The Ramifications for Neurological Development, Resiliency and Psychopathology of Early Childhood and Adult Attachment Patterns: Therapeutic Considerations

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Abstract

The implications of childhood attachment patterns and neurological development have significant ramifications on adult attachment patterns, resiliency, and the development of psychopathology. This thesis explores early childhood development, childhood and adult attachment patterns, and the effect of an attachment disruption on the individual’s brain structure and corresponding views of self and others. The client’s pattern of attachment has vital implications for the mental health practitioner. This thesis offers therapeutic considerations for the development of an effective therapeutic alliance with each type of insecure attachment pattern. Empirical validation of the Adlerian concepts of: Life Style, early recollections and social interest are also explored.
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Attachment theory has its roots in the pioneering work of John Bowlby during the mid 1930’s. Bowlby recognized the infant’s use of various attachment signals to maintain proximity to the caregiver is a survival instinct built into the very essence of the child’s being. In the 1960’s and 1970’s Mary Ainsworth’s research not only expanded Bowlby’s hypothesis, but also revealed that a secure attachment is formed as the mother responds to her infant in an accurate and sensitive manner, thus reflecting a type of attuned communication that provided the infant with a “felt security” in the attachment relationship. Ainsworth’s most recognized research contribution may have been identifying three distinct attachment patterns: secure, insecure-avoidant, and insecure-ambivalent.

During the 1980’s Mary Main identified a fourth pattern of attachment known as the disorganized attachment pattern. Main also explored the implications of early attachment experiences: as nonverbal interactions encoded in the mind, as internal representations, and as the structured mental processes that influence the child’s future relationships with self and with others. In the 1990’s, and into the next decade, Peter Fonagy has widened Main’s focus of internal representations to include the individual’s ability to monitor the mental states of others, as well as self. His research indicates that an individual’s reflective capacity enables that person to adopt a reflective stance towards experience and gain insight and empathy towards self and others. This ability can mediate early attachment difficulties enabling this individual, as a parent, to raise securely attached children.
Personality and social psychologists have used concepts and findings from attachment research, focusing primarily on the mother-infant relationship, to understand the role of adult mental representations of attachment experiences in adult attachment patterns and emotion regulation. In the early 1990’s Kim Bartholomew (1991) developed a two-dimensional model derived from an individual’s attachment anxiety and/or avoidance to systematize a four-category adult attachment classification (Bartholomew & Horowitz, 1991). Anxiety and avoidance strategies in an individual’s attachment system are secondary attachment strategies referred to as the hyper-activation of the attachment system, and deactivation of the attachment system (Mikulincer & Shaver, 2008).

More recently Allen Shore and Daniel Siegel began research on the links between neuroscience and attachment theory. The research seems to indicate that the four patterns of attachment detected by Ainsworth and Main may structure the ongoing development of circuits in the brain. As a result, an attachment disruption, especially disorganized attachment, can impair the individual’s neurological function and may predispose individuals to personality difficulties and psychopathology in later life, especially Borderline Personality Disorder (BPD). In contrast, a secure attachment may provide the individual with the inner resources for adaptive coping during times of trauma and loss.

Both attachment theory and the link between neuroscience research and attachment patterns have significant implications for the mental health practitioner. The attachment pattern of the client should be taken into consideration as the therapist develops a therapeutic alliance, and designs effective interventions for that client. It is also imperative for the therapist to maintain a reflective stance and be cognizant of his or her own attachment style and the corresponding effect on the therapeutic relationship.
John Bowlby, the founder of attachment theory, began his journey while teaching in a progressive school for children. In 1936, Bowlby became unsettled about the disturbances he noticed with children raised in institutions. He observed that children growing up in nurseries and orphanages frequently displayed a range of emotional problems, as well as the inability to form lasting relational bonds. Bowlby also noticed that children who experienced prolonged separations during early development seemed so traumatized that they turned away from close relational bonds. Alarmed by his observations, Bowlby began paying close attention to the mother/infant bond in order to understand human development.

Bowlby focused primarily on development during the first three years of life. From birth to three months, Bowlby hypothesized that the baby is equipped with a variety of attachment behaviors, gestures and signals that enable the infant to maintain proximity to their caregivers. The most obvious of these signaling behaviors is the infant’s cry, which is a distress call when the baby is in pain or is frightened. During the later half of this phase, the baby begins to smile fully at the sight of a human face; this intense social smile includes direct eye contact. According to Bowlby, attachment behaviors include crying, smiling, babbling, grasping, sucking, and following.

From four to six months, an infant begins to focus on familiar people and the baby’s social responses begin to become much more selective. Babies begin to contain their smiles, coos, gurgles, and babbles to familiar people. Toward the end of this phase, babies narrow their responsiveness to a few select people and to one in particular. The attachment figure is usually the mother, but it can be the father or another caregiver. Babies seem to develop the strongest
attachment to the person who has been the most responsive to their attachment signals and who has engaged in the most enjoyable interactions with them (Bowlby, 1988).

From six months to three years of age, the child’s attachment and active proximity-seeking to the primary attachment figure intensifies. This is especially apparent as the infant cries out in protest when the primary caregiver leaves the room, signifying separation anxiety. Observers have also noted the intensity with which the baby greets the mother after she has been away for a brief time. The exclusiveness of baby’s attachment to its primary caregiver is evident about 7 or 8 months of age when the infant displays a marked fear of strangers. This reaction ranges from a slight vigilance to outright cries at the sight of a stranger, with stronger reactions usually occurring when the baby feels ill or is in an unfamiliar setting (Bowlby, 1988).

As infants learn to crawl, they take a more active role in keeping their primary attachment figure close. An infant will monitor the caregiver’s whereabouts, and any sign that the caregiver may suddenly depart releases a “following” attachment behavior. Bowlby suggests that, similar to other species, human babies have formed an imprint on a particular attachment figure. If the caregiver starts to leave, the baby immediately follows, until the child regains proximity. This observation enabled Bowlby to understand why infants and young children become so distraught when separated from their parents during this critical stage of development. This instinct is a built-in survival mechanism for the child. A caregiver’s abrupt departure creates an intense fear response in the baby. On some level, a child may sense that losing contact with the primary caregiver equals death (Bowlby, 1988).

If a one year-old child has doubts that arise about mother’s responsiveness and availability the child will tend to be anxious about exploring new situations at any distance from her. In contrast, if the child has come to the conclusion that mother loves me and will be there
when I really need her, he or she in turn can explore the environment with more courage and enthusiasm. Even so, the child will periodically monitor his or her mother’s presence since the child’s need for mother is vital (Crain, 2005). Based on numerous day-to-day interactions, the child gains the security that mother is accessible and responsive to his or her needs by the end of the first year. During the ages between 6 months and 3 to 4 years, children are intensely forming attachments and lack the independence and cognitive capacities to deal with separations in adaptive ways (Bowlby, 1988).

As children approach their third birthday, they begin to have some understanding of the caregiver’s plans and can visualize the parent’s behavior while he or she is away. Consequently, the child is more willing to let the parent go. Attachments are an ongoing hallmark of the human experience. Adolescents tend to break away from parental dominance and form attachments to parental substitutes. Although adults consider themselves independent, they still seek proximity to loved ones in times of crisis. The elderly find that they must increasingly depend on the younger generation. Bowlby has little to say about attachments after the age of three; however, he believed that attachment remains very important throughout an individual’s life span. “All of us, from the cradle to the grave, are happiest when life is organized as a series of excursions, long or short, from a secure base provided by our attachment figure(s)” (Bowlby, 1988).

Although Bowlby was a psychoanalyst, his work was largely ignored for decades. A rift developed between Bowlby and the psychoanalytic community as he challenged some of the basic tenets of psychoanalysis. For example, one principle Bowlby challenged was the reality of the impact of experience verses fantasy on the psychological functioning of the child. The clinical implications of attachment research has generated a significant interest over the past two
decades largely due to the work of Mary Ainsworth, Mary Main and Peter Fonagy, each personally inspired by John Bowlby’s deep concern for the welfare of children.

*Mary Ainsworth*

The purpose of Mary Ainsworth’s research position with John Bowlby was to investigate the psychological impact of early mother/child separation. This position led to a forty year collaboration that transformed attachment theory and research. After relocation to Uganda with her husband, Ainsworth launched the first ever naturalistic, longitudinal study of infants in interaction with their mothers (Wallin, 2007). Ainsworth observed 26 families with unweaned infants. She visited each family for two hours every two weeks, while collecting data that began to answer basic questions about the development of attachment. The data Ainsworth gathered confirmed Bowlby’s attachment suppositions. First, her research validated that around the age of six to nine months, the infant has a clear preference for mother developing into a powerful attachment bond. Second the attachment relationship is evidenced by the infants’ intense preference for mother when distressed or alarmed. Third the infant uses mother as a secure base for exploration, and actively approaches her upon reunion. From the data collected, Ainsworth tentatively concluded that the mother’s maternal attunement to her infant’s attachment signals was of vital importance. This later finding gave credence to Bowlby’s original hypothesis that healthy child development occurred as both mother and infant experienced pleasure in the attachment relationship (Bowlby, 1988).

In 1963, Ainsworth conducted another research study in Baltimore as she recruited 26 pregnant mothers to participate in a home-based study of early attachment (Wallin, 2007). Following childbirth, the mother/infant interactions were carefully documented over the course of one year. Ainsworth then structured a laboratory assessment that lasted approximately 20
Attachment

minutes. She expected that the combination of an unknown setting, mother/infant separation, and a stranger would trigger the behavioral responses of the attachment system. The majority of the infant’s responded in the manner Ainsworth predicted. These infants demonstrated the capacity to explore freely and then to be comforted by connection with their attachment figure. However, Ainsworth noted that a minority of infants seemed to favor exploration over mother and avoided connection with her upon reunion. In contrast, an even smaller minority of infants gave up exploration and remained continuously preoccupied with mother’s whereabouts. Upon reunion these infants were inconsolable, responding either passively or angrily to mother’s attempts of comfort. In her control study, now referred to as the “Strange Situation,” Ainsworth observed three distinct patterns of infant attachment: secure, insecure-avoidant, and insecure-ambivalent that corresponded with the pattern of mother-infant interaction in the home (Ainsworth, 1989).

The Secure Infant

The secure infant used his or her mother as a secure base from which to explore. When a mother left the child in the “Strange Situation” the child was temporarily distressed. However, when mother returned, the child actively greeted her and was readily comforted. Once reassured, the infant eagerly ventured forth to explore the environment once again. The babies identified as securely attached demonstrated a capacity to explore freely and to be consoled by connection. In the home, mothers of secure infants had been observed to be sensitive and responsive to their baby’s attachment signals and communication. When the infant exhibited various attachment signals the mother would respond in such a way that communicated she was attuned to her infant’s needs. Rather than imposing her own agenda on the infant the mother aligned her own rhythms with that of the child. For example, if the child cried the mother tenderly picked up the infant and lovingly provided care and comfort but only for as long as the infant wanted to be
held. These mothers were characterized by sensitivity rather than insensitivity, acceptance
instead of rejection, collaboration in contrast to control, and emotional availability rather than
indifference.

Ainsworth found that secure infants cried less than the insecure infant during the second
half of their first year and were more willing to comply with their parent’s wishes. Ainsworth’s
research study demonstrated that a secure attachment system provides the child with a
continuous sense of “felt security”. When the child felt secure, exploration, expansion and
growth in the child’s development occurred. When observed in peer and school settings, children
who feel secure as infants with respect to their mother reflect greater resilience as well as social
and exploratory competence than insecure children (Main, 1996). In 1992, this pattern was found
to characterize 65% to 70% of the one year olds evaluated in the Strange Situation in the United
States samples (Van Ijzendoorn & Sagi-Schwartz, 2008).

The Insecure-avoidant Infant

Ainsworth noted that the insecure-avoidant infant appeared quite independent throughout
the Strange Situation control study. Although these infants explored, the children did not use
their mothers as a secure base but simply ignored them. When their mothers left the room, these
children did not become upset nor seek proximity to the mother when she returned. If a mother
tried to pick up her child, these infants tried to avoid her by turning away or averting her gaze.
Since these infants display such independence in the strange situation, they struck many people
as exceptionally healthy. However, Ainsworth thought the infants were suffering from some
degree of emotional trauma. Their detachment reminded her of children who had experienced
painful separations. The home observation supported her theory. Ainsworth noted, and additional
research later confirmed, that mothers of the avoidant infant were emotionally unavailable,
uncomfortable with physical contact, withdrew when their infant appeared to be sad, and brusque when interaction did occur. Overall, the mother’s were relatively insensitive, interfering, and rejecting. Ainsworth’s overall conclusion was that the avoidant infant adopted an indifferent self-contained posture to protect themselves from rejection. They attempted to block out their need for mother to avoid further disappointment. These children seemed to have sacrificed connection altogether in favor of exploration. Bowlby speculated that this defensive behavior can become a fixed and pervasive part of the personality (Bowlby, 1988). The child becomes an adult who is overly self-reliant and detached, a person who can never let down his or her guard and trust others sufficiently to form close relationships (Bowlby, 1988).

The avoidant infant’s lack of distress can easily be misinterpreted as calm. The heart rates during the separation period from mother of the insecure-avoidant infant, is elevated similar to the visibly distressed but secure infants, during the separation period from mother. However, the avoidant infant’s level of cortisol, the body’s principal stress hormone is significantly greater than that of secure infants (Sroufe & Waters, 1977b; Spangler & Grossmann, 1993 as cited in Wallin 2007; Main, 1996). The avoidant infant seems to have come to the conclusion that his or her signals for comfort and care will not be heeded. Ainsworth’s observations in her home-study indicated that the mother had actively denied their infant’s attempt for connection. In one high-risk research study, children who were avoidant in relation to their mother were observed to victimize others (Main, 1996). This avoidant pattern was found in the 1992 study to affect about 20% of the infants in United States (Van Ijzendoorn et al., 2008).

The Insecure-ambivalent Infant

During her investigation, Ainsworth identified two types of insecure ambivalent infants: angry and passive. Both types of infants are too preoccupied with mothers’ whereabouts to
explore freely, and they react to their mother’s departures with overwhelming distress. In the Strange Situation, these infants were clingy and preoccupied with their mothers’ location and became extremely distressed when their mothers left the room. Yet these infants were distinctly ambivalent toward mother when she returned. At one moment the infant reached out for mother; then in the next moment angrily pushed her away. At home, these moms typically treated their babies in an unpredictable fashion. The mother was warm and responsive on some occasions, but not on others. This inconsistency had apparently left the babies uncertain whether mother would be available when needed. As a result, they usually wanted to keep mother close at hand. This need for proximity greatly intensified in the Strange Situation. In one high-risk sample these ambivalent-resistant children were observed to most-likely be victims of their avoidant peers (Main, 1996). This pattern typically characterizes 10% to 15% of the one year olds in 1992 United States samples (Van Ijzendoorn et al., 2008).

While Mary Ainsworth’s research empirically validated John Bowlby’s hypotheses regarding the vital importance of the mother/infant bond, she made independent contributions that proved critical in the development of attachment theory. Ainsworth’s research analyzed the types of mother/child interactions in the natural environment of the home that most likely produced the three patterns of attachment noted in the Strange Situation (Ainsworth, 1989). Many of Ainsworth’s original findings relating to Strange Situation behavior have been replicated. The majority of infants worldwide have been found secure, with greater variation in the distributions of the avoidant, secure, and resistant-ambivalent, respectively (Van Ijzendoorn, 1995). Ainsworth also expanded Bowlby’s theory beyond the focus of “proximity of the attachment figure”, to one that provided the infant with a sense of “felt security.” In addition, she revealed that it was the mother’s quality of communication with her infant that was of primary
importance. The mother’s accurate reading of her infant’s nonverbal signals reflected a type of attuned communication. With this type of connection, the infant signals with various cues, and the mother reacts in a sensitive and responsive manner.

*Mary Main*

*The Insecure-disorganized/disoriented Infant*

Ainsworth’s research sparked tremendous interest in the arena of developmental research. Many gifted and talented research students chose to work with her. Perhaps the most prominent, Mary Main detected a fourth pattern of attachment referred to as a disorganized/disoriented attachment. As cited in Main (1996) she meticulously reviewed 200 unclassifiable Strange Situation videotapes in a controlled study conducted by Main and Solomon (1990). Her review revealed that a great majority of these infants, exhibited a diverse range of behavior when reunited with their mothers that she found perplexing, contradictory, or bizarre (Main, 1996). This behavior included rocking on hands and knees with face averted after an abortive approach; freezing all movement, arms in air, with a trance-like expression; moving away from the parent to lean head on wall when frightened; and rising to greet the parent then falling prone (Main, 1996). As a result of Main’s observations a fourth, insecure-disorganized-disoriented infant attachment category was developed.

Infants are genetically preprogrammed to turn to their parents when distressed and are utterly dependent on them for care. Main’s hypothesis is that the development of disorganized attachment emerges from an infant’s interactions with a caregiver that is also perceived by the infant as frightening, frightened, or dissociated. Any behavior from the parent that directly frightens a child, places him or her in a behavioral paradox since it activates simultaneous impulses that are in direct conflict. For example, when afraid and needing reassurance, a child
may have no option other than to seek support from a caregiver who is also perceived as frightening. Disorganized infants seem incapable of applying any consistent strategy to bond with their parents. The child’s anxiety and distress are not lessened upon contact with the caregiver. Instead, one source of stress is merely traded for another, leaving these children with no viable coping options. Since all infants are programmed, when alarmed, to seek parents as a safe haven, these children will want to both flee to and from the parents who are the source of alarm (Main, 1996).

Children with histories of disorganized-disoriented attachment are most at risk for developing severe pathological problems. One of the most notable features of infants with disorganized attachment patterns is their incoherent and ineffective attempts to self-regulate upon reunion with the caregiver after a brief separation. These infants exhibit behaviors like freezing and rocking, reflecting and dissociation (Main, 1996). The clearest connection between infant attachment and adult psychopathology are between disorganized attachment and dissociative behavior in adolescence and early adulthood (Dozier Chase Stovall-McClough & Albus, 2008).

*Internal Working Models of Attachment*

Mary Main also explored the implications of early attachment experiences that are encoded in the mind as representations. She empirically validated and expanded upon Bowlby’s hypothesis of the individual’s internal working models of attachment (Bowlby, 1988). Main suggested that these internal working models are conscious rules for the structured process of information about attachment. These rules serve as filters to obtain, or limit access to information regarding attachment-related experiences. These models direct, not only feelings and behaviors, but also attention, memory, and cognition (Main, Kaplan, & Cassidy, 1985) Mary Main
proposed that children’s reunion responses to parents, such as those observed in the Strange Situation, or other reactions following brief or major separations, can be indicative of the infant’s internal working model of the relationship (Main et al., 1985). These models are developed through the child’s perception of numerous interactions with his or her caregiver. The strategy chosen by the child represents his or her best attempt to obtain a sense of felt security in the attachment relationship. Alder referred to these internal working models as the client’s “Style of Life.”

The securely attached individual tends to have internal working models of self as good, wanted, worthwhile, competent, and lovable. Caregivers are responsive, sensitive, caring, and trustworthy. The world as safe and life is worth living. Whereas, the individual with a disordered attachment, can have internal working models of self as bad, unwanted, worthless, helpless, and unlovable. Caregivers are unresponsive, insensitive, hurtful, and untrustworthy. The world is unsafe and life is not worth living (Levy, 2000). The individual with a chronic and persistent attachment disruption internalizes the lack of adequate care, love, and protection as self-induced. As a result, the perception of self is unlovable, helpless, and responsible for the maltreatment he or she received.

Main examined internal representations through a longitudinal study of attachment that tracked a group of middle-class families as their infants developed through childhood, adolescence, and beyond. The initial stage used in the Strange Situation as an assessment. Five years later, Main conducted videotaped evaluations of 40 families (Main et al., 1985). Main designed her research to explore the individual’s attachment history as reflected in the complexity of memories, emotions, and beliefs that influenced present and future attachment behaviors and relationships. Main’s most powerful methodological contribution in the continued
development of attachment theory is the Adult Attachment Interview (AAI). The AAI allows researchers to explore the effect of attachment on an individual’s internal structures and processes. Since internal working models cannot be witnessed directly by observation, Main developed a brilliant research methodology that enabled researchers and clinicians alike to envision the inner world of children as well as parents. In Main’s longitudinal study she utilized the AAI to “prime” the attachment system and to explore the subject’s experience of loss, rejection, and separation. The AAI has been extensively used in research studies to assess attachment in adulthood just as the Strange Situation protocol has been used for assessment of attachment in infancy. Unlike the Strange Situation protocol, the AAI assesses adult attachment classification independent of any particular attachment relationship. Instead, it shows an adult’s overriding state of mind in regard to attachment relationships.

Main’s longitudinal research found a correlation between the child’s Strange Situation behavior with the primary parent at 12 months of age, and the structure of the inner world of the child five years later. In essence, the Strange Situation classifications predicted the AAI results (Main et al., 1985). Main also discovered an intergenerational correlation between the child’s behavior in the Strange Situation and the parent’s “state of mind” in regard to attachment. Replicated by Main as well as numerous investigative research studies, the AAI classification by the parent predicts the Strange Situation classification of the child with 75% accuracy in regard to security versus insecurity.

*Adler’s Assessment of the Client’s Style of Life*

Mary Main provided empirical evidence supporting John Bowlby’s hypothesis of internal working models relating to attachment. Main later referred to these models as ‘states of mind.’ Adler earlier referred to these ‘states of mind’ as the client’s life style. In assessing the client’s
Life Style, Adler considers the ways in which individuals make sense of self and others on the basis of behavior, underlying beliefs, emotions, and desires. Adler believed that, beginning in early childhood, children develop a theory that enables them to understand to some degree, and predict what others will do in light of the children’s interpretation of other people’s behavior.

According to Adler, a child perceives, interprets and assimilates his or her own situation consisting of genetic structure, care-giving system, and environmental influences. Then based on these perceptions the child creatively responds to his or her situation. When Adler examined the chosen direction of a client, he found that the creative possibilities for an individual to interpret and respond to a given set of circumstances are limitless. Adler attempted to understand the goal-directed movements of a client to evaluate what the client interprets, or misinterprets, as success. Adler referred to the client’s efforts to meet life’s difficulties, to overcome inferiority and to attain a more positive situation, as the client’s style of life.

Adler encouraged his clients to share their earliest recollections because he believed those memories expressed each client’s style of life. According to Adler there are no “chance memories.” Of the numerous early childhood experiences, the client chooses to remember, only those which he or she “feels” has significance. Thus memories become a story the client uses to warn, comfort, focus and prepare him or her to meet the future with an already tested style of action. The client then meets the current difficulty with skills acquired in early life.

Adler made use of these early memories to gain insight into both the client’s misperceptions, and the view of self, and others. The Adlerian therapist can elicit early recollections by using the current problem and asking the client to reflect back to an early memory, when he or she had similar thoughts, bodily sensations, and feelings. A 2007 study by Tobin, Wardi-Zonna, and Yezzi-Shareef (2007) gathered early recollections from nine children
and adolescence who met the diagnostic criteria for RAD. The purpose of the study was to investigate the participants’ internal working models. The thematic patterns that emerged from the children’s early memories appear consistent. These children viewed themselves as alone, others as hostile or abandoning, and events as unfair or frustrating. A thematic analysis finds these children and adolescence had unmet emotional needs, along with an expressed need to be loved or cared for. The prevailing affect experienced by these children and adolescence was both sadness and fear. The researchers observed a constricted and blunted affect displayed among the participants when gathering the early recollections. The result of this study indicates that obtaining early recollections from the client is an effective means for understanding the unique perspective of the child, and appears to agree with the internal working models reflected in attachment research.

Peter Fonagy

The Individual’s Capacity for Reflective Functioning

Peter Fonagy, as a junior lecturer at the University College of London in 1980, was appointed as the liaison to coordinate the seminars and consultations of John Bowlby, the Freud Memorial Professor of Psychoanalysis. As Fonagy sat in on Bowlby’s lectures he was profoundly affected by Bowlby’s ideas as well as Bowlby’s deep concern for the welfare of children. While Mary Main used the AAI to focus on the adult’s capacity to monitor self through thought and recall in relation to attachment history, Fonagy and his colleagues widened the lens to include the individual’s capacity for reflective functioning. During the course of their research, Fonagy and his colleagues discovered that the presence of reflective functioning in mothers’ was a greater predictor of infant security than adult attachment classifications. In
contrast, these researchers were able to link the absence or distortion in reflective functioning with psychopathology, in particular borderline personality disorder (Fonagy, 2008).

Fonagy embarked on a control study on the transgenerational transmission of attachment patterns. Throughout the study, Fonagy and his colleagues conferred with John Bowlby and also received training from Mary Main for conducting the AAI interview. The research team recruited 100 expectant couples and utilized the AAI to assess the parents’ attachment state of mind before the infant’s birth. This study was noteworthy for several reasons. First, the study found that the parents’ state of mind as evidenced using the AAI before the infant’s birth could predict the infant’s Strange Situation secure or insecure attachment classification at 12 months in 75 percent of the cases (Fonagy, Steele, & Steele, 1991). Second, the study revealed the direct intergenerational link between the mother and father’s capacity for reflective function, and the ability to raise secure children. The results indicated that parents with strong reflective capacity were three to four times more likely to have secure children than parents with poor reflective functioning (Fonagy, Steele, Steele, Moran & Higgitt, 1991b). Fonagy proposed that a strong reflective capacity could break the transgenerational transmission of insecure attachment; the cycle that typically predisposes parents with adverse attachment histories to raise insecure children.

As a result, Fonagy came to regard reflective functioning as absolutely central to attachment. In a review of attachment literature, Cassidy and Shaver state that mothers’ reflective functioning was more predictive of infant security than were their adult attachment classifications (Slade, 2008). Fonagy believed that attachment was not an end goal by itself, but that secure attachment laid the foundation for the ability to develop a strong reflective capacity. It is the ability to reflect that enables individuals to understand their own behavior, as well as
understand, interpret and predict the behavior of others. For example, a son notes that his mother’s “rejection” of him might have occurred as a result of her depression rather than her direct hostility towards him. Fonagy devised a Reflective-Functioning Scale for research studies to assess an individual’s reflective functioning capacity. The capacity for reflective function is the ability to see ourselves and others as individuals with psychological depth. This includes the capacity to respond beyond observed behaviors and be cognizant of the desires, feelings, and beliefs that make the behavior of others meaningful and understandable (Fonagy, et al., 1991b). As a result, the capacity for reflective functioning, also referred to as mentalization, allows the individual to make sense of self and others. Fonagy believed that an important indicator of a person with a high quality of mentalization, is the awareness that he or she cannot know fully what is in someone else’s mind, yet recognizes that another’s behavior reflects needs, desires, feelings, beliefs, goals, and purposes (Fonagy & Target, 2006). Reflective functioning can be briefly summarized as the individual’s capacity for insight and empathy.

Implications for the Family System

In analyzing intergenerational transmission of attachment, Fonagy proposes that an individual’s secure attachment is built upon the foundation of affect regulation. This in turn provides secure attachment, and the capacity for strong reflective functioning. The newborn is utterly vulnerable and dependent upon the caregiver to provide a felt sense of security in facing the bodily, emotional, and environmental challenges of life outside of the womb. To obtain this felt security, the infant depends completely on the caregivers to modulate its overwhelming effects. Parents who convey empathy and appreciation for the child’s stance provide the groundwork, for a child’s capacity for affect regulation. Parents who succeed at containing their
infant’s distress will typically have a securely attached child who will develop a strong capacity for reflective functioning.

Emotionally attuned parents transmit their empathy and capacity for coping through affect mirroring that is both “contingent” and “marked.” Contingent mirroring occurs when the parent’s facial and vocal interactions with the baby accurately correspond to the child’s emotional experience rather than the parent’s. Mirroring is marked as the parent exaggerates the child’s affect in a manner that communicates enjoyment, or comfort in containing the infant’s disturbed affect. In this manner, contingent and marked mirroring gives back to the baby his or her own self (Fonagy, 2008). When the parent resonates with the infant, reflects, and expresses accurately the inner state of the baby, the parent facilitates the opportunity for the infant’s emotions to be recognized, validated and shared.

There is evidence to suggest that the absence of this exaggerated contingent mirroring, is associated with the development of disorganized attachment (Koos & Gergely, 2001). Understanding others mental state is difficult for a child who does not know what it is like to be understood as an individual with psychological depth (Fonagy, et al., 2006). “If the caregiver is either, too much themselves (non-contingent mirroring), or too much the child (unmarked mirroring), the child cannot develop a sense of separateness in the same kind of effective way (Fonagy, 2008). The preoccupied parent may be able to empathically mirror the infant’s distress, but may not effectively cope with it. On the other hand, the dismissing caregiver may fail to convey empathy but succeed in communicating a sense of stability. When a parent chronically fails to contain their child’s painful affects, the child of an insecurely attached caregiver tends to internalize the parent’s responses to overwhelming affects.
According to Fonagy, as such a caregiver’s reflective functioning capacity is characterized by marked contingent mirroring, and this skill can mediate a caregiver’s problematic early development, this can enable such parents to raise securely attached children. Even those parents who have a frightening upbringing themselves can help their children develop secure attachment relationships. This is possible when the parents have made sense of their own early life experiences, understand the impact of early relational experiences on present relationships, and have come to terms with their early life experience.

Adler and Social Interest

Adler chose the term “social interest” as the most adequate description of an individual’s attitude toward life. The term, social interest, denotes the innate aptitude through which an individual becomes responsive to reality, primarily, the social situation. The following terms have been used as English equivalents in defining social interest: Social feeling, community feeling, fellow feeling, sense of solidarity, communal intuition, community interest, social sense, and social interest (Ansbacher & Ansbacher, 1956). Perhaps the most descriptive definition of social interest is the ability to identify and empathize with others. A person with a strong social interest is able “to see with the eyes of another, to hear with the ears of another, to feel with the heart of another.” This capacity for identification, which enables the individual to develop in intimacy, friendship, love of mankind, sympathy, and occupation is the byproduct of social interest. Social interest can only be cultivated in the context of relationships with others.

Adler considered social interest as an innate human potential that an individual needs to cultivate. As in reflective functioning, social interest is most naturally developed in the early childhood secure attachment relationship. Adler acknowledged the beginnings of social interest in the early mother/infant relationship. That other-directedness begins at birth as infant
development requires the cooperation of both mother and child. Adler also emphasized the importance of extending social interest to the family unit and community at large. Adler believed that social interest can only come to life in the social context. The child must eventually go from the mother’s care into a much wider circle of human contacts. When caregivers do not encourage the child to expand his or her social environment, the child remains unprepared to meet the problems presented by social living.

Fonagy believed that attachment was not simply the end goal, but rather that secure attachment laid the foundation for developing a strong reflective function that enables the individual to have insight and empathy. The concept of reflective functioning significantly overlaps with Adler’s concept of social interest. Although Adler did not focus on the early mother/child relationship, he focused instead on the outcome of a healthy mother/child relationship; the development and cultivation of social interest in his clients. Adler believed that social interest was the barometer for measuring an individual’s mental health. Fonagy et al., (1991b) empirically validated Adler’s belief when he provided evidence that the absence or distortion of reflective function is a major aspect in the psychopathology of especially severe personality disorders such as BPD.

Fonagy and colleagues believed that the reflective function is cultivated through the attachment relationship when an infant’s mental state is adequately understood by a caring, attentive, and nontreating adult. However, Fonagy and brain research findings reveal that the benefits of a secure attachment can still be cultivated in an individual with an insecure attachment. Fonagy referred to this as the individual earning secure attachment status, thus enabling the adult to raise children with a secure attachment.
The Implications of an Attachment Disruption

Even in the best of circumstances the primary caregiver will not always be attuned to the infant’s emotional and physical needs. This misalignment in the attachment relationship can lead to brief moments of distress in the child. Responsive care-giving can repair the imbalance in the child. As the caregiver and infant create states of positive arousal, interactive repair modulates states of negative arousal. In this way, the fundamental building blocks of attachment and its associated emotions are constructed. The baby becomes attached to the regulating caregiver who expands opportunities for positive affective experiences and minimizes negative affective states. “Good enough” mothering and responsiveness to the infant’s emotional needs after separation and/or distress helps facilitate regulated events that allow for an expansion of the child’s coping capacities. The security of the attachment bond is the primary defense against trauma-induced psychopathology (Schore, 2002).

In contrast, an attachment disruption occurs when the caregiver is inaccessible and/or reacts to the infant’s expression of emotion and stress in an unfitting and/or rejecting manner. The caregiver demonstrates minimal or unpredictable response to the infant’s needs and/or distress. Instead of soothing the child, the caregiver induces extreme levels of stimulation and arousal. Without soothing from a reliable and consistent caregiver, a traumatized child is unable to regulate his or her mental state and to restore emotional equilibrium. Unless these children’s unregulated states are brought under control, they expend all their energy attempting to regulate their personal state of being. A disruption in attachment occurs when the caregiver withdraws interactive repair functions, and consistently leaves the infant for long periods in a distressed state of being. Tragically, severe and persistent states of dysregulation require children to resort to pathological forms of internal escape since this terrifying state is beyond their developmental
coping abilities (Schore, 2002). An infant that is chronically shifting into survival modes has little energy available for growth. As a result, consistently traumatized infants forfeit potential opportunities for socio-emotional learning during critical periods of right brain development (Schore, 2002).

A review of contemporary attachment research shows that severe failures of early attachment relationships, and specifically the abuse and neglect associated with disorganized attachment patterns, are likely to impair the right brain’s regulatory stress and coping-related functions and to produce maladaptive, infant and adult mental health (Dozier et al., 2008; Schore, 2002).

Psychopathology in Early Childhood

In profoundly serious cases of an attachment disruption, some young children suffer from the psychopathology of Reactive Attachment Disorder (RAD). As defined by the DSM-IV-TR (American Psychiatric Association, 2000), RAD is a condition associated with a severe attachment failure. This disorder most likely results from chronic and severe early experiences of neglect, abuse, abrupt separation from caregivers between the ages of six months and three years, frequent change of caregivers, or a lack of caregiver responsiveness to a child's communicative efforts. A child can be vulnerable to RAD if the caregivers persist in neglect of the child’s basic emotional needs for comfort, stimulation, and affection.

RAD is characterized by markedly disturbed and developmentally inappropriate ways of relating socially that begins before the age of five (American Psychiatric Association, 2000). The DSM-IV-TR specifies two types of symptom manifestations for a RAD diagnosis. A child manifesting the inhibited type of RAD shows a persistent failure to initiate or respond to most social interactions in a developmentally appropriate way. This child exhibits a pattern of
excessively inhibited, hyper-vigilant or highly ambivalent responses. For example, the infant displays behaviors such as, frozen watchfulness, resistance to comfort, or a mixture of approach and avoidance. In the disinhibited type, there is a pattern of diffuse attachments. This child exhibits indiscriminate sociability, or a lack of selectivity in the choice of attachment figures. Children with RAD are presumed to have grossly disturbed internal working models of relationships which can lead to interpersonal and behavioral difficulties in later life.

**Parental Stance to Enhance the Development of the Child**

Karlen Lyons-Ruth (1999) reviewed the outcomes of multiple studies and research practice and summarized four significant characteristics identified with positive developmental outcomes in parent-child interactions. Overall her research revealed that communication is collaborative, articulate and rational in nature. First, the parent orients communication in a way that seeks to understand the child’s feelings, desires, needs, and views in regards to a whole array of experiences (Lyons-Ruth, 1999). Second, the parent initiates interactive repair when a disruption in the relationship occurs (Lyons-Ruth, 1999). Third, the parent upgrades the conversation to keep up with the child’s rising development, interest and potentials (Lyons-Ruth, 1999). Fourth, when the child or adolescent’s sense of self and others is in flux, the parent sets limits and remains actively engaged and struggles with the child (Lyons-Ruth, 1999).

**Personality and Social Psychologists and Adult Attachment Style and Dynamics**

*Adult Attachment Style Classifications*

In the early 1990’s Kim Bartholomew developed a two-dimensional model derived from an individual’s attachment anxiety and avoidance to systematize a four-category adult attachment classification (Bartholomew, et al., 1991; Griffin & Bartholomew, 1994; Mikulincer, et al., 2008). These dimensions are conceptually similar to those that underlie Ainsworth’s infant
attachment patterns. At present most researchers ascribe to this model of adult attachment, including many issues related to emotion regulation (Mikulincer et al., 2008).

The anxiety and avoidance strategies of the individual’s attachment system are secondary attachment strategies referred to as the hyperactivation of the attachment system, and deactivation of the attachment system (Mikulincer et al., 2008). The function of these secondary attachment strategies are psychological defenses against the frustration and pain caused by a lack of felt security in the early attachment relationship. While these strategies may have been adaptive in the context of the early attachment relationship they often become maladaptive with coping in later life stressors and relationships.

*The Avoidant Dimension*

People who score high on the avoidance dimension tend to have a negative view of others and utilize deactivation strategies when the attachment system is threatened. Deactivating strategies evolve from previous experiences in which emotionally cool, distant, reacting, or hostile caregivers reacted to infants’ cries for help and support by withdrawing, disapproving or reacting with anger (Mikulincer et al., 2008). If the caregiver persists in this kind of behavior, the child will most likely inhibit, suppress, of deactivate normal attachment behavior, which in turn leads to an “avoidant” attachment style (Mikulincer et al., 2008).

The “deactivation affect regulation strategy” enables the individual to maximize distance from attachment figures. Avoidant individuals distance themselves from distress-eliciting material. This distancing is accomplished by diverting attention, and inhibiting deep, elaborate encoding of information, rather than by actively repressing it from memory. This strategy is designed to hold distressing material out of awareness and memory right from the start, reducing the accessibility of negative memories. The emotions they do recall are somewhat shallow
psychologically. The deactivating strategy is thought to be used for defensive exclusion of painful memories. The individual attempts to deactivate potentially threatening situations by maintaining distance in relationships; the purpose is to minimize distressing and painful emotions.

These individuals report discomfort with close relationships, and difficulty depending on significant others. Furthermore, they strive to avoid perceived vulnerability, dependency, self-disclosure, and interdependence. This includes the wide range of feelings and desires that normally accompany an activated attachment system. Avoidant individuals tend to be characterized by compulsive self-reliance, and preference for emotional distance from others (Bartholomew et al., 1991; Griffin et al., 1994; Mikulincer, Shaver & Pereg, 2003). Through these behaviors, the avoidant individual is able to suppress attachment related distress and discount threats that may activate the attachment system.

*The Anxiety Dimension*

Hyper-activation strategies are formed through previous experiences in which inattentive, self-preoccupied, or anxious attachment figures were perceived as more likely to respond favorably if the typical attachment signals of crying, calling, and clinging were amplified to the point of demanding a response (Mikulincer, et al., 2008). Since this response is sometimes effective in relieving distress, and sometimes not due to the unpredictable nature of the caregiver, it is highly resistant to extinction (Mikulincer, et al., 2008). People who utilize these hyper-activation strategies tend to be especially vigilant to perceived threats, fears, needs, and doubts. Those that adopt this strategy are predisposed to excessive dependency behaviors, the purposes of which are to maintain proximity to the attachment figure.
Secure Pattern of Attachment

Utilizing Bartholomew’s two dimension approach, securely attached individuals score low on both the avoidance and anxiety dimensions. Research consistently finds that secure people can adaptively manage life stressors. The attachment system is activated mainly by threats to well-being. Securely attached individuals tend to acknowledge distress without becoming overwhelmed by it. These people have internalized their secure base as an inner resource that helps them cope and adapt to various distressing circumstances. Not only do securely attached people view stressful events as manageable, but they also have confidence in others’ goodwill which facilitates their optimistic and hopeful attitude toward life. In threatening or difficult life events, these individuals tend to revise erroneous beliefs, to explore their own strengths and weakness, and reflect the capacity for insight and empathy (Mikulincer et al., 2003).

Dismissing Avoidant Pattern of Attachment

The dismissing avoidant pattern is characterized by a positive view of self, and a negative view of others; thereby having a high level of avoidant characteristics. Dismissing individuals downplay the importance of others whom they have experienced as rejecting. In this manner they are able to maintain high self-esteem and a negative view of others. However, these positive self-views are likely to be built of defensive structures, such as perfectionist attitudes. These individuals can have a compulsive reliance on their perfectionist, performance orientation attitudes in order to head off the possibility that others may discover their flaws and reject them (Shorey, 2006).

Therapeutic implications with the dismissing client. The dismissing clients tend to deny their need for help (Slade, 2008). Moving these clients from isolation to intimacy requires
coaxing their brains’ right hemispheres into the relationship. For the purpose of avoiding
closeness and feeling, a dismissing client may have learned to use mainly the left-hemisphere of
his or her brain to organize his or her world according to linear logic and language. In his book
Attachment in Psychotherapy (2007, Wallin suggests that the therapist be attuned to the
dismissing client’s subtle affective cues, by noticing nonverbal gestures, tone of voice, posture,
etcetera, cultivating right-hemisphere awareness. By definition, the dismissing client tends to
devalue others. This exposes a double bind in the therapeutic relationship. The dismissing
client’s defensive strategy is to devalue relationships, including the therapeutic relationship.
These individuals’ avoidance of intimacy preempts the possibility of establishing close
relationships that might otherwise help them update their internal working models of other
people (Bartholomew et al., 1991).

Although empathy and confrontation are vital ingredients in opening the client to
emotional experience, the dismissing client often requires more than empathic mirroring and
interpretation (Wallin, 2007). It is helpful for therapists to express deliberate or spontaneous
expression of their subjective experiences of what it’s like to be on the receiving end of these
clients’ behaviors and communication. This is what Adler referred to as cultivating the client’s
social interest, since the client often fails to empathize and understand his or her impact on
others. In the therapeutic setting the therapist can run the risk of over self-disclosure
(preoccupied attachment style). However, there are also risks in presenting an overly controlled
or reserved, demeanor (the dismissing attachment style) (Wallin, 2007). The empathically
attuned, securely attached therapist is most likely to find the balance (Dozier, Cue, & Barnett,
1994).
Psychopathology associated with the dismissing style. The dismissing states of mind appear to reflect attempts to minimize attachment needs. Theoretically, pathology associated with the dismissing state of mind involves turning attention away from one’s own feelings. This would include disorders such as antisocial personality disorder, eating disorders, substance abuse and dependence, hostile forms of depression, and externalizing forms of anxiety disorders (Dozier et al., 2008). The review of the attachment research provides evidence that appears to support this hypothesis with some exceptions (Dozier et al., 2008).

Preoccupied Pattern of Attachment

The individual with a preoccupied attachment style is likely to manifest a negative view of self, and a positive view of others. The defensive strategy most often used in coping with perceived relational threats is to blame self rather than others. In this manner they are able to maintain a positive view of others, at the expense of a negative self-evaluation (Bartholomew et al., 1991). These people score high on the anxiety dimension, and tend to use hyper-activation as an affect regulation strategy. When a preoccupied person perceives a threat in the attachment system, he or she attempts to minimize relational distance by eliciting support through clinging and controlling behaviors. Behind these behaviors is an insatiable need for intimate relationships to validate the self. The absence of intimacy leaves the preoccupied individual vulnerable to extreme distress. Preoccupied, with fears of abandonment, rejection, and loneliness, these individuals tend to focus on their own distress, ruminate on negative thoughts, and adopt emotion-focused coping strategies. Unfortunately, such a strategy typically exacerbates rather than diminish the preoccupied person’s internal distress.

The therapeutic stance with the preoccupied client. Research indicates that a preoccupied client’s neediness and dependency makes it difficult to use the therapist
productively (Dozier et al., 2008). The preoccupied client may present themselves as being very vulnerable and fragile, and others typically reinforce this perception by taking care of them (Dozier et al., 1994). While dismissing clients appear to cut off from the social-emotional right brain, the preoccupied seem to struggle with accessing the left brain’s ability to make logical sense out of overwhelming emotion.

The preoccupied client is most likely to connect to others through helplessness and dependency. Desperate to avoid being abandoned, the client is often too fearful to assert themselves, and too willing to please. In the therapeutic relationship these clients often feel compelled to achieve closeness by maintaining the appearance of helplessness while making the therapist feel helpful and needed (Wallin, 2007). Therapists need to be alert to their potential needs to rescue or to be idealized. It is imperative for the therapist to see the defense strategy and internal working models underlying the client’s behavior. The therapist needs to give the client the opportunity to struggle with the fear and distrust that makes compliance and pleasing seem so necessary. As the client feels less compelled to please, comply and monitor the therapist’s response, he or she can then focus attention on the self and personal experience.

Most likely, the goal of the hyper-activation strategy of attachment is to ensure the attention and care of those who otherwise seem unavailable, mirroring the client’s preoccupied childhood attachment experience. The therapist needs to respond to the deeper feelings that underlie the client’s wide array of distressful behaviors. The therapist can then foster a more expansive version of closeness in relationships so the client can be more fully and authentically present rather than disappear into preoccupation regarding the availability of others (Wallin, 2007). The preoccupied client tends to underestimate existing strengths and resources so the therapist must refuse to accept the client’s negative self appraisal. It is helpful if the therapist,
through encouragement, expects more of the client than the client himself. The securely attached therapist appears to have an easier time in seeing the purpose of the client’s behavior as the client’s indirect pleas for connection while experiencing intense fear of unmet needs and perceived abandonment (Dozier et al., 1994).

_Psychopathology associated with the preoccupied style._ The preoccupied state of mind appears to reflect attempts to maximize attachment needs. Theoretically pathology associated with the preoccupied state of mind involves absorption with one’s own feelings. This involves internalizing forms of depression and anxiety, as well as borderline personality disorder (Dozier et al., 2008). Review of the attachment literature appears to support this hypothesis with some exceptions (Dozier et al., 2008).

_Fearful Avoidant Attachment Pattern_

The fearful avoidant attachment style reflects a higher level of attachment trauma and is characterized by a negative view of self and a negative view of others. Individuals with a fearful style were consistently associated with social insecurity and lack of assertiveness (Bartholomew et al., 1991). This style results in both a high level of avoidance and anxiety. These individuals feel, similar to the preoccupied person, an intense need to be accepted, supported and reassured due to their negative image of self. Yet often these persons as Mary Main articulated ‘freeze mid-stride’ as they perceive relational threats at relatively low levels. In response the individual then strives to avoid anticipated rejection and abandonment from significant others.

_The therapeutic stance with the fearful unresolved client._ The client with disorganized attachment is characterized by consistently overwhelmingly painful experiences that result in an attachment disruption without a corresponding repair in the relationship. In early attachment relationships, the developing hippocampus is temporarily deactivated by trauma. The child
repeatedly experiences intense feelings of fear, helplessness, humiliation, shame, and/or abandonment in relation to attachment figures that did not provide subsequent repair (Shapiro & Maxfield, 2003 as cited in Wallin, 2007). This cumulative relational trauma requires the child, and predisposes the adult, to resort to primitive self-defense mechanisms. These defenses, when below the client’s awareness, may bring the client’s unstable internal world into the relationship with the therapist. As the client enters into the relationship with the therapist, the client’s feelings which often arise are associated with attachment trauma.

With the disorganized client, both empathic attunement and secure limit setting is imperative. Without empathic attunement, the client can not feel understood. Without setting limits, the therapist may feel too overwhelmed and angry to offer empathy and meaningful help. It is necessary for therapists to pay close attention to their own subjective experiences in relation to feelings, images, impulses that arise. The therapist also needs to assess what the unresolved client needs as the client inevitably reenacts prior unresolved relationships. Utilizing this subjective barometer is the right brain to right brain connection that is so crucial for secure attachment (Fonagy, 2008). When the therapist succeeds in providing help through empathy, limit setting, and reliable availability the client’s attachment expectations are disconfirmed. Often the therapist must be willing to endure round after round of attunement, misattunement, and interactive relational repair before the unresolved client can begin to trust. The client may experience the therapist’s help as controlling, intrusive, and/or misattuned, and intense fears of abandonment and/or betrayal may arise. Understandably, the disorganized/unresolved client experiences unstable, stormy, and extraordinarily difficult relationships; this often includes the therapeutic relationship.
Many unresolved clients are extremely reluctant to let their guard down. Helping the client recall the trauma, naming trauma-related feelings and bodily sensations, making implicit memories explicit within the context of an increasingly secure therapeutic relationship are among the essential ingredients in the treatment of the unresolved client (Wallin, 2007).

*Psychopathology associated with fearful/unresolved client.* Borderline, dissociative, post-traumatic stress and antisocial disorders appear to be associated with unresolved trauma, as is an early childhood history of disorganized attachment (Dozier et al., 2008). Children who have caregivers that do not provide protection from harm and are at times threatening themselves leave children with little option but to develop significant distortions of self and others as well as maladaptive coping mechanisms. These severe distortions are laid down as patterns in the neuro-pathways of the brain, thus the development of Borderline and antisocial personality disorders (Dozier, 2008). Maladaptive coping solutions are reflected in the pathology of dissociative disorders and post traumatic stress disorder (Dozier et al., 2008).

*Therapist’s Attachment Style and the Effect on the Therapeutic Relationship*

It is most beneficial for the therapist to cultivate and develop the internal resources reflected in a securely attached individual. Dozier, Cue, and Barnet (1994) evaluated the attachment classification of therapists and their clients, and found that insecure therapists tend to reinforce the insecure attachment patterns of their clients. The secure therapist seems to have the resources necessary to respond to the client in a manner that facilitates change, even when this response creates interpersonal discomfort. Furthermore, the secure therapist does not seem to perpetuate the client’s existing insecure patterns of relating to others, and encourages the client to move towards more secure patterns of relating. In this manner, the therapeutic relationship differs from other relationships. A secure therapist can take responsibility for reactions to the
client that stem from the therapist’s own childhood. Many times the insecurely attached clinician responds in a complementary fashion to the client’s behavior and defenses, and can perpetuate the client’s view of relationships (Dozier et al., 1994).

The hyper-activating and deactivating defensive strategies are likely to bias the insecurely attached individual’s appraisals of self and others, mainly in threatening situations that activate the attachment system (Mikulincer, Orbach, & Iavnieli, 1998). The circumplex analysis of the two dimensional model allows the individual to approximate each of these four attachment prototypes to varying degrees, thus providing a multidimensional assessment of attachment (Bartholomew et al., 1991).

Attachment patterns: Resilience and Coping with Later Trauma

Secure attachment appears to enhance an individual’s ability to view life’s stressors as manageable, and to maintain the view that external obstacles can be overcome. Secure persons tend to hold more optimistic expectation about their abilities to cope with stressful events, and are more likely to turn to others for support. This secure mindset may reduce anxiety and enable the individual to formulate positive, constructive strategies. It is also an indicator of the ability to solicit support from others in order to facilitate adaptive coping with environmental stressors. This in turn results in more positive expectations of one’s ability to regulate negative moods, more hopeful attitudes toward life, and hardier, more stress-resistant attitudes (Mikulincer et al., 2008).

Mikulincer, Florian, and Weller (1993) investigated the association between adult attachment style and an individual’s reaction to the Iraqi missile attack on Israel. The findings in this study confirm the different reaction patterns of individuals based on a specific attachment style: secure, ambivalent, and avoidant as evident in a real-life traumatic event. In response to the
missile attacks during the Gulf War, the hyper-vigilance of ambivalent persons manifested itself in heightened emotion-focused coping, and in high reported levels of posttraumatic emotional distress. In contrast, avoidant persons relied more on distancing coping for dealing with the traumatic events, removing anxiety and depression from their emotional responses, while probably expressing their distress indirectly through higher somatization. Avoidant people also reported more hostility, regardless of the objective level of situational threat, possibly reflecting a generally antagonistic approach toward the world.

In a rigorous control study, Wayment and Vierhaler (2002) explored participant attachment styles and three specific reactions to bereavement: grief, depression, and somatization. The study consisted of a sample of 91 adults who had lost a loved one in the past 18 months. Results from the study suggest that persons who have adopted an anxious-ambivalent attachment style appear more likely to display increased levels of depression and anxiety over time. Avoidant individuals tend to avoid displaying negative affects immediately after a loss, and may continue to do years afterward. However, individuals with an avoidant style may have more of a greater tendency for somatic complaints in lieu of higher levels of grief or depression. This is consistent with other research that confirms the avoidant types either are able to avoid experiencing emotional distress, or are at greater risk to have emotions to work themselves out in physical complaints.

Secure individuals seem less likely than anxious-ambivalent types to interpret the loss in a way that might lead to depression. It appears that the secure person’s positive view of self and others provide the inner resources for adaptive coping during times of loss, such as bereavement. As a result, it appears that secure persons are less susceptible to more pathological reactions,
such as depression. A therapist who knows the client’s attachment style may more easily identify those at-risk following bereavement. This will significantly aid in earlier intervention.

Dieperink, Leskela, Thuras, and Engdahl (2001) investigated adult attachment style and post-traumatic stress disorder (PTSD) symptomatology in 107 veterans who have been prisoners of war (POW). This study examined the relationships between adult attachment styles, severity of trauma experienced as an adult, and PTSD symptoms. Overall, 65 percent of the 107 former POWs reported insecure attachment styles. This was significantly higher than the 45 percent rate reported in studies of college students (Shaver & Hazan, 1993 as cited in Dieperink, et al., 2001). Among those with insecure attachment, 42 percent met current criteria for PTSD, compared to 10.8 percent of those reporting secure attachment (Dieperink, et al. 2001). Veterans with insecure attachment styles had significantly higher scores on all the three PTSD symptom criteria groups. These three symptom clusters include: re-experiencing intrusive recollections of the traumatic event, avoiding thoughts; feelings, and activities associated with the trauma; and hyperarousal which includes sleep disturbances, exaggerated startle response, irritability, anger outbursts, difficulty concentrating, and/or hypervigilence. Conversely, on the secure scale, those veterans meeting PTSD criteria had scores that were significantly lower in symptomatology than those with insecure attachment.

These research findings indicate that insecurely attached POWs were more likely to develop PTSD and to manifest more symptoms than POWs with a secure attachment style. In the study, attachment style was the strongest predictor of PTSD symptoms. Trauma severity and weight loss in captivity contributed to a much lesser extent.

Based on the findings of these three controlled research studies, attachment style may be an important risk or resilience factor for determining the impact of traumatic life stressors; such
as, complicated grief, reactions to war related stressors, and war related PTSD. In such cases, a secure attachment style could be protective because a positive view of oneself and others permits better use of both internal and external supports. The secure person seems to have a higher tolerance of traumatic events, and less likelihood of developing psychopathology when exposed to such events. Unsuccessful early attachment behavior might lead to cognitive biases against the availability of others during times of stress. Those with insecure attachment see others as unreliable and are consequently less likely to elicit help from others effectively, if at all, in coping with and recovering from the effects of trauma. Such biases, combined with poor affect regulation, could mean that an individual is more easily overwhelmed by trauma and less resilient in its aftermath.

Insecure people -- both preoccupied and avoidant -- have an early attachment experience characterized by unstable and unpredictable distress regulation by the caretaker, and a sense of personal inadequacy in relieving one’s own discomfort. Traumatic early attachment experiences may develop into a generalized internal working model that reacts to all life difficulties as threatening, irreversible, and uncontrollable. When encountering such situations, insecure people may react with strong emotional distress, which continues even after the actual threat is over. Their sense of smallness, powerlessness, and a sense of a lack of belonging and support may thwart the resolution of trauma.

Secure people may have attained in early attachment experiences the inner resources that help facilitate effective coping with future stress situations. The current findings show that these inner resources manifest in optimistic expectations, a strong sense of self-efficacy, and self-confidence in seeking outside help in time of need. Positive early attachment experiences teach people that adversities, although difficult, are manageable. This fosters a generalized, stable
constructive attitude that helps buffer emotional distress (Mikulincer, Florian, & Weller, 1993; Mikulincer et al., 2008).

Given these study findings, attachment style should be a consideration in assessment and planning for those coping with a traumatic event, such as the bereaved and combat veterans. More attention should be given to developing a working alliance with clients who have an insecure attachment style. If attachment style is taken into account when working with a client with PTSD, fewer problems are likely to occur while developing the therapeutic relationship. In this way, problems with relationships in general are less likely to be incorrectly attributed to the traumatic event. The therapist will see clearly that the problems may be related to the client’s older patterns of behavior and longer-term intervention will be needed.

Neuroscience and Attachment Theory

Moving into the new millennium Allen Shore and Daniel Siegel began research on the links between neuroscience and attachment theory. The research indicates that the four patterns of attachment detected by Ainsworth and Main appear to structure the ongoing development of the brain (Siegel, 2007). Many of the interconnections in the cortex begin to develop immediately after birth. These are influenced by both genetics and experiences as the child interacts with his or her environment (Siegel, 2007). Schore (2002) describes how the attuned responsiveness of the mother creates strong neural and psychological health in the infant. Recent neurological research reveals that the period of most rapid brain growth occurs during the first 33 months of life (Schore, 2002). The nurturing interactions that enable the caregiver and infant to form a secure attachment also determines the neural development of the child’s brain and profoundly influences the mind, body, emotions, relationships, and values of the growing child.
The incoming stimuli of mother’s sensitive touch, soothing voice, and peaceful presence trigger activity in the baby’s brain. The mother’s attuned communication with her infant establishes a neural network that associates these maternal stimuli with a feeling of safety. Repeated experiences such as these gratify the infant’s basic needs. The help the infant maintain emotional and physical balance and lay the foundation for a secure attachment.

*The Structure of the Brain*

Picture the brain as the neural equivalent of a three-story, side-by-side duplex divided down the middle to represent the right brain/left brain (Wallin, 2007). The first story represents the brainstem, the second story the limbic system, and the third story the neocortex. The bottom floor, the brainstem, develops first. The brainstem regulates basic bodily functions, including the infant’s attachment signals. It is important to note that the brainstem modulates arousal and regulates the autonomic nervous system (ANS). When the infant feels safe, the sympathetic nervous system calms the body and slows the heart so that social engagement becomes possible. When the infant feels endangered, the sympathetic nervous system is mobilized for fight or flight. If the infant feels in mortal danger, the more primitive parasympathetic system shuts down and immobilizes the infant. The infant feels helpless and freezes or rather “plays dead.” Over arousal, due to early attachment trauma, can lead to maladaptive responses to low-level threats in everyday situations.

The limbic system is the second floor of the duplex, the emotional part of the brain where the individual processes feelings. It represents nonverbal language that makes possible effective social interaction. In addition, the limbic system is vital for memory, learning, and motivation. Whether an infant’s cry evokes mother’s comforting presence, irritation, fear, or indifference,
these experiences are encoded in the infant’s emotional memory and guide future evaluations of security or risk (Neborsky, 2006).

The amygdala, well developed at birth, can be described as the stairway from the brainstem to the limbic system. The amygdala is responsible for an individual’s instant appraisal, and intuitive sense of other people. When a threat is perceived, the amygdala appraises sensory input instantaneously then signals the brainstem to activate the para-sympathetic nervous system. This primes the body for the fight or flight response. The response can become maladaptive when an individual has a traumatic attachment that taints the present circumstance. For example, clients with a history of traumatic attachment may be predisposed to perceive various social signals as dangerous when, in fact, they could be unclear, non-threatening, or even positive.

The amygdala does not have the ability to differentiate according to the context of the present situation. The hippocampus begins to develop during the second to third year of life and continues to mature through late adolescence. Secure attachment allows the developing hippocampus to regulate the reactivity of the primitive amygdala. Regrettably, severe relational trauma can temporarily shut down the hippocampus or inhibit its development. Then, the child is left in an unregulated state due to the amygdala’s over-vigilant and non-discriminate reaction. Although the adult is capable of exhibiting mature response patterns, neurological evidence suggests that the adult brain may regress to an infantile state when it is confronted with severe stress (Schore, 2002; Siegel, 2007).

In the therapeutic setting, it is helpful to be attuned to the client’s over-arousal. The therapist can then help the client effectively modulate their levels of physiological arousal, and their insecurities around relational engagement. It is imperative to remember that early preverbal attachment memories are emotional memories that exist for the most part out of the client’s
conscious awareness. Hence, the client may automatically associate closeness with danger. These preverbal memories tend to be global, over-generalized, have an undue influence on the client’s personality structure (Wallin, 2007).

In many cases, these preverbal memories may only be retrieved through the sensations, feelings, images, or impulses that reflect active internal representations of the client’s early attachment experience (Schore, 2002; Neborsky, 2006). After psychological safety has been established in the therapeutic relationship, the therapist can encourage the client to re-experience and reprocess early relational fears and hurts through the recollection of early memories. The therapist can incorporate therapeutic exercises that facilitate the client in rewriting these experiences in a way that transforms the past and develops new healthier associations in the brain. Then the therapist can help the client to challenge existing internal working models in relationships with significant others and in social encounters in everyday life. Thus, the client begins to cultivate the capacity for reflective function or as Adler noted social interest.

On the third level of the duplex lies the cerebral cortex. Its purpose is to make sense of experiences and organize interactions with others. The cerebral cortex matures gradually as it accumulates experiences and new learning throughout the individual’s lifespan. The middle, prefrontal cortex is the most advanced area of the cortex. It has two main regions. The first region is the ‘rational mind’, which specializes in cognitive intelligence. This region networks with the hippocampus and the linguistically oriented left hemisphere. The second region specializes in emotional intelligence. This second section, the middle prefrontal cortex, has rich connections to the amygdala and the emotionally oriented right brain (Siegel, 2007). The middle prefrontal cortex is an integrative region that links the body proper, brainstem, limbic system and
cortex. This region of the brain, acts as a mediator of attachment behavior, affect regulation, social communication, and reflective function. (Schore, 2002; Siegel, 2007).

The cortical area, is located directly behind the eyes, is called the orbitofrontal cortex (OFC). It regulates the amygdala’s rapid responses to perceived threats. The OFC appears to discriminate, and contextualize threatening emotional signals, such as threatening facial expressions, allowing the person to discern the degree of threat. This contrasts with the more reactive function of the primitive amygdala. The ability of the OFC to discriminate the level of threat helps the individual develop self-regulation and social relatedness. If sophisticated parts of the cerebral cortex remain underdeveloped or biologically impaired, the individual can have difficulty with affect regulation, assessing his or her own impact on others, and responding adeptly to social cues (Schore, 2002; Siegel, 2007). The OFC is well-connected to other areas of the brain and has the capacity to integrate and synthesize information coming from somatic body sensations, emotions, and thoughts; all of which allow the individual to be in tune with others. Schore (2002) refers to the OFC as the senior executive of the social-emotional brain. The caregiver with a fully developed OFC facilitates the development of attachment security in his or her child.

The two units in the duplex represent the right and left hemispheres. The right hemisphere responds emotionally, holistically, nonverbally, intuitively, relationally, and receptively. This hemisphere responds to the whole context, rather than the individual parts. The right brain can take in the context and multiple perspectives on an experience and, in an attuned manner decipher nonverbal communication. The left hemisphere responds in an entirely different manner. It interprets experience through language. It functions with a logic that is linear,
methodical and includes a focus on details. As a result, this hemisphere is equipped to calculate future possibilities.

The third story, the neocortex, is able to take an experience through the senses of the body, and then encode these repeated experiential patterns in the mind as memories (Siegel, 2007; Wallin, 2007). These memories in turn influence the mind’s ability to predict what to anticipate in the immediate and distant future. As a result, internal working models fashioned from numerous early attachment experiences with the caregiver affect a person’s perceptions. These early life experiences of attachment and nurturance are the first patterns the brain lays down: the model of self, others and the world. Healthy early attachment relationships strongly influence the development and integration of the brain stem, limbic and cortical functions as well as the right and left hemispheres.

*Therapeutic Ramifications of Brain Research*

The therapist needs to understand the developments of both the brain and secure attachment in order to respond to the client in ways that facilitate integration and security. Current research reveals that both adult and children’s brains can be reshaped by current experience. The work not only establishes new neural connections, but it also alters the architecture of the brain (Siegel, 2007). The discovery of neural plasticity is encouraging for clinicians who want to foster therapeutic change effectively.

The attachment model combined with the reactivity of the ANS, indicates that a person’s maladaptive ways of regulating emotion and relationships can be driven by fear: such as fear of rejection, abandonment, neglect, danger, and many other possibilities. From this perspective, hyper-activating and deactivating defense strategies observed in the insecurely attached client can be seen as functions to protect the self from unbearable affects, as well as a way to protect
the caregiver. For example, a child may experience terror from losing the caregiver through neglect and/or abandonment. Rage is an easier emotion to bear than terror. Holding this fear and rage inside can protect the child from the unbearable fear of losing the attachment figure who, the child may perceive, was not willing or able to help bear his or her intense emotions.

Brain and attachment research also reveals to therapists the importance of focusing on clients’ nonverbal communication. It is crucial to focus on what is sensed, felt, and done by the client, rather than only that which is communicated verbally. A potent resource for strengthening the client’s capacity for affect and self-regulation is attention to the internal experience, especially bodily sensations (Wallin, 2007). This focus helps ground clients in the present moment, and regulates the distress associated with a traumatic past and a feared future (Wallin, 2007). Asking clients to label what they feel in their bodies can expand cortical capacities in processing somatic/affective experience. The therapist can help enhance the client’s bodily awareness so he or she can have a growing sense that feelings can be painful without becoming overwhelming. This process can facilitate the client’s conscious processing and integration or, as Fonagy referred to it, reflective functioning.

The preoccupied client with reoccurring trauma tends to reenact the trauma in subsequent relationships, including with the therapist (Wallin, 2007). The preoccupied client’s “hyper-activating” strategy appears to be associated with a highly reactive autonomic nervous system. This is manifested in an exaggerated startle reflex and the length of time it takes the client to regain equilibrium (Mikulincer, 2008). This type of client is especially vulnerable to rapid, intense reactions to perceived threats. It is as though the amygdala were unmodulated by the hippocampus. Some clients become extremely agitated as if in a fight or flight mode, others can become drowsy, dissociate or freeze.
Further research indicates that using language to describe distressing experiences reduces the overwhelming neural impact. For example, subjects shown upsetting images and instructed to describe the image show much less activation of the amygdala than subjects who were exposed to images without corresponding verbalization (Wallin, 2007). In addition, evidence suggests that “reappraisal” or “reframing” difficult emotional experiences can modulate the amygdala’s reactivity (Siegel, 2007). In summary, it appears that affect regulation can be strengthened when language and interpretation are enlisted in the present moment processing of emotionally charged material, including nonverbal, bodily based feelings.

Brain research also provides evidence that emotion regulation is enhanced through meditative focus on the breathing body. Siegel (2007) noted that individuals who anchor their meditative practices by focusing on the breath show cortical thickening, particularly in areas that integrate thoughts with bodily-based feelings. The therapeutic ramifications indicate that focusing on somatic, emotional, and internal working models, within a secure therapeutic relationship can help establish new connections in the brain, moving the client towards psychological integration.

Kabat-Zinn, (2003) as cited in Siegel (2007) defines mindfulness as the awareness that emerges through paying attention on purpose, in the present moment and nonjudgmentally, to the unfolding of experience moment by moment. Siegel, (2007) clarifies nonjudgmental as not “grasping onto judgments,” since the mind continually comes up with reactions that assess and react. In his review of attachment literature and neuroscience literature, Siegal (2007) believes that through secure attachment and mindful awareness practice, individuals could obtain well-being, compassion and resilience. Furthermore, both secure attachment and mindful awareness are represented by certain integrative regions of the prefrontal cortex {Siegel, 2007}
Some children grow up without ever experiencing the attunement of a loving caregiver that enabled them to “feel felt.” This mental state is crucial for vibrant relationships and a sense of feeling understood and at peace. Siegal (2007) proposes that mindful awareness is a form of intrapersonal attunement that allows a person to become his or her own best friend. This type of attunement may lead the brain to grow in ways that promote balanced self-regulation resulting in neural integration that facilitates flexibility and self-understanding (Siegel, 2007). This enables one to embrace his or her internal world and, as a result, embrace the minds of others with kindness and compassion. This type of attunement and reflective function is found in individuals who are able to provide their children with secure attachment (Fonagy et al., 1991b; Wallin, 2007; Fonagy, 2008).

Attachment Disruption, Brain research and Adult Psychopathology

Disruptions in the parent-child bond are precursors to insecure attachment in adulthood. Maladaptive relationship patterns that develop in early childhood can continue to regulate relationship behavior into adulthood. From a neurobiological standpoint, a child who found attachment figures frightening may fail to develop the integrative neural structures that help modulate the brain’s emergency response system: the amygdala. Without such integration and regulation, low level threats will likely provoke an extremely intense autonomic response. The lack of integration and over-reactivity of the amygdala can result in all-or-nothing, black-or-white, either-or forms of feeling, thinking, and relating. This produces experiences of self and other that are compartmentalized, oversimplified, unrealistic, and unstable (Wallin, 2007). People can be viewed as heroes or villains, persecutors or victims, rescuers or helpless (Wallin, 2007). The unresolved client’s view of others can easily slide from one category to its opposite.
Borderline Personality Disorder (BPD)

Fonagy, (2008) proposes that the combination of genetic predisposition, early inadequate mirroring, and the relational trauma reflected in a disorganized attachment shape the pathology of BPD. The impact of relational trauma is most likely to be felt as a caregiver’s general failure to consider the child’s perspective. The child experiences neglect, rejection, excessive control, a lack of support, incoherence, and confusion. These experiences can devastate the world of the developing child and leave deep scars that are evident in their social-cognitive functioning and behavior.

Fonagy considers reflective functioning a major developmental achievement that originates and develops in the context of the attachment relationship. The disruption of reflective functioning development is a major aspect of the psychopathology of BPD. Fonagy and his colleagues were able to associate failures of reflective functioning with psychopathology, most notably borderline personality disorder (Cassidy & Shaver, 2008; Fonagy, 2008). The ability to understand others depends on whether an infant’s mental state was adequately understood by a caring, attentive, and nonthreatening adult.

As cited in Fonagy (2008) Levy (2005) reviewed nine research studies that have examined attachment patterns with clients diagnosed with BPD. Although the relationship of a BPD diagnosis and a specific attachment type is not evident from these studies, it is obvious that BPD is strongly associated with insecure attachment. Only 6-8% of BPD clients in these studies tested as having a secure attachment. Individuals with BPD appear to have the capacity for reflective function in normal conditions. However, when emotionally aroused and in intense interpersonal encounters, these individuals tend to misread minds, both their own and others.
Therapeutic Ramifications with BPD Clients

Research suggests that many, if not most, borderline clients are both preoccupied and unresolved with respect to recurrent trauma (Fonagy, 2008; Tobin et al., 2007). The BPD client struggles with not merely painful emotions, but feelings that are overwhelming in their intensity. These clients often feel chaotic and empty inside. The BPD client’s relationships are typically stormy, and often end in what feels like betrayal. Reflecting a disorganized fearful attachment, the BPD client often fluctuates between terror of dependency and a seemingly bottomless need for validation. These individuals may appear desperate for help, yet convinced that their overwhelming needs will drive others away. Wallin, (2007) describes working with BPD clients as “trying to save a drowning man who fights off aid as if it were an attack.” The challenge for the therapist with a BPD client is to remain engaged, maintain firm boundaries, and refuse to be pushed away.

The first priority for the therapist is to establish a strong, positive therapeutic relationship. When this is accomplished the client experiences being genuinely accepted and cared for. The therapist must utilize acceptance and nurturing strategies balanced with change demanding strategies in a clear and centered manner (Linehan, 1993). The therapist needs to express warmth and control simultaneously within the therapeutic setting. Maintaining control in a session depends upon a strong therapeutic relationship. The BPD client will probably experience a therapist who does not convey warmth and acceptance as hostile and demanding. It is imperative for the therapist to possess empathetic attunement to accomplish this therapeutic alliance. Without it, the client may feel invalidated, alone and/or threatened and betrayed. The client will then believe that the therapist has given up on him or her.
A significant amount of emotional suffering for the BPD client stems from maladaptive behavioral strategies to obtain self-validation. If the therapist focuses primarily on change, this can emphasize the client’s fragility and continue the cycle of invalidation. The therapist needs to find ways to utilize the client’s strengths while consistently maintaining the belief that the client possesses the inner resources to build a meaningful life (Linehan, 1993). This combination can serve as a catalyst for change in the BPD client.

When the attachment system is triggered, the individual with BPD does not have capacity to reflect on feelings, thoughts and wants; the client is overwhelmed and swallowed up by current circumstances. Fonagy and colleagues found that the individual’s strong reflective functioning capacity was protective in instances of trauma. This capacity significantly decreases the likelihood of developing severe psychopathology such as borderline personality disorder. Alder believed that an individual’s capacity for “social interest” insulated and protected the individual from developing psychopathology.

Conclusion

Understanding how attachment figures provide secure attachment helps the mental health practitioner promote psychological healing and integration in an atmosphere of felt security for the client. Consistent with Fonagy’s findings, it is helpful for the therapist to offer a contingently marked collaborative and coherent dialogue which makes room for the client’s feelings, thoughts, and desires. Second, the empathically attuned therapist is sensitive to disruptions in the therapeutic relationship and initiates constructive repair. Third, the therapist consistently maintains a stance of acceptance combined with the encouragement that expects the client to reach slightly beyond believed capabilities. Fourth, the therapist, when fitting, is willing to
challenge, require reasonable limits, and struggle with the client while remaining engaged in the relationship.

What makes successful therapy so difficult to achieve is that the target organ, the right hemisphere, has no language. It is stimulated by and communicates through images, sensations, and facial expressions. Raising right hemisphere nonverbal feelings to consciousness increases the likelihood that symptoms will be reduced in the client and that character change will ensue. This sounds simple but, in reality, this is an enormously difficult task. The brain can develop an elaborate defensive structure to protect the client from fear without solution, or the fear of upsetting the attachment figure beyond his or her emotional capacity (Neborsky, 2006).

Understanding attachment theory, research findings and the neuroscience of attachment helps the therapist to create an atmosphere of care, compassion, and safety for the client. Neborsky (2006) says that providing the client with an atmosphere of care, compassion, and safety where it feels safe enough to visit the past and experience the intense feelings of the “frightened one” may be the singularly most crucial healing factor in psychotherapy. The art of therapy is to facilitate an environment that primes the attachment system, where the client begins to discover and recover all the yearnings for affection that accompany an authentic intimate relationship. It is crucial that a therapist be trustworthy and genuinely respect those yearnings for affection and intimacy that everyone has but which, in these clients, has sadly been deprived, lost, and in some cases deactivated (Bowlby, 1988).

Establishing an effective therapeutic alliance with an individual who has an insecure attachment pattern requires all the intuition, imagination, and empathy of which a therapist is capable. It is also necessary to have a solid understanding of the client’s unique style of coping. Therapeutic intervention with the insecurely attached client is an enormously difficult
undertaking. This is because the client’s defense system often elicits responses from the clinician that confirm the client’s dysfunctional internal working models. The attachment strategies that the client developed in childhood may have been adaptive for coping in his or her family of origin; however, these strategies are often ineffective when interacting with others, including the clinician. Many clinicians have suggested that the effective therapist reflects on what is evoked internally and responds in a manner that helps the client reformulate working models or expectations in relationships (Wallin, 2007; Bowlby, 1988).
REFERENCES


