Clinical Implications of Attachment Theory:
Relational Psychotherapy
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The Origins of Attachment Theory

- John Bowlby (1907-1990)
- Mary Ainsworth (1913-1999)

John Bowlby

- Began medical and psychoanalytic training in London in 1929.
- Analyzed by Joan Riviere, a Kleinian, with whom he had a difficult analysis
- Supervised in child analysis by Melanie Klein, whose views about the centrality of the child's internal objects he essentially rejected
<table>
<thead>
<tr>
<th>John Bowlby</th>
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<tr>
<td>• Member of British Middle Group after WWII and also joined Tavistock Clinic</td>
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<td>• Collaborated with James Robertson on film, “A Two-year-old Goes to Hospital”</td>
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<td>• With Robertson, identified sequence of protest, despair, and detachment in children separated from their mothers</td>
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<td>• Read Konrad Lorenz in 1952</td>
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<td>• Used Lorenz’s work on imprinting in birds to create attachment theory</td>
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<td>• In 1958, defined attachment as an innate behavioral system in birds and mammals that is not dependent on feeding</td>
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<td>• Theory supported by Harlow’s monkey studies</td>
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<td>• Hypothesized that attachment protects young organisms from predation by increasing mother-infant proximity</td>
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<td>• Proposed five component instincts for attachment: crying, clinging, smiling, sucking, and following</td>
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Mary Ainsworth

• Moved to London in 1950 and began working with Bowlby
• Moved to Uganda in 1954 and did pioneering study of attachment in a Ganda village
• Linked attachment security, as manifested by baby’s use of mother as a secure base for exploration, and maternal sensitivity

Mary Ainsworth

• Moved to Baltimore in 1956 and joined faculty at Johns Hopkins, where in 1963 she began her second major attachment study, a naturalistic study of the first year of life
• Found that maternal sensitivity in first three months of life predicted harmonious mother-infant interaction at one year

Mary Ainsworth

• Devised an experimental procedure, the Strange Situation (Ainsworth & Wittig, 1969), as part of the Baltimore study and correlated its results, obtained at one year, with mother-infant interactions observed during the first quarter
The Strange Situation

- With the Strange Situation, Ainsworth found three infant-parent attachment styles:
  A. Insecure-Avoidant (20-25%)
  B. Secure (60-65%)
  C. Insecure-Ambivalent or Resistant (10-15%)

Consequences of Attachment Style

- Data on childhood stability of Strange Situation classification are mixed (rs ranging from -.10 to .50 with AAI in young adulthood)
- Secure—self-reliant, confident, popular
- Avoidant—isolated, often aggressive and bullying, reactive to stress
- Resistant—fretful, anxious, dependent, needy
- Role of Internal Working Models (IWMs)
The Contributions of Mary Main

- Disorganized/Disoriented (D) Attachment Style
- Adult Attachment Interview (AAI)

Disorganized/Disoriented (D) Attachment Style

- Derived from infants considered difficult to classify in the Strange Situation
- Found even in infants coded Secure (B)
- Involves brief displays of highly unusual infant behavior like freezing in a trance or simultaneously clinging and averting gaze
- Termed Disorganized (D) because of contradictory activation of approach and avoidance, as if parent were source of fear

Disorganized Attachment and Parental Behavior

- Disorganized infant attachment linked to frightening/frightened parental behavior ($r = .28$), e.g.,
  - Using "haunted voices" with the infant
  - Freezing or entering a trancelike state, as if dissociated
  - Hissing or growling at the infant
  - Bearing canine teeth at the infant
  - Appearing to be frightened of the infant
Disorganized Attachment and Parental Behavior

• Disorganized attachment also linked to disrupted parental affective communication (Lyons-Ruth); \( r = .35 \):
  – Negative-intrusive behavior
  – Role confusion
  – Withdrawal
  – Affective communicative errors
  – Disorientation

Disorganized Attachment and Parental Behavior

• Infants whose parents displayed anomalous behavior 3.7 times more likely to display disorganized attachment than other children, \( r = .34 \)
• Infants and children classified as disorganized very likely (>85%) to be classified as insecure in early adulthood (19+ years old)

The Adult Attachment Interview

• Semistructured interview created by Carol George, Nancy Kaplan, and Mary Main, with scoring system developed by Main and Ruth Goldwyn
• Derived from Bowlby’s IWM concept
• Inquires into subject’s history of attachment relationships
• Scoring depends not on content of report but on coherence of subject’s discourse
The Adult Attachment Interview

Coherence of discourse is scored with reference to linguistic philosopher H. P. Grice’s four maxims for cooperative conversation:

- quality (be truthful and have evidence for what you say)
- quantity (be succinct yet complete)
- relation (be relevant or perspicacious)
- manner (be clear and orderly)

Attachment classification on AAI parallels ABCD classification in Strange Situation (N = 1012 mother-infant dyads)

Ds Dismissing (25.4%/19.6%)
F Secure-Autonomous (56.3%/55.2%)
E Preoccupied (18.3%/10.4%)
U/d Unresolved-Disorganized (n.a./14.9%)

Parental AAI status predicts infant Strange Situation status (van IJzendoorn, 1995)

For secure-insecure split, meta-analysis found 75% classification accuracy, kappa = .49, d = 1.06, r = .47, N = 854

For ABC split, classification accuracy = 70%, kappa = .46, N = 661

For ABCD split, classification accuracy = 63%, kappa = .42, N = 548
Attachment and Psychopathology

- Insecure attachment and psychopathology are related (26% clinical samples, N = 685, secure vs. 55% nonclinical samples secure)
- Links between insecure attachment and depression depend on comorbid pathology

Attachment and Psychopathology

- Anxiety disorders (e.g. Panic) are often Preoccupied in three-way attachment classification, but PTSD from child abuse is often Unresolved
- In borderline personality disorder, almost all subjects are insecurely attached, usually Preoccupied, and half are Unresolved

Attachment and Psychopathology

- In eating disorders, anorexia with restriction is associated with Dismissing attachment, and all other eating disorders are often Preoccupied
- Somatoform disorders are associated with Dismissing attachment
- Among substance abusing mothers, attachment style is often Preoccupied or Unresolved, and most of the children are insecure
Attachment and Psychopathology

- Schizophrenia is associated primarily with Dismissing attachment and secondarily with Unresolved attachment, but this finding partially reflects globally disordered speech
- Among violent criminal offenders (e.g., antisocial personalities), almost all subjects (c. 95%) are insecurely attached and often dismissing or unresolved

Attachment and Psychopathology

- Among Holocaust survivors, more than half of subjects are Unresolved
- In general, and with many exceptions, Dismissing attachment is associated with externalizing problems, and Preoccupied attachment is associated with internalizing problems

Attachment and Psychopathology

- Histories of childhood separation or loss often found in depression, panic disorder, and agoraphobia
- History of childhood separation, abuse, or neglect often found in Antisocial PD
- Resistant Attachment in childhood predicts panic disorder in adolescence
- Disorganized Attachment in childhood predicts dissociative sx in adolescence
Psychotherapeutic Implications: Relational Therapy

• Attachment theory derives historically from the British Psychoanalytic Society’s Middle Group, one of the two main sources of modern relational psychoanalysis

• Premises of psychoanalytic therapies:
  – Mental functioning is mostly unconscious
  – Psychopathology results when important but painful concerns, usually from childhood, are rendered unconscious through defense
  – Warded-off psychological concerns are reenacted in therapy through the transference
  – Psychotherapy focuses mainly understanding and working through the transference

• Premises of the relational approach:
  – Attachment or relatedness is a primary drive not reducible to sex or aggression
  – The therapist cannot remain neutral but rather is an inevitable participant in the therapeutic relationship
Psychotherapeutic Implications: Relational Therapy

- Freud posits that attachment derives from sexuality and that infants start life indifferent to objects
- Freud's writings stress the analyst's detachment and "neutrality," rather than active engagement and participation
- Freud as a therapist was interactive and supportive, not neutral and detached (Lynn & Vaillant, 1999)

Psychotherapeutic Implications: Differences with Freud

- Freud (1905): "There are thus good reasons why a child sucking at his mother's breast has become the prototype of every relation of love. The finding of an object is in fact a refinding of it."

- Freud (1912) on transference: "If someone's need for love is not entirely satisfied by reality, he is bound to approach every new person he meets with libidinal anticipatory ideas . . . . Thus it is a perfectly normal and intelligible thing that the libidinal cathexis of someone who is partly unsatisfied . . . should be directed as well to the figure of the doctor."
Psychotherapeutic Implications: Differences with Freud

• Freud (1913): “When are we to begin making our communications to the patient? . . . Not until an effective transference has been established in the patient, a proper rapport with him. If one exhibits a serious interest in him, . . . he will of himself form such an attachment and link the doctor up with one of the imagos of the people by whom he was accustomed to be treated with affection. . . .”

Psychotherapeutic Implications: Differences with Freud

• Freud (1913): “It is certainly possible to forfeit this first success if from the start one takes up any standpoint other than one of sympathetic understanding. . . .”

Psychotherapeutic Implications: Differences with Freud

• Freud (1915): “Originally, at the very beginning of mental life, the ego is cathected with instincts and is to some extent capable of satisfying them on itself. We call this condition ‘narcissism’ and this way of obtaining satisfaction ‘auto-erotic.’”
### Psychotherapeutic Implications: Differences with Freud

- **Freud (1915):** “At the very beginning [of life], it seems, the external world, objects, and what is hated are identical.”
- **Freud (1915):** “Hate, as a relation to objects, is older than love. It derives from the narcissistic ego’s primordial repudiation of the external world . . . .”

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### Psychotherapeutic Implications: Differences with Freud

- **Freud (1940):** “It is hard to say anything at all about the behavior of the libido in the id and in the super-ego. All that we know about it relates to the ego, in which at first the whole available quota of libido is stored up. We call this state absolute primary narcissism.”

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### Psychotherapeutic Implications: Differences with Freud

- **Freud (1912):** “I cannot advise my colleagues too urgently to model themselves during psycho-analytic treatment on the surgeon who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully as possible.”

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Psychotherapeutic Implications: Differences with Freud

• Freud (1912): “The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him.”

Psychotherapeutic Implications: Differences with Freud

• Freud (1915): “Besides, the experiment of letting oneself go a little way in tender feelings for the patient is not altogether without danger. Our control over ourselves is not so complete that we may not suddenly one day go further than we had intended. In my opinion, therefore, we ought not to give up the neutrality [indifference] towards the patient, which we have acquired through keeping the counter-transference in check.”

Psychotherapeutic Implications: Relational Therapy

• Balint (1937): “This form of object relation [primary object-love] is not linked to any of the erogenous zones; it is not oral, oral-sucking, anal, genital, etc., love, but is something on its own.”
Psychotherapeutic Implications: Relational Therapy

- Balint (1937): “The biological basis of this primary object relation is the instinctual interdependence of mother and child; the two are dependent on each other but at the same time they are tuned to each other, each of them satisfies himself by the other without the compulsion of paying regard to the other. Indeed, what is good for the one, is right for the other.”

- Fairbairn (1944): “... libido is primarily object-seeking (rather than pleasure-seeking as in the classical theory) ...”

- Winnicott (1960): “I once said [c. 1940]: ‘There is no such thing as an infant’, meaning, of course that wherever one finds an infant one finds maternal care, and without maternal care there would be no infant.”
Psychotherapeutic Implications:
Relational Therapy

• Sullivan (1940): “The field of Psychiatry is the field of interpersonal relations--a personality can never be isolated from the complex of interpersonal relations in which the person lives and has his being.”

Psychotherapeutic Implications:
Relational Therapy

• Sullivan (1953): The infant’s “generic needs all require cooperation from another; thus the need for tenderness is ingrained from the very beginning of things as an interpersonal need.”

Psychotherapeutic Implications:
Relational Therapy

• Bowlby (1973): “The young child’s hunger for his mother’s love and presence is as great as his hunger for food . . . .”

• Bowlby (1988): “Attachment theory regards the propensity to make intimate emotional bonds to particular individuals as a basic component of human nature, already present in germinal form in the neonate and continuing through adult life into old age.”
Psychotherapeutic Implications: Relational Therapy

• Bowlby (1980): “Intimate attachments to other human beings are the hub around which a person’s life revolves, not only when he is an infant or a toddler or a school child but throughout his adolescence and his years of maturity as well, and on into old age.”

Psychotherapeutic Implications: Relational Therapy

• The (Im)Possibility of Neutrality
• Freud (1915): Neutrality derives from keeping the countertransference in check.
• Sullivan (1953, 1954): The therapist as participant-observer
• Interpersonal psychoanalysis: The therapist as observing participant

Psychotherapeutic Implications: Relational Therapy

• Clara Thompson (1956): “The total personality of the analyst affects the total personality of the patient.”
Psychotherapeutic Implications:
Relational Therapy

• Winnicott (1949): “Hate in the Countertransference”
• Heimann (1950): “I am using the term ‘counter-transference’ to cover all the feelings which the analyst experiences towards his patient.”
• Rickman (1950): Psychoanalysis as a two-body psychology

Psychotherapeutic Implications:
Relational Therapy

• The Inevitability of Countertransference
• Racker (1957): “The first distortion of truth in ‘the myth of the analytic situation’ is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities . . .”
• The Inevitability of Enactment

Psychotherapeutic Implications:
Relational Therapy

• Frieda Fromm-Reichmann (1960): “The self-respecting psychiatrist will keep in mind that he is in a superior category as compared with his patients only by virtue of his special training and experience, and not necessarily in any other way.”
Psychotherapeutic Implications: Attachment Therapy

• Bowlby (1988): “[A] patient’s way of construing his relationship with his therapist is not determined solely by the patient’s history: it is determined no less by the way the therapist treats him. Thus the therapist must strive always to be aware of the nature of his own contribution to the relationship which, amongst other influences, is likely to reflect . . . what he experienced himself during his own childhood.”

Psychotherapeutic Implications: Attachment Therapy

• Bowlby (1977): “[H]owever long or short the therapy, evidence is clear that, unless a therapist is prepared to enter into a genuine relationship with a family or individual, no progress can be expected.”

Psychotherapeutic Implications: Attachment Therapy

• The therapeutic relationship is an attachment relationship that is fundamental to psychotherapy
• Psychopathology derives from insecure childhood attachment
• Aspects of IWMs of insecure attachments are split off from consciousness but continue to influence conscious behavior
• Psychotherapy is a relational process
Psychotherapeutic Implications: Attachment Therapy

• The therapist provides a secure base for exploration of these insecure attachments and their associated IWMs
• Insecure attachments are reenacted in the transference, in the here-and-now
• The main purposes of exploring past attachments are to mourn past losses and to clarify and change present attachments

Psychotherapeutic Implications: The Return of Bad Objects

• Freud (1914): “We must be prepared to find . . . that the patient yields to the compulsion to repeat, which now replaces the impulsion to remember, not only in his personal attitude to his doctor but also in every other activity or relationship which may occupy his life at the time . . . .”

• Freud (1920): “The manifestations of a compulsion to repeat . . . exhibit to a high degree an instinctual character and, when they act in opposition to the pleasure principle, give the appearance of some ‘daemonic’ force at work.”
Psychotherapeutic Implications: The Return of Bad Objects

- **Freud (1920):** “In the case of children’s play, we seemed to see that children repeat unpleasurable experiences for the additional reason that they can master a powerful impression far more thoroughly by being active than they could by merely experiencing it passively.”

Psychotherapeutic Implications: The Return of Bad Objects

- **Freud (1920):** “It seems, then, that an instinct is an urge inherent in organic life to restore an earlier state of things” (italics in original).

Psychotherapeutic Implications: The Return of Bad Objects

- **Fairbairn (1943):** “What are repressed are neither intolerably guilty impulses nor intolerably unpleasant memories, but intolerably bad internalized objects” (italics in original).
- **Fairbairn (1943):** “It is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil.”
Psychotherapeutic Implications: The Return of Bad Objects

• Fairbairn (1943): “A sinner in a world ruled by God may be bad; but there is always a certain sense of security to be derived from the fact that the world around is good . . . . In a world ruled by the Devil the individual may escape the badness of being a sinner; but he is bad because the world around him is bad.”

Psychotherapeutic Implications: The Return of Bad Objects

• Fairbairn (1943): “The child not only internalizes his bad objects because they force themselves upon him and he seeks to control them, but also, and above all, because he needs them” (italics in original).

Psychotherapeutic Implications: The Return of Bad Objects

• Fairbairn (1943): “What Freud describes under the category of ‘death instincts’ would appear to represent for the most part masochistic relationships with internalized bad objects.”
Attachment Theory and Countertransference

- Countertransference as information about the therapist
- Countertransference as information about the patient

Mutuality, Asymmetry and the Role of Boundaries

- Aron (1996): “Psychoanalysis . . . is mutual but inevitably asymmetrical--inevitably because it is the patient seeking help from the analyst and it is the patient coming to the analyst’s office and paying the analyst; it is the analyst who is the professional and is invested with a certain kind of authority and responsibility.”

Attachment Therapy:
Specific Clinical Implications

- Insecure attachment styles have specific psychotherapeutic consequences
  - Dismissing: emotional distant
  - Preoccupied: labile, needy
  - Unresolved/disorganized: areas of dissociation
Attachment Theory: Specific Clinical Implications

• Look for points of incoherence in the patient’s discourse
• Keep the clinical focus on the patient’s capacity to reflect on mental states (e.g., metacognitive monitoring [Main], mentalization [Fonagy])

Attachment Theory: Specific Clinical Implications

• Losses and separations are central to the patient’s clinical course
• Even persons with Secure attachment may wind up in your office