' impact is a function of the quality of their affect-mirroring and their ability to "contain" their child's distress through responses that convey empathic understanding, a capacity to cope, and awareness of the child's emerging intentional stance. The mirroring provided by secure parents is both contingent and marked. Noncontingent mirroring may be associated with avoidant attachment and the "pretend" mode of experience; unmarked mirroring may be linked to preoccupied attachment and the mode of psychic equivalence. In general, security begets security, while the defensive strategies adopted by parents tend to be passed on to their children.

From Main's perspective, security develops as a function of the parents' sensitive responsiveness to affective expressions of the child's need

both for proximity, on the one hand, and autonomous exploration, on the other. Insecurity results when dismissing parents discourage their children's attachment behavior or when preoccupied parents discourage their autonomy. The emotional logic of such parenting flows, according to Main, from the insecure parents' unconscious need to preserve their existing state of mind in regard to the childhood experience they had with their own parents. (This need may partly explain the paradox that while many of us are critical of our parents' parenting, we usually duplicate aspects of that parenting, all our conscious intentions notwithstanding.) Dismissing parents, for example, may ignore, reject, or attempt to suppress their baby's tearful bids for contact and connection because they trigger, outside awareness, anxiety-provoking associations to the painful inadequacies of their own parents' responses to them when they were children.

Parents and therapists alike have the potential to foster a mutually reinforcing synergistic relationship between affect regulation and attachment. To the extent that the parent can attune to the child's emotional signals, there is the potential to respond effectively to the child's emotional needs (either by relieving her distress or visibly enjoying her pleasure). In doing so, the parent strengthens the attachment bond. In turn, the parent—experienced increasingly as a safe haven and secure base—becomes more and more capable of helping the child to access, modulate, differentiate, and use her emotional experience. Much the same can be said of the therapist in relation to the patient.

Attachment figures help their “developmentally disadvantaged” partners (children, patients) to evolve patterns of affect regulation that both shape and are shaped by patterns of relationship. If a child gets help with the feelings he expresses, he will tend to become comfortable and skilled at knowing and showing what he feels—which is, in turn, a big part of knowing how to have a secure relationship. Schore's (2003) definition of attachment as “the dyadic regulation of emotion” (p. 256) underscores that healthy development hinges on a relationship that makes room for, and helps make sense of, the child's emotional experience—or, in psychotherapy, the emotional experience of the patient.

RELATIONAL PROCESSES AND DEVELOPMENTAL DESIDERATA

The word “desideratum” is defined as “something desired that is essential” (Merriam-Webster Dictionary, 2003). Much of the contribution of attachment theory research—to parenting and therapy alike—lies in its identification of the relational desiderata linked to the development of a secure and integrated self. The underlying assumption here is that, early in life, lived patterns of interaction and affect regulation register internally as representations of various sorts that shape our future responses to experience in

more or less persistent ways. In what follows we'll explore how these patterns are internalized and attempt to identify the sorts of experiences that most effectively foster healthy development.

Bowlby hoped his work might help parents to provide the kinds of relationships that would enable their children to become secure and resilient. Initially he emphasized the importance of the parent's accessibility to the child at times of need. Later, in light of Ainsworth's research highlighting the centrality of the parents' sensitive responsiveness to the infant's nonverbal signals, Bowlby stated that parents must be responsive as well as accessible. The question, of course, is what it means to be “sensitively responsive” as a parent or, for that matter, as a therapist.

With regard to infants, Ainsworth's research is particularly informative. Babies whose crying during the first three months evoked the most prompt and frequent responses of soothing from their parents were, at 12 months, the children who cried least and were most secure. (So much, perhaps, for letting our babies cry.) Ainsworth also highlighted the “attachment/exploration” balance and “secure base” behavior that was successfully fostered by parents equally comfortable with the infant's needs for proximity and autonomy (Ainsworth et al., 1978).

As for life beyond infancy, the attachment researcher Karlen Lyons-Ruth (1999) culled the literature, distilling the empirical findings into a framework for what she calls “collaborative communication.” Such communication generally enabled children to develop security, flexibility, and coherent internal working models of attachment. Her framework has four elements.

First, the caregiver should be receptive to the whole range of the child's experience (not just her expressions of distress) and should attempt to learn as much as possible about what the child feels, wants, and believes. Clearly, this kind of openness or inclusiveness can foster the integration so central to attachment theory's understanding of healthy development. Second, the caregiver should initiate efforts at repair when the relationship with the child is disrupted. Doing so builds the child's expectation that, through interaction with others, her lost emotional equilibrium is likely to be restored. Third, the caregiver should actively “scaffold” the child's emerging abilities to communicate—initially, say, by attempting to put into words what the preverbal child cannot yet articulate and, later, by asking the child to “use your words.” Fourth, the caregiver must be willing to actively engage with the child, to set limits and allow the child to protest, during periods when her sense of herself and others is in developmental flux. This willingness to struggle makes possible for the child the experience of staying connected even while feeling separate.

The fact that collaborative communication depends on “getting to know another's mind” (Lyons-Ruth, 1999, p. 583) recalls Fonagy's observation that the parents of securely attached children appear capable not

only of empathizing and coping with their child's distress, but also of recognizing the "intentional stance" of the child. That is, they can respond to the child's behavior in light of the feelings, beliefs, and desires that seem to underlie it. Even when the behavior in question is at odds with their own wishes, these parents can respond as if aware of the *context* within which the behavior of the child can be seen to make sense. (Note that these are usually parents who can mobilize a well-developed reflective or mentalizing self.)

Many writers stress the importance in developmental relationships of "contingent communication"—that is, communication in which the caregiver's response to the child matches, fits, or resonates with the child's emotional experience. From birth if not before, according to Trevarthen, Fonagy, and others, the human being is a "contingency detector" whose original preference for perfect stimulus-response contingencies shifts at roughly three months of age:

Whereas infants' initial focus on perfect contingencies enables them to discover their bodily self in the physical world, their subsequent focus on highly but imperfectly contingent social responsiveness enables them to discover their mental self in the social world. (Allen & Fonagy, 2002, p. 9)

When, subjectively speaking, the caregiver actually *shares* in a version of the child's experience, such contingent communication allows the child to "feel felt," in Siegel's (1999) evocative phrase. Stern covers related ground with his notion of *affect attunement* suggesting that a significant part of what enables a child to feel that her subjective states are valid and sharable are parental responses that echo her emotional experiences, but—crucially—in a different sensory register. This cross-modal responsiveness (the child squeals with joy and her mother's body answers with a responsive shimmy) allows the child to feel known—without it, she may only feel imitated.

Communication that is collaborative, contingent, and affectively attuned is the heart of the prescription to parents who would provide for their children the experience of a secure base. Needless to say, the effort to facilitate this quality of communication is no less vital in psychotherapy than in parenting. As Bowlby (1988) wrote, "unless a therapist can enable his patient to feel some measure of security, therapy cannot even begin. Thus we start with the role of the therapist in providing . . . a secure base" (p. 140).

The affectively attuned responses of the parent or therapist that help the child or patient to feel felt may depend upon what Schore (2003) calls "right-brain-to-right-brain communication" (p. 50). His notion is that our receptivity and responsiveness to the affective signals of others are a product of the right brain's capacity (largely through the orbitofrontal cortex) to

process emotion that is expressed nonverbally—that is, through facial expression, tone of voice, posture, gesture and so on. A patient of mine put it this way, "I say something and then you get this look on your face, so I *know* that you know what I feel."

I believe Schore is right when he suggests that a particular frame of mind is called for if the parent or therapist is to be capable of such right-brain communication. In this connection, he alludes both to Freud's recommendation that the analyst function from a stance of "evenly hovering attention" and to Bion's notion that effective clinicians must have access to their own "reverie." Certainly it has been my experience in relation to my patients and children alike that my ability to tune in emotionally hinges on my capacity to be quite fully present—open and in the moment—rather than preoccupied or distant. In the parent or therapist, such receptive states of mind—which I'm tempted to characterize as "mindful"—seem to engender responses that flow naturally from the requirements of the moment including, in particular, the emotional needs of the child or patient.

Repeated experiences of such emotionally attuned responsiveness contribute to positive expectancies that may gel as increasingly secure internal working models. Put differently, such experiences are lessons in how to have a comfortable and effective relationship—with oneself and one's emotions as well as with others.

It's worth emphasizing here that as a parent or therapist, it is not necessary to be always and perfectly attuned: In this connection, good enough will certainly do. As Stern (2002) has facetiously but instructively noted, it is an empirical finding that the very best mothers generally make a mistake with their infants at least once every 19 seconds. Stern's Change Process Study Group (2005), Beebe and Lachmann (2002), and a host of self psychologists agree that what is more important than avoiding the disruptions that are an inevitable feature of relationships is tolerating and repairing them. In fact, such sequences of disruption and repair, misattunement and reattunement, are vital interactions whose internalization specifically encourages confidence that misunderstandings can be resolved—and, more broadly, that distress can be weathered, because it can be relieved.

CO-CREATION, INTEGRATION, AND INTERSUBJECTIVITY

Thus far we've been looking at what the research tells us about the kinds of responsiveness conducive to the development of a secure and integrated self. Clearly, there are valuable insights here with regard to the stance and behavior that parents in relation to their children—and therapists in relation to their patients—might deliberately attempt to adopt. They include contingent, affectively attuned communication (Siegel, 1999; Stern, 1985);

an approach that conveys empathy, an ability to cope, and an appreciation of the child's "intentionality" (Fonagy et al., 1995); a framework of response that embodies *inclusiveness* in relation to the breadth of the child's subjective experience, *scaffolding* of the child's emerging capacities, a *readiness to initiate repair* when there is disruption, and a *willingness to struggle* with the child when necessary (Lyons-Ruth, 1999).

But it is important to note that—as the “collaborative” part of Lyons-Ruth’s framework of collaborative communication implies—a developmentally oriented relationship is never the exclusive creation of one partner or the other. Thus, infant–parent relationships have been described as mutually regulated and co-created. The studies of Jaffe, Beebe, Feldstein, Crown, and Jasnow (2001), Tronick (1989), Sander (2002), and others all conclude that mother and infant constitute a dynamic system in which each partner’s conduct affects, and is affected by, the conduct of the other. It’s probably no accident that the conclusions of infant–parent research dovetail with those of clinical “researchers” in the relational/intersubjective tradition (Mitchell, 1995; Stolorow et al., 1987; Aron, 1996) who identify “mutual reciprocal influence” as a pervasive feature of the interactions between patient and therapist.

Of course, the degree of influence that a parent exerts in a developmental relationship is generally thought to be greater than that exerted by the child. For example, studies have shown that sensitively responsive parenting can transform infants assessed at three months as temperamentally “difficult” (hard to soothe or arouse) into children who were reassessed at 12 months as “easy”; likewise, when parenting is problematic, so-called easy temperaments have been shown to become difficult (Belsky, Fish, & Isabella, 1991). In addition to having greater influence, the parent has, of course, greater responsibility for helpfully shaping the relationship with the child and, ideally, greater flexibility when it comes to doing so.

Granting these differences, each partner nonetheless has a reverberating impact on the other that generates coordinated and mutually regulating patterns of communication in the interaction of the two. Parent and child “track” each other, lead and follow, take turns, and mirror each other (or fail to) in patterns that are distinctive for every dyad. These patterns reflect the affective attunement of the partners and the quality of contingent responsiveness between them—that is, the degree to which the responses of each partner are contingent upon, or a fitting match with, the initiatives of the other.

Research clearly documents such co-constructed patterns in the face-to-face communication between mothers and infants at play. Sequences of match, mismatch, and repair are seen to occur with split-second coordination. Studies using split-screen video (with the baby’s face and torso on one side and the mother’s on the other) have revealed such an exquisite syn-

chrony of vocal as well as facial expressions that each partner’s behavior in the interaction can be predicted, in twelfth of a second increments, from that of the other. Infants at four months were videotaped interacting with their mothers and at 12 months were assessed using the Strange Situation protocol. Of greatest interest is the finding that what differentiates relationships that foster secure attachment from those that do not is the *degree* of bidirectional coordination in the dyad.

Security at one year was predicted when tracking between mother and infant was in the midrange—such that coordination was “present but not obligatory” (Beebe & Lachmann, 2002, p. 104)—while insecure attachment was predicted when tracking was at either a high or low level. High levels of coordination seemed to reflect excessively vigilant monitoring of the partner, while low levels appeared to indicate withdrawal, inhibition, or simply a lack of fit between the partners. Optimally, in other words, the contingent responsiveness in the communication of infants and parents is close but not perfect. This has implications for psychotherapy as well as parenting.

Beebe and Lachmann help to clarify these implications when they discuss this research in terms of the balance between *interactive regulation* and *self-regulation*. In interactive regulation, one partner focuses on and “uses” the responses of the other to manage his or her own internal states of emotion and arousal. (The infant seeking relief from distress, for example, may tune in to the soothing cadences of the mother’s voice.) In self-regulation, by contrast, states of emotion and arousal are managed by turning *away* from the partner and *inward* toward the self (as shown, for example, in the infant’s gaze aversion, leaning away, oral self-comforting, and rocking). A balance of interactive and self-regulation is reflected in the kind of midrange tracking that predicts secure attachment. High bidirectional tracking reflects a skew toward interactive regulation (a kind of overinvolvement with the partner) and predicts ambivalent or disorganized attachment, while low tracking reflects a bias toward self-regulation (underinvolvement with the partner) and predicts avoidant attachment.

Thinking in terms of these findings regarding interactive and self-regulation can be helpful when it comes to understanding and being of use to our patients. In treatment, those with a strong tilt in the direction of interactive regulation, rather than self-regulation, are the ones who vigilantly track our every response and/or seem utterly reliant upon us to help them manage their difficult feelings. These are usually patients who would be described as preoccupied with the attachment figure’s availability (or, more precisely, their fear of its lack). They behave as if they are hopeless, both about relieving their distress on their own and about the possibility of engaging help without making their distress overwhelmingly obvious to others. The problem for these patients (and their therapists) is not their de-

pendency per se. Instead, it is the fact that their wary need for others monopolizes their attention so thoroughly that they have little opportunity to know and make use of their own resources and desires. What needs reintegrating in these patients is their ability to live, as it were, *inside* themselves rather than feeling that their center of gravity lies *outside* themselves, in the minds and reactions of others.

Of course, we also work with many patients whose vulnerability resides in their overdeveloped capacity for self-regulation. Usually seen to operate from a “dismissing state of mind” with respect to attachment, they tend to be ostentatiously self-sufficient. What Bowlby calls their “compulsive self-reliance” often leaves their therapists (and spouses) feeling as if they have little to offer that is needed or valued by these patients. Their deactivating attachment strategy leaves them distant from the awareness of any feelings or impulses that might bring them close to their disavowed needs to connect with others. Usually, in the psychotherapy of such patients, it is precisely their attachment-related feelings, impulses, and needs that must be reintegrated.

The findings of the face-to-face infant–parent research dovetail with those of Ainsworth’s Strange Situation studies. The conclusion that midrange tracking is developmentally optimal is consistent with Ainsworth’s understanding that secure attachment is reflected in a balance of proximity seeking and exploration, connection and autonomy, relatedness and self-definition. From the face-to-face videotaped exchanges, one must conclude that a secure outcome is associated with a quality of contingent responsiveness between mother and infant that is close but imperfect. Such responsiveness is part of what enables infants to learn that their own internal states are “sharable” and, at the same time, distinct from those of others.³

I would suggest that the developmental desirability of midrange tracking—and the fluid balance of self- and interactive regulation it reflects—underscores the importance in parenting and psychotherapy alike of making room for the subjectivities of *both* partners in the relationship. “Primary maternal preoccupation” (Winnicott, 1975) encourages the likelihood that, for a time, the mother will make a greater priority of her baby’s subjectivity than her own; and of course, the helping role and ethical responsibility that therapists assume usually encourage a greater focus on the patient’s subjectivity than on their own. Yet the perfectly attuned mother (or therapist) who completely suspends or brackets her own subjectivity is probably neither a feasible ideal nor an entirely desirable one.

In the first place, most of us are simply incapable of parking our own needs and limitations outside the door of the baby’s room or the consulting room. When we stretch too far beyond ourselves in trying to do so, there are usually unintended and unwelcome consequences that follow. Second, our children and patients grow not only through experiences of “fit” but

also through experiences of separateness and difference. As Benjamin (1990/1999) has clarified, the capacity for mutual recognition—that is, the ability to recognize (and be recognized by) an other as a separate subject, rather than an object—emerges from the discovery that the other, and the relationship itself, can survive anger and conflict. Put differently, episodes of disruption and repair are a vital part of learning to balance the needs for self-definition and relatedness.

Without the give and take of two distinct subjectivities, the child or patient may learn that “there’s only room for one”: one voice, one will, one whose needs always dominate, one who controls the interaction. When occupying an avoidant–dismissing state of mind, it may feel as if—of necessity—there’s only room for the self. For those in an anxious-preoccupied state of mind, it may feel as if there’s only room for the other. Secure attachment makes room for both.

The interaction of two distinct subjectivities—in which each is capable of participating psychologically in the experience of the other—is the essence of intersubjectivity. Stern (2004) has said that we’re all “hard-wired” for intersubjectivity. (He points out that our brains are structured in such a way that the real question is why we’re not constantly captured by the experience of other people.) Apparently the basic mechanisms of such “interexperience”—Stern references the discovery of mirror neurons—are a feature of the human nervous system virtually from birth. Recall in this connection Meltzoff’s (1985, 1990) studies showing that as early as 42 minutes outside the womb, infants will imitate the facial gestures of an adult model. Having observed the adult sticking out his tongue, infants will attempt to do the same. Long before they know much about self and other, or about tongues, babies are apparently capable of making a connection between what they *see* on someone else’s face and what they *feel* on their own. Such cross-modal matching appears to demonstrate an astoundingly early-developing capacity for interrelatedness of self and other.

This capacity for rudimentary relatedness—a precursor of more evolved forms of intersubjectivity—is probably an outgrowth of the collection of brainstem-based reflexes that prime the attachment and caregiving systems, making of our first close relationships the vital developmental crucibles that they are. Not only in infancy, but throughout our lives, our interaction with intimate others upon whom we depend provides the key context for psychological growth and change. Tronick (1998) has suggested that both infant–parent and patient–therapist relationships make development possible by generating “dyadically expanded states of consciousness” (p. 290). This is a version of the understanding—shared by clinical theorists of intersubjectivity (Bollas, Mitchell, Stolorow) as well as attachment researchers (Fonagy, Lyons-Ruth)—that we need the mind of another in order to know and to “grow” our own mind.

Through the kinds of co-created, mutually regulated, intersubjective interactions from which security or insecurity emerge, children learn both how to have a relationship and how to regulate their emotions. Similarly, it is in the quintessentially intersubjective setting of the therapeutic interaction that our patients can potentially learn how to have a better relationship with others and with their own feelings as well. Key to the developmental outcome in both cases is the quality of the affective communication in the relationship.

To what extent does such communication allow the partners to get in synch so as to experience a sense of mutual recognition and “fittedness”? To which affective signals from the child (or patient) does the parent (or therapist) respond to in an attuned and collaborative fashion? And which affective signals are ignored, misread, or discouraged? More broadly, how big a container for affective communication and experience does the relationship provide? Circling back to Bowlby, Main, and Stern: That which the attachment relationship(s) can accommodate, the individual has the potential to integrate.

NOTES

1. In the process of integration, developmental experiences of relating, feeling, and thinking are intimately linked and mutually influential. For example, “if a person has not been helped with integrating strong feelings, then action may take the place of thinking” (Hobson, 2002, p. 175).
2. Siegel’s conceptualization here is helpful because it highlights both the “deficits” of the predominantly avoidant/dismissing patient and the undeveloped capacities that require therapeutic attention if they are ever to be reintegrated. From a neuroscience angle, such patients may need from the therapist an approach that helps them gain access to the input of the emotionally informed, holistically oriented right brain—from which they can appear to be cut off.
3. Interestingly, several studies have shown that an avoidant outcome is correlated with very high tracking of the infant by the mother, while the infant here responds as if in flight from the mother’s attention: This pattern of interaction has been described as “chase and dodge” (Beebe & Lachmann, 2002, p. 111). Evidently, infants—like most of us—need some space. Thus, sensitive responsiveness clearly involves an attunement to the child’s needs for self-regulation and “open space” (Sander, 1980) as much as for interactive regulation and the connection it fosters.

PART III

FROM ATTACHMENT THEORY TO CLINICAL PRACTICE

As we have seen, relationships of attachment are the primary context for development. Nonverbal, affective experience within an attachment context constitutes the original core of the self. This is the same context that shapes the stance of the self toward experience, which in turn can exert a decisive influence on development, particularly in the face of adverse circumstances. These are the insights of attachment theory research with the most significant implications for psychotherapy.

Because our first relational experiences are mainly lived outside the domain of language, our crucial internalizations of early relationships register as representations, rules, and models that cannot be linguistically retrieved. For these hard-to-reach representations to later be modified—for old working models to be updated—they must be accessed, that is, experientially engaged. In therapy, such representations in the patient often become accessible only as they are communicated through other-than-verbal channels. Thus a focus on the realms of preverbal, nonverbal, and paraverbal experience is indispensable—both to make sense of the original learning that occurred in the patient’s first relationships and to facilitate the relearning that can occur in the new relationship with the therapist. This is the subject matter of Chapter 8.