HANDOUTS

Attachment in Psychotherapy

Presented By

David J. Wallin, Ph.D.

AGENDA

Thursday

Relational Transformation, Non-Verbal Experience, and the Mindful Self

9:00 **How Attachment Relationships Shape the Self**

- In Childhood
- In Psychotherapy

10:20 **Break**

10:35 **The Patient's Attachment Patterns and The Therapist's Interventions**

- The Impact of the Therapist's Attachment Patterns
- The Dismissing Patient: From Isolation to Intimacy
- The Preoccupied Patient: Making Room for a Mind of One's Own
- The Unresolved Patient: Healing the Wounds of Trauma and Loss

12:00 p.m. ***Lunch***

1:15 **Accessing Nonverbal Experience and the Domain of the Dissociated**

- Working with Evocations, Enactments, and the Body

2:35 ***Break***

2:50 **Upgrading the Stance Toward Experience**

- Embeddedness: When Feelings are Facts, When "Pretend" is "Real"
- Mentalizing: Reflecting on Mental States
- Mindfulness: The Present Moment and the Awareness of Awareness

4:15 Adjournment

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Friday

From the Inside Out:
Therapist Attachment Patterns as Sources of Insight and Impasse

8:30 **Why Focus on the Therapist?**

- The Myth of the "All Good" Therapist
- The Therapist's Attachment History as Resistance and Resource
- Trauma and the Therapist

9:50 ***Break***

10:05 **How the Attachment Patterns of Therapist and Patient Interact**

- Mismatches, Collusions, Collisions

11:30 ***Lunch***

12:45 p.m. **Identifying the Therapist's Attachment Patterns**

2:05 ***Break***

2:20 **Mindfulness in Action**

- Exploring Interacting Attachment Patterns as They Unfold

3:45 Adjournment (Pick up certificates)

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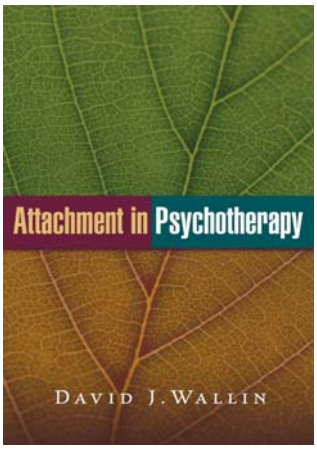


ATTACHMENT IN PSYCHOTHERAPY

RELATIONAL TRANSFORMATION, NONVERBAL EXPERIENCE, AND THE MINDFUL SELF

"*Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler, but throughout his adolescence and his years of maturity as well, and on into old age.*"

John Bowlby, 1980

"*Human beings of all ages are found to be at their happiest and to be able to deploy their talents to best advantage when they are confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise.*"

John Bowlby, 1973

The Story of Attachment Theory

BOWLBY: *Attachment is a biological imperative: the bond of the infant to the caregiver is critical for physical and emotional survival*. Because the infant MUST attach, the infant WILL adapt—for better or for worse—to the needs and vulnerabilities of the caregiver. Those behaviors, feelings, desires which can be contained in the relationship of the infant to the caregiver will be integrated by the infant; those that threaten the attachment bond will be defensively excluded, dissociated, disowned.

The Story of Attachment Theory

AINSWORTH: The quality of the *nonverbal communication* in the attachment relationship determines the infant's security or insecurity. Differing patterns of nonverbal communication result in distinctly different attachment patterns: *secure*, insecure-*avoidant*, or insecure-*ambivalent*.

The Story of Attachment Theory

MAIN: These early biologically driven nonverbal interactions register in the infant as *mental representations* and *rules for processing information* that influence, in turn, how freely the older child, adolescent, and adult is able to think, feel, remember, and act.

The Story of Attachment Theory

MAIN and *FONAGY*: Secure attachment is associated with a *reflective* stance toward experience. Such a stance involves the capacity for *metacognition* (thinking about thinking) and *mentalizing* (considering experience in light of the mental states that underlie it).

THREE FINDINGS OF ATTACHMENT THEORY RESEARCH WITH THE MOST PROFOUND AND FERTILE IMPLICATIONS FOR PSYCHOTHERAPY

Co-created relationships of attachment are the key context for development.

Clinical Implication: Just as the original attachment relationship(s) enabled the child to develop, it is ultimately the *new* relationship of attachment with the therapist that allows the patient to change. In generating a secure base, we help patients both to deconstruct the attachment patterns of the past and to construct new ones in the present.

Preverbal experience makes up the core of the developing self.

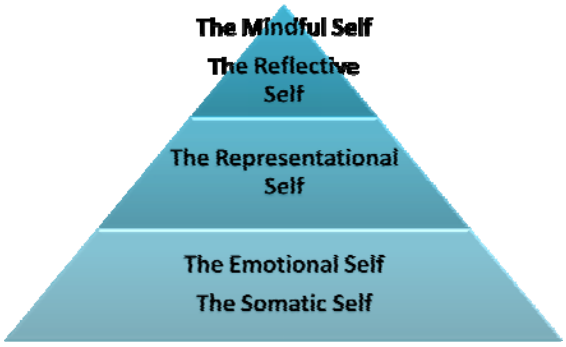
Clinical Implication: We must tune in to the nonverbal expressions of "unverbalizable" experience. What can't be said will tend to be evoked *in* others, enacted *with* others, or embodied. We must therefore attend to our own subjective experience, the transference-countertransference enactments we co-create with our patients, and the language of emotion and the body—for all these are routes to accessing and eventually integrating disowned and dissociated experience.

The stance of the self toward experience predicts attachment security better than the facts of personal history themselves.

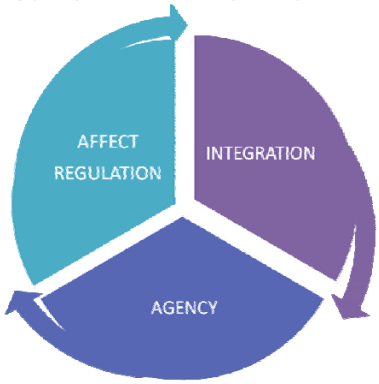
Clinical Implication: We must cultivate in ourselves and attempt to elicit in our patients the capacity for an increasingly reflective (mentalizing) and mindful stance toward experience.

THE BIG PICTURE

THE MULTIPLE DIMENSIONS OF THE SELF



Synergy of Three Key Capacities



THE ATTACHMENT RELATIONSHIP AS A DEVELOPMENTAL CRUCIBLE

Developmental Desiderata

- Make the dialogue inclusive
- Actively initiate repair
- Upgrade the dialogue
- Be willing to engage and struggle

THE AGENDA TODAY: *WHAT WE CAN DO*

- CULTIVATE MINDFULNESS
- STRENGTHEN MENTALIZING
- WORK WITH DISMISSING, PREOCCUPIED, AND UNRESOLVED STATES OF MIND
- WORK WITH THE NONVERBAL DIMENSION: THE EVOKED, THE ENACTED, THE EMBODIED

MENTALIZING AND MINDFULNESS: THE DOUBLE HELIX OF PSYCHOLOGICAL LIBERATION

"The contents of the mental stream are not as important as the consciousness that knows them."
Mark Epstein, 2001

MENTALIZING AND MINDFULNESS, DEFINED

Mentalizing—reflecting on experience in light of underlying mental states—and **mindfulness**—deliberate nonjudgmental attention to the present moment—are distinct, but complementary ways of knowing and responding to experience.

MENTALIZING AND MINDFULNESS, CONTRASTED AND COMPARED

- **Mentalizing** focuses attention on the psychological *depth* of experience—including its *unconscious* dimension and its history.
- **Mindfulness** concentrates attention on the *breadth of* experience in the here and now.
- **Mentalizing** makes sense of the *contents* of experience, while **mindfulness** directs attention to the moment-by-moment *process* of experiencing.
- **Metacognition** and **meta-awareness**: *Thinking about thinking* (and feeling) and *awareness of awareness*.

MENTALIZING AND MINDFULNESS: THE THERAPEUTIC ACTION

- *Both* allow us to recognize how *the interpreting mind mediates our experience of the world.*
- *Both* facilitate dis-embedding, dis-identification, and de-automatization.
- *Both* strengthen the capacities for agency, affect regulation, and integration.
- Synergy of the double helix: Insight induces calming and calming induces insight.
- In psychotherapy, mindfulness often needs to *precede* explicit mentalizing.

Psychotherapy as Two-Person Meditation

"…in most psychodynamic treatments there is a rush toward meaning, leaving the present moment behind."

Daniel Stern, 2004

The Healing Potential of Mindfulness

- The "*no-self*" and the *internalized secure base.*
- Mindfulness diminishes both avoidance ("*let it be*") and anxious preoccupation ("*let it go*").
- Mindfulness brings us into the body.
- Mindfulness can foster acceptance.
- It can widen the somatic/emotional "window of tolerance" by modulating both SNS amygdale-based over-reactivity and PNS hypo-arousal ("shutdown").

More on the Therapeutic Action of Mindfulness

- *Mindfully labeling mental events diminishes their force*, enlisting cortical resources to modulate subcortical emotional responses.
- It helps foster *dis-identification* and *de-automatization.*
- It generates *knowledge of the mind*: How our experience is constructed and reconstructed moment-by-moment ("impermanence") and the distinction between what happens *to us and what happens in us.*

The Mindful Therapist

- Meditation practice.
- "Beginner's mind" (Suzuki) and "evenly hovering attention" (Freud): Approaching the patient "without memory, desire or understanding" (Bion)
- When mindful attention is hijacked by rigid thinking or intense emotion, return to the breath or body to locate conscious awareness.
- Bring heightened focus to *here-and-now experience,* rather than try to "make something happen" or "facilitate change."
- "Fifty minutes to live."

Fostering Mindfulness in the Patient

- What works for the therapist can work for the patient.
- Intervene to draw patient's attention to the *here and now.*
- Intervene to cultivate *acceptanc*e of present experience.
- Help patients grasp difference between events and their reactions to events.
- Intervene to heighten awareness that thoughts and feelings are fluid mental events rather than concrete "realities."

Mentalizing in Psychotherapy

"The patient has to find himself in the mind of the therapist and, equally, the therapist has to understand himself in the mind of the patient…Both have to experience a mind being changed by a mind."

Bateman and Fonagy, 2006

Learning to Mentalize in Childhood

"…the precursor of the mirror is the mother's face…If the mother's face is unresponsive, then a mirror is a thing to be looked at but not looked into."

D.W. Winnicott, 1971

Fostering Mentalizing: The Goals

The *therapist's* mentalizing is key to kindling the patient's as we aim to foster a process of shared reflection that can:

- Generate *multiple* perspectives on experience—rather than being trapped in the "reality" of one view.
- Make sense of experience on the basis of underlying mental states.
- Relate internal and external reality rather than equate or dissociate them.

Fostering Mentalizing: The Focus

- Focus more on patient's *mind* than on the patient's *behavior*.
- Focus on *affect i*n the immediacy of the moment—especially in the context of the therapeutic interaction.
- Focus on *current lived experience* (including the patient's *present* experience in recalling the past).
- Focus more on the *process* than on the *content* of the therapeutic interaction.

Gauging Patients' Mentalizing Capability

- Over-estimating the patient's mentalizing ability can be perilous.
- The strength of the patient's mentalizing is inversely proportional to the intensity of the patient's emotion.
- Does patient show awareness of mental states as the context for experience and behavior?
- Is there a grasp of the *appearance/reality distinction* and of *representational diversity* and *representational change*? In other words, can the patient consider multiple perspectives on the same experience and recognize that experience can change over time?

Fostering Mentalizing: The Hierarchy of Interventions

- Reassurance, support, empathy.
- Clarification and affective elaboration.
- Challenge/confrontation.
- Interpretive mentalizing.
- Mentalizing the transference-countertransference situation.

ATTACHMENT PATTERNS AND THERAPEUTIC INTERVENTION

The Dismissing Patient: From Isolation to Intimacy

Recognizing the dismissing state of mind and the deactivating attachment strategy

- The obsessive/narcissistic/schizoid continuum
- The AAI (insistence on lack of recall, normalizing/idealizing childhood history, overly succinct)
- The cortical/left-brain/parasympathetic nervous system skew

The Dismissing Patient: From Isolation to Intimacy

Empathy, confrontation, and self-disclosure

Patterns of enactment

- The devaluing pattern
- The idealizing pattern
- The pattern of control

The Preoccupied Patient: Making Room for a Mind of One's Own

Recognizing the preoccupied state of mind and the hyperactivating attachment strategy

- The hysteric/borderline continuum
- The AAI (intense troubling feelings intrude, leaving the communication tangential, vague, incomplete, and hard-to-follow)
- The subcortical/right-brain/sympathetic nervous system skew

The (hysteric) pattern of helplessness

The (borderline) pattern of anger and chaos

The Unresolved Patient: Healing the Wounds of Trauma and Loss

Recognizing the unresolved state of mind

- The AAI (lapses in discourse and reasoning)
- Dissociation, projective identification, evocations of intense countertransference
- Hyperactivation (freaking out/acting out) and deactivation (spacing out)

Creating a secure relationship and confronting trauma are interweaving therapeutic processes.

Putting trauma into words

NONVERBAL EXPERIENCE IN PSYCHOTHERAPY

Wordless Language and the "Unthought Known"

The emotional core of the self can be linguistically inaccessible for reasons that are *developmental*, *defensive*, and/or *neurobiological:*

- Attachment models and rules emerge prior to the acquisition of language.
- Experiences that threaten the attachment bond are dissociated.
- Brain centers for speech and autobiographical memory only go "online" between 18 and 36 months of age.
- Trauma that is acute and/or relational suppresses the activity and development of these same neural structures.
- Early-forming internal working models reflect implicit, procedural knowing rather than explicit, linguistically retrievable facts or memories.

Wordless Language and the "Unthought Known"

What cannot be spoken will be evoked in others, enacted with others, and/or embodied.

- Focusing on the nonverbal realm fosters the inclusive dialogue conducive to the resumption of healthy development.
- Such a focus provides a "royal road" to dissociated experience whose access is a precondition for its integration.

Evocations of the Unthought Known

Knowing the patient "from the inside out"

- Projective identification as "body-to body communication"
- The clinician's subjectivity as a vital therapeutic resource
- Projective identification as a two-way street

Evocations of the Unthought Known

What is to be done with what is evoked?

- Understanding our subjective experience
- Making use of our subjective experience

Enactments of the Unthought Known

Transference/countertransference enactments arise where the attachment patterns of patient and therapist interlock.

- Unrecognized enactments (shared embeddedness) can make the therapeutic dialogue less inclusive and less collaborative.
- Bringing awareness to enactments can reveal otherwise invisible facets of the patient, the therapist, and their relationship.

Enactments of the Unthought Known

Recognizing enactments

- *What are we actually* doing *with the patient?*
- Patterns of enactment: Collusion and collision
- Enactments as repetition, enactments as repair

Acting on our awareness of enactments: Intervening

- Processing internal experience, sharing internal process
- Interpretation, personal expressiveness, and the therapist's ability to change

Embodiments of the Unthought Known

"Change ultimately requires connection to bodily experience that has been dissociated." (Bucci, 2002)

- Bodily sensation is the substrate of emotion and formative preverbal experience is largely bodily experience. To reach the emotional, nonverbal core of the self, the "talking cure" must make a place for the body.
- Reading the body
- Talking about the body

Embodiments of the Unthought Known

- Mobilizing the body
- "De-somatization" of the mindless body: The unresolved patient
- "Re-somatization" of the disembodied mind: The dismissing patient

"Essentially, one might say, the cure is effected by love."

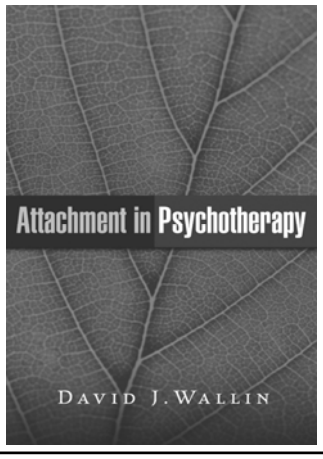
Freud in a letter to Jung, 1906

FROM THE INSIDE OUT

THE THERAPIST'S ATTACHMENT PATTERNS AS SOURCES OF INSIGHT AND IMPASSE

SKETCHING THE BACKDROP

- In childhood and psychotherapy, co-created relationships of attachment are the key context for development.
- The parent's security, insecurity, and/or trauma are regularly transmitted to the child.
- As therapists, our ability to help generate a secure attachment relationship with the patient largely depends on our own attachment history—and our relationship to that history.



Why Focus on the Therapist?

"We are the tools of our trade."

Pearlman and Saakvitne, 1995

Why Focus on the Therapist? (continued)

- The myth of the "all good" therapist
- The healing potential of the therapeutic relationship is ultimately determined by the *interaction* of the attachment patterns of patient and therapist.
- Therapy heals when the new attachment relationship can allow the (often dissociated) core vulnerabilities of the patient *and* the therapist to be engaged—and successfully managed.

The Therapist's Attachment Patterns as Sources of Insight and Impasse

- Attachment patterns are patterns of *knowing*—thinking/feeling/remembering –as well as relating.
- We know others *most* deeply on the basis of what we know about ourselves.
- Our ability to know others will be limited by what we're unable or unwilling to know about ourselves.
- Impasses in treatment are usually related to the therapist's *own* attachment patterns, dissociations, and core vulnerabilities as these interact with those of the patient.

Trauma and the Therapist

- Intergenerational transmission of trauma
- Disorganization compensated for by controlling-caregiving strategy
- The vulnerability of the traumatized therapist.

The Impact of the Therapist's Attachment Patterns

- The therapist's "attachment style": Avoidant, anxious, fearful-avoidant
- The therapist's attachment history: Primary attachment figures and the nature of their influence
- The therapist's dissociated experience.

Enactments: Where the Attachment Patterns of Patient and Therapist Interlock

- **Mismatches**
- **Collusions**
- **Collisions**

Interacting Attachment Patterns of Therapist and Patient

- Dismissing Patient/Dismissing Therapist
- Dismissing Patient/Preoccupied Therapist
- Preoccupied Patient/Dismissing Therapist
- Preoccupied Patient/Preoccupied Therapist
- The Unresolved state of mind in patient and/or therapist.

What is to be done?

- ***Mindfulness in action*: Becoming aware of, and exploring, what we're doing with the patient *while* we're doing it.**
- ***Three key questions to ask ourselves*:**

  What am I actually *doing* with this patient?

  What is the *implicit relational meaning* of what I'm doing?

  What might be my *motivation* for doing what I'm doing?

What else is to be done?

- Managing our own affects
- Mindfulness
- Mentalizing
- Negotiation: Empathy, interpretation, self-disclosure, confrontation, repairing disruptions.

CHAPTER 1

Attachment and Change

. . . the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world.

—JOHN BOWLBY (1988, p. 140)

In the world according to Bowlby, our lives, from the cradle to the grave, revolve around intimate attachments. Although our stance toward such attachments is shaped most influentially by our first relationships, we are also malleable. If our early involvements have been problematic, then subsequent relationships can offer second chances, perhaps affording us the potential to love, feel, and reflect with the freedom that flows from secure attachment. Psychotherapy, at its best, provides just such a healing relationship.

Precisely how as psychotherapists we can enable our patients to grow beyond the limits imposed by their history is a question that attachment theory does not directly address. Yet the ongoing research inspired by Bowlby's original insights has enormous clinical value, offering us a progressively clearer view of the development of the self in a specifically relational context.

In attempting to harness the power of this research, I have identified three findings that appear to have the most profound and fertile implications for psychotherapy: first, that co-created *relationships of attachment* are the key context for development; second, that *preverbal experience* makes up the core of the developing self; and third, that the *stance of the self toward experience* predicts attachment security better than the facts of personal history themselves.

In drawing out the clinical implications of these three core conclusions, I reach into the attachment literature, of course. But I also reach beyond it, not only to intersubjective and relational theory but also to affective neuroscience—which Allan Schore (2004) calls the "neurobiology of attachment"—as well as cognitive science, trauma studies, and explorations of consciousness. The present chapter plumbs the three core findings regarding the developmental centrality of attachment relationships, preverbal experience, and the reflective function. And it distills their clinical yield in a model of psychotherapy that involves the *transformation of the self through relationship*. My aim here is to convey the orientation to emotional healing—the clinical philosophy derived from reviewing research, theory, and personal experience—that underlies all the various approaches I take in order to be of help to my patients.

As I will explain, the proposed model of psychotherapy as transformation through relationship describes a trajectory that parallels the unfolding story of attachment theory itself. Bowlby (1969/1982) began by recognizing that attachment is a biological imperative rooted in evolutionary necessity: The attachment relationship to the caregiver(s) is critical to the infant's physical and emotional survival and development. Given the requirement to attach, the infant must adapt to the caregiver, defensively excluding whatever behavior threatens the attachment bond. Mary Ainsworth's research (Ainsworth, Blehar, Waters, & Wall, 1978) then clarified that it is the quality of the *nonverbal* communication in the attachment relationship that determines the infant's security or insecurity—and along with it, the infant's approach to his or her own feelings. Mary Main's investigations (Main, Kaplan, & Cassidy, 1985) illuminated the ways in which these early biologically mandated nonverbal interactions register in the infant as mental representations and rules for processing information that influence, in turn, how freely the older child, adolescent, and adult is able to think, feel, remember, and act. Finally, Main (1991) and Peter Fonagy (Fonagy, Steele, & Steele, 1991a) highlighted the crucial importance of the stance of the self in relation to its own experience. They showed that security of attachment, resilience, and the ability to raise secure children all are correlated with the individual's capacity to adopt a reflective stance toward experience. Thus, from Bowlby to Ainsworth, Main, and Fonagy, the evolving narrative of attachment theory has unfolded through a focus on intimate bonds, the nonverbal realm, and the relation of the self to experience.

The same three themes organize the model of therapy as transformation through relationship. In this model, the patient's attachment relationship to the therapist is foundational and primary. It supplies the secure base that is the *sine qua non* for exploration, development, and change. This sense of a secure base arises from the attuned therapist's effectiveness in helping the patient to tolerate, modulate, and communicate difficult feel-

ings. By virtue of the felt security generated through such affect-regulating interactions, the therapeutic relationship can provide a context for accessing disavowed or dissociated experiences within the patient that have not—and perhaps cannot—be put into words. The relationship is also a context within which the therapist and patient, having made room for these experiences, can attempt to make sense of them. Accessing, articulating, and reflecting upon dissociated and unverbalized feelings, thoughts, and impulses strengthen the patient's "narrative competence" (Holmes, 1996) and help to shift in a more reflective direction the patient's stance toward experience. Overall, the *relational/emotional/reflective process* at the heart of an attachment-focused therapy facilitates the integration of disowned experience, thus fostering in the patient a more coherent and secure sense of self.

TRANSFORMATIVE RELATIONSHIPS

Very much as the original attachment relationship(s) allowed the child to develop, it is ultimately the *new* relationship of attachment with the therapist that allows the patient to change. To paraphrase Bowlby (1988), such a relationship provides a secure base that enables the patient to take the risk of feeling what he is not supposed to feel and knowing what he is not supposed to know. The therapist's role here is to help the patient both to deconstruct the attachment patterns of the past and to construct new ones in the present. As we have seen, the patterns played out in our first attachments are reflected subsequently not only in the ways we relate to others, but also in our habits of feeling and thinking. Correspondingly, the patient's relationship with the therapist has the potential to generate fresh patterns of affect regulation and thought, as well as attachment. Put differently, the therapeutic relationship is a developmental crucible within which the patient's relation to his own experience of internal and external reality can be fundamentally transformed.

THE UNTHOUGHT KNOWN

Given the prelinguistic roots of the patient's original attachment patterns, and the disavowals and dissociations they may have demanded, the therapist must tune in to the nonverbal expressions of experience for which the patient has as yet no words. That is, the therapist must find ways to connect with what Christopher Bollas (1987) has called the patient's "unthought known." Grasping the unspoken (or unthinkable) subtext of the therapeutic conversation requires what several writers (Bateson, 1979; Bion, 1959) have referred to as the clinician's "binocular vision" that

tracks the subjectivity of both the patient and the therapist. The underlying assumption here is that the patient who cannot (or will not) articulate his own dissociated or disavowed experience will *evoke* it in others, *enact* it with others, or *embody* it. The clinical implication is that the therapist must pay particular attention to her own subjective experience, to the transference–countertransference enactments jointly created by patient and therapist, and to the nonverbal language of emotion and the body—for all these are routes to accessing and eventually integrating what the patient has had to deny or disown.

THE STANCE TOWARD EXPERIENCE: REPRESENTATION, REFLECTION, AND MINDFULNESS

Along with its emphasis on the centrality of relational and nonverbal experience, attachment research underscores the salience of the reflective function and metacognition. More broadly, this research reveals the decisive impact of the stance of the self toward its own experience.

Secure attachment is clearly associated with a reflective stance toward experience. In Main's (1991) account, this stance rests on the metacognitive capacity to recognize the "*merely* representational nature" of our own beliefs and feelings (p. 128). With such a stance, we can step back from the immediate "reality" of experience and respond in light of the mental states that might underlie it—to use Fonagy's term, we can "mentalize." With greater freedom to mentalize, we are less likely to be inescapably gripped by emotional reflexes laid down in the course of our first relationships. As research using Main's Adult Attachment Interview has revealed, the reflective stance toward experience is entirely different from that found in insecure individuals who tend either to minimize and deny the impact of their experience (in the dismissing state of mind) or to be overwhelmed by it (in the preoccupied state of mind). As a rule, the more we are able to mobilize a reflective stance the more resilient we will be, and the more capable of raising secure children.

By the same token, to "raise" secure patients, we must cultivate in ourselves this capability for reflection in psychological depth. And, of course, we must nurture it in those who come to us for help. As therapists, our efforts to foster or disinhibit our patients' mentalizing capacities are an essential feature of the help we offer. To the extent that we make it possible for patients to mentalize, we strengthen their ability to regulate their affects, to integrate experiences that have been dissociated, and to feel a more solid, coherent sense of self.

Beyond the capacity for a reflective stance, I would argue that there exists the potential for a stance toward internal and external experience that

is, in some sense, "deeper" and closer to the subjective center of ourselves. I am thinking here about a stance that involves deliberate nonjudgmental attention to experience in the present moment—that is, a stance of *mindfulness* (Germer, Siegel, & Fulton, 2005; Kabat-Zinn, 2005). While mindfulness is not part of the vocabulary of attachment, this construct from Buddhist psychology seems a natural outgrowth of attachment theory and research. In fact, Phillip Shaver, coeditor of the *Handbook of Attachment,* told me that recently, in preparing a scientific presentation for the Dalai Lama, he had occasion to read nearly a dozen books on Buddhism. To his surprise, he found the psychology there to be not only consistent with but in many respects virtually identical to the psychology of attachment theory (Shaver, personal communication, 2005).

To clarify what is meant by a stance of mindfulness, imagine four concentric rings each of which represents an element that contributes to the moment-to-moment experience of being a "mindful self."

The outermost ring stands for external reality. The world of external reality includes not only the events that happen to us and the situations we co-create but also, perhaps most importantly, the people with whom we are involved.

Moving inward there is a second ring that stands for the representational world: that is, the mental models of previous experience that relieve us of the necessity to reinvent the wheel with every new moment. These representational models orient us, shaping our interpretations of past and present, and establishing our expectations for the future.

Within the second ring is a third, standing for that part of ourselves that is capable of a reflective stance toward experience—in shorthand, the "reflective self." Here our representations, including our internal working models, are understood to mediate or filter our experience of external reality. We neither equate the subjective world of representations with the objective world of external reality nor deny the impact of external reality upon our subjective experience. With such a stance we can reflect, consciously and unconsciously, on the meaning of our experience rather than simply take that experience at face value. This affords us a significant measure of internal freedom.

Attachment theory deals explicitly only with the elements represented by these first three rings: external reality, the representational world, and the reflective self. It seems to me, however, that there is a trajectory to the evolving narrative of attachment theory that points like an arrow to a fourth ring inside the other three. This fourth ring represents what I am calling the mindful self.

To put it somewhat cryptically, this self is the answer to the question, Who (or what) is it that actually reflects on experience? For if a reflective stance involves metacognition—thinking about thinking—then it seems

natural to ask *who is it that is thinking the thoughts about thinking*. You might try, as I did, to close your eyes and pose this question to yourself. My own (experientially derived) response to the question took me by surprise. It was: *no one*. Dovetailing with a fundamental tenet of Buddhist psychology, this elusive understanding reflects the paradox that the mindful self can be at once a secure self and no (personal) self at all, but only awareness (see Goldstein & Kornfield, 1987; Kornfield, 1993; Engler, 2003).

Jeremy Holmes (1996), who writes eloquently about attachment, touches on the same paradox when he acknowledges borrowing from Buddhism the term *nonattachment* to describe an "equidistant position" that includes awareness *both* of the depth and breadth of the self's experience *and* of the fact that the self is "ultimately a fiction" (p. 30).

Another angle on this matter of mindfulness: While the reflective stance toward experience entails metacognition, a mindful stance involves *meta-awareness*—that is, awareness of awareness. Put differently, the self that *reflects* on experience attends to the contents of experience while the self that is *mindful* attends to the process of experiencing. Such mindful attention illuminates the process by which experience is constructed (Engler, 2003).

Fonagy alludes to research highlighting the clinical potential of mindfulness meditation as an adjunct to psychotherapy. He notes that "what we would call 'mentalizing' is directly enhanced by meditation practice" (Allen & Fonagy, 2002, p. 35). Fonagy's point is undoubtedly well taken. Yet mindfulness involves more than formal meditation. And meditation supports more than mentalizing.

The regular exercise of mindful awareness seems to promote the same benefits—bodily and affective self-regulation, attuned communication with others, insight, empathy, and the like—that research has found to be associated with childhood histories of secure attachment (Siegel, 2005, 2006). Although there may be other explanations for these parallel outcomes, I would suggest that they arise from the fact that mindfulness and secure attachment alike are capable of generating—though by very different routes—the same invaluable psychological resource, namely, an *internalized* secure base.

Secure attachment relationships in childhood and psychotherapy help develop this reassuring internal presence by providing us with experiences of being recognized, understood, and cared for that can subsequently be internalized. Mindfulness practice can potentially develop a comparably reassuring internal presence by offering us (glimpsed or sustained) experiences of the selfless, or universal, self that is simply awareness. Such experiences are often marked by profound feelings of security, acceptance, and connection, in relation as much to others as to ourselves (Linda Graham, personal communication, 2006).

As therapists, our own capacity to be mindful may be critical to our efforts to be of help to our patients. First, and perhaps most crucially, a mindful stance fosters the experience of being firmly lodged in the present moment. The British psychoanalyst Wilfrid Bion (1970) captures this state of open presence as well as any Buddhist philosopher when he extols the advantages of approaching the patient "without memory, desire, or understanding" (pp. 51–52). Thus rooted in the here and now—rather than the remembered past, the wished-for future, or the abstractions of theory—we are less vulnerable to our own tendencies to be either dismissing or preoccupied. A mindful stance allows us to be more fully present, open, and capable of responding—like the "good enough" attuned parent—to the requirements of the moment as these emerge in our interaction with the patient. Second, a mindful and present-centered stance fosters an experience of being inside, and aware of, the body. The resulting attunement to our own somatic responses amplifies the signals that allow us to tune in to the nonverbal expressions of the patient's internal state. Thus, mindfulness can potentially enhance accurate empathy as well as our ability to connect with the patient's unarticulated, and perhaps dissociated, experience. Third, mindfulness (like a secure state of mind with respect to attachment) fosters an attitude of acceptance—a nondefensive openness and receptivity to experience *as it is* that can help us make room for the full spectrum of the patient's feelings, thoughts, and desires. In this way, mindfulness in the therapist may facilitate a relationship with the patient that fosters the process of integration.

Such integration may be not only a primary goal of psychotherapy but also (as previously suggested) a consequence both of secure attachment and of the practice of mindful awareness. As part of what makes the therapeutic relationship a transformative one, the therapist's mindful stance may have a "contagious" quality—kindling the patient's own experience of mindfulness very much as expressions of the therapist's reflective stance help to kindle the patient's ability to mentalize. With some patients, in addition, it may be helpful for the therapist to encourage the formal practice of meditation.

I trust I have made it clear that, viewed through the lens of attachment theory and research, the healing power of psychotherapy derives primarily from the therapeutic interaction. The new relationship of attachment that the patient forms with the therapist can potentially function as a developmental crucible. In the chapters to follow, I delve more deeply into the three key themes—the relationship, the nonverbal dimension, and the stance of the self toward experience—that orient my work with every patient. The chapters in Part I summarize the story of attachment theory and research, establishing in the process the book's conceptual foundation. Part II de-

scribes the impact of attachment relationships on the developing self. Part III makes the first bridges from attachment theory to the practice of psychotherapy. Part IV explains the clinical implications that follow from identifying the patient's prevailing pattern(s) of attachment. Part V details further the nature of therapeutic work in the nonverbal realm as well as the ways in which we can attempt to both cultivate in ourselves and elicit in our patients a more reflective and mindful stance toward experience.

ADULT ATTACHMENT INTERVIEW

1. To begin with, could you just help me to get a little bit oriented to your family—for example, who was in your immediate family, and where you lived?

2. Now I'd like you to try to describe your relationship with your parents as a young child, starting as far back as you can remember.

3–4.Could you give me five adjectives or phrases to describe your relationship with your mother/father during childhood? I'll write them down, and when we have all five I'll ask you to tell me what memories or experiences led you to choose each one.

5. To which parent did you feel closer, and why?

6. When you were upset as a child, what did you do, and what would happen? Could you give me some specific incidents when you were upset emotionally? Physically hurt? Ill?

7. Could you describe your first separation from your parents?

8. Did you ever feel rejected as a child? What did you do, and do you think your parents realized they were rejecting you?

9. Were your parents ever threatening toward you—for discipline, or jokingly?

10. How do you think your overall early experiences have affected your adult personality? Are there any aspects you consider a setback to your development?

11. Why do you think your parents behaved as they did during your childhood?

12. Were there other adults who were close to you—like parents—as a child?

13. Did you experience the loss of a parent or other close loved one as a child, or in adulthood?

14. Were there many changes in your relationship with your parents between childhood and adulthood?

15. What is your relationship with your parents like for you currently?

FIGURE 3.1. Brief précis of the Adult Attachment Interview protocol excerpted from George, Kaplan, and Main (1996). The AAI cannot be conducted on the basis of this brief, modified précis of the protocol, which omits several questions as well as the critical follow-up probes. The full protocol, together with extensive directions for administration, can be obtained by writing to Professor Mary Main, Department of Psychology, University of California at Berkeley, Berkeley, CA 94720. From Hesse (1999). © 1999 by **The Guilford Press**. Reprinted by permission.

The "Reflective-Functioning" Scale

To evaluate the strength of an individual's mentalizing capacity, Fonagy and his colleagues devised the Reflective-Functioning Scale. Designed for research purposes, this scale can also be used informally to enhance clinical judgments about the kinds of interventions our patients may be able to benefit from. A strong mentalizing capacity—and perhaps in treatment, receptivity to the therapist's interpretations—is likelier to be present when the interviewee (or patient) demonstrates:

- Awareness of the nature of mental states—for example, that our understanding of ourselves and others is invariably incomplete; that people may modify mental states to minimize pain; that people may deliberately disguise internal states; that certain psychological responses are predictable given certain circumstances.
- Explicit effort to identify mental states underlying behavior—for example, plausibly accounting for behavior in terms of beliefs, feelings, desires; understanding that our interpretations of others may be influenced by our own mental states; realizing that feelings about a situation may be inconsistent with observable aspects of the situation.
- Recognition of the "developmental" aspects of mental states—for example, that what was felt yesterday may be different from what is felt today or tomorrow; that parents' behavior is both shaped by their own parents' behavior and shapes the behavior of their children; that childhood perspectives often need to be revised in light of adult understanding.
- Awareness of mental states in relation to the interviewer (or therapist)—for example, that without being told, the therapist cannot know what the patient knows; that the therapist may have her own distinctive emotional responses to the patient's story; that the therapist's history, and consequently, her mental states may well be different from those of the patient (adapted with permission from Fonagy, Target, Steele, & Steele, 1998).

EXPERIENCES IN CLOSE RELATIONSHIPS

The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

___ 1. I prefer not to show a partner how I feel deep down.
___ 2. I worry about being abandoned.
___ 3. I am very comfortable being close to romantic partners.
___ 4. I worry a lot about my relationships.
___ 5. Just when my partner starts to get close to me I find myself pulling away.
___ 6. I worry that romantic partners won't care about me as much as I care about them.
___ 7. I get uncomfortable when a romantic partner wants to be very close.
___ 8. I worry a fair amount about losing my partner.
___ 9. I don't feel comfortable opening up to romantic partners.
___ 10. I often wish that my partner's feelings for me were as strong as my feelings for him/her.
___ 11. I want to get close to my partner, but I keep pulling back.
___ 12. I often want to merge completely with romantic partners, and this sometimes scares them away.
___ 13. I am nervous when partners get too close to me.
___ 14. I worry about being alone.
___ 15. I feel comfortable sharing my private thoughts and feelings with my partner.
___ 16. My desire to be very close sometimes scares people away.
___ 17. I try to avoid getting too close to my partner.
___ 18. I need a lot of reassurance that I am loved by my partner.
___ 19. I find it relatively easy to get close to my partner.
___ 20. Sometimes I feel that I force my partners to show more feeling, more commitment.
___ 21. I find it difficult to allow myself to depend on romantic partners.
___ 22. I do not often worry about being abandoned.
___ 23. I prefer not to be too close to romantic partners.

___ 24. If I can't get my partner to show interest in me, I get upset or angry.
___ 25. I tell my partner just about everything.
___ 26. I find that my partner(s) don't want to get as close as I would like.
___ 27. I usually discuss my problems and concerns with my partner.
___ 28. When I'm not involved in a relationship, I feel somewhat anxious and insecure.
___ 29. I feel comfortable depending on romantic partners.
___ 30. I get frustrated when my partner is not around as much as I would like.
___ 31. I don't mind asking romantic partners for comfort, advice, or help.
___ 32. I get frustrated if romantic partners are not available when I need them.
___ 33. It helps to turn to my romantic partner in times of need.
___ 34. When romantic partners disapprove of me, I feel really bad about myself.
___ 35. I turn to my partner for many things, including comfort and reassurance.
___ 36. I resent it when my partner spends time away from me.

Audio Courses David J. Wallin, PhD

Mapping the Terrain of the Heart: Passion, Tenderness and the Capacity to Love.

Instructors: David Wallin Ph.D and Stephen Goldbart Ph.D. 6 Hours CE Credit.

In their widely acclaimed book, psychologists Wallin and Goldbart used psychoanalytic, systems, and object relations theories to "map" the journey taken by adults in intimate relationships. Their map focuses on six necessary capacities: erotic involvement, merging, idealization, integration, refinding, and self-transcendence. Focusing primarily on heterosexual couples, the authors believe their findings are also applicable to homosexual couples and close but non-romantic relationships as well. This audio-taped course lays out the specific clinical implications of the book. The first three-hour segment summarizes the contemporary theory of romantic love that makes up the core of the book. The second segment shows how this framework can be used to orient the therapist's efforts to help individuals and couples with problems in love.

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To order : Please make checks payable to David J. Wallin, Ph.D. Mail to 902 Curtis Street. Albany, CA 9470. Tapes are $ 48 each or $68 for tape and Continuing Education Units.

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Praise for *Mapping the Terrain of the Heart*

"Coming from an object relations developmental psychoanalytic perspective, Goldbart and Wallin have provided an elegant, rich, sophisticated, compassionate and compelling map of the territory of intimacy. I have recommended this book to colleagues and patients, used it in courses on couples therapy, and continue to benefit from the authors' insights. This is an indispensable book for anyone interested in the mysteries of love."
Dennis J. Zeitlin, MD, *Associate Clinical Professor of Psychiatry, University of California, San Francisco*

"Engaging, psychologically sound and highly readable...clarifies the pathways that can block or lead to emotional and physical intimacy. Based on the authors' rich clinical experience, this book makes exceptionally enlightening reading for lay couples as well as the mental health professionals who work with them."

Cleo Eulau, LSCW, Clinical Professor of Psychiatry Emerita, Stanford University Medical School

"I have given this book to dozens of my friends. Its extraordinary combination of hard-won psychoanalytic insight, clarity of writing, and heartful patience with the human condition make *Mapping the Terrain of the Heart* the most useful book I know of for understanding the challenges of romantic relationships."
Richard Tarnas, PhD
Author, *The Passion of the Western Mind* and *Cosmos and Psyche*

“Do we really need another book on love? For me, the answer is: Yes, if that book is *Mapping the Terrain of the Heart*...[It] presents an analysis of what makes or breaks love that will interest not only mental-health professionals, but anyone who has ever tried to find and stay with a significant other."
Owen Renik, MD
Author, *Practical Psychoanalysis for Therapists and Patients*

"I know of no other book that says as much about passionate and tender love with as much clarity, insight, and grace. Mapping the Terrain of the Heart translates the most profound insights of contemporary psychoanalysis into a framework for understanding romance, sexuality, and committed intimacy. In language that is vivid and accessible, Goldbart and Wallin have given us a comprehensive psychology of love. If I were to recommend a single book on the subject of romantic love, it would be this one
Michael Lerner, PhD

“Goldbart and Wallin’s model is an original integration, extension, and systematization of successful psychodynamic ideas as they relate to love....remarkable in its wealth of specifics and its systematic integration of cognitive, motivational, and developmental factors; individual differences; and implications for therapy. Anyone reading this book (and willing to self-reflect) will be rewarded with insights that could catalyze significant relationship development...the writing is exceptionally clear, jargon-free, and with ample interesting examples--all the more remarkable given the depth and sophistication of the material.”
Arthur Aron, PhD
In *Contemporary Psychology*