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Attachment in the consulting room: towards a theory of therapeutic change

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Effective therapists need guiding models, but, paradoxically, the benefits of psychoanalytic psychotherapy may not flow from its espoused theories. Using an attachment framework, it is argued that psychoanalytic psychotherapy in common with all therapies has three principal components: an attachment relationship; meaning-making; and change-promotion. Secure and insecure models of attachment help understand how therapists guide the therapeutic relationship in helpful or unhelpful directions. Freedom of meaning-making is a mark of secure attachment. Change is promoted by placing clients in a 'benign bind' characterised by: close engagement; discrepancy between client transferential expectations and therapist response; and exploration and verbal descriptions of the feelings arising from these discrepancies. An attachment meta-perspective helps reconcile apparent differences between differing psychoanalytic and non-psychoanalytic theoretical perspectives.

Keywords: attachment theory; theory; psychoanalytic psychotherapy; attachment relationship; meaning-making; change promotion

Los psicoterapeutas eficaces necesitan modelos que los guíen pero,paradójicamente, los beneficios de la psicoterapia psicoanalítica quizás no fluyen fácilmente de las teorías que los propugnan. Usando el marco de referencia de la teoría del Apego,decimos que la terapia psicoanalítica en común con todas las terapias,tiene tres components principales: una relación de apego,darle sentido a las experiencias y promover cambios en el individuo. Modelos de apego seguros e inseguros ayudan a comprender cómo los terapeutas guían la relación terapéutica hacia direcciones que pueden ayudar o no. La libertad para encontrar significados es signo de un apego seguro. El cambio se produce al establecer con los clientes una relación estrecha y benigna caracterizada por: compromiso,discrepancia entre las expectativas transferenciales del cliente y del terapeuta y exploración y descripción verbal de los sentimientos derivados de esa discrepancia. Una meta en perspectiva fundamentada en el apego ayuda a reconciliar las diferencias aparentes entre diferentes perspectivas teoréticas psicoanalíticas y no psicoanalíticas.

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Terapeuti efficaci necessitano di modelli guida, ma, paradossalmente, i benefici della psicoterapia psicoanalitica possono non derivare dalla teoria abbracciata. Usando il contesto dell'attaccamento sosteniamo che la psicoterapia psicoanalitica ha tre principali componenti in comune con le altre terapie: una relazione d'attaccamento; produzione di significato; e promozione di cambiamento. Modelli sicuri ed insicuri d'attaccamento aiutano a comprendere come i terapeuti guidano la relazione terapeutica in maniere più o meno d'aiuto. La libertà di produrre significato è un segnale di un attaccamento sicuro. Il cambiamento è promosso dal porre il cliente in un 'legame benigno' caratterizzato da: un stretto legame; discrepanza tra il transfert delle aspettative del cliente e le risposte del terapeuta; esplorazione e descrizione verbale delle sensazioni provenienti da queste discrepanze. Una meta-prospettiva dell'attaccamento aiuta a riconciliare differenze evidenti tra differenti prospettive teoriche psicoanalitiche e non-psicoanalitiche.

Pour être efficaces, les thérapeutes ont besoin de modèles pour les guider mais paradoxalement les avantages de la psychothérapie psychanalytique ne semblent pas circuler au-delà des théories qu'elle adopte. En prenant comme cadre de référence la théorie de l'attachement nous avançons ici l'argument que la psychothérapie psychanalytique comme toutes les thérapies, possède trois composantes principales : une relation d'attachement, la production de sens et la possibilité de changements. Les formes sécurisées et insécurisées d'attachement nous aident à comprendre comment les thérapeutes guident la relation thérapeutique d'une manière aidante ou non. Produire du sens librement est la marque d'un attachement sécurisé. Un changement s'opère lorsque les clients sont placés dans un « lien bénin » caractérisé par : un engagement proche; une divergence entre les attentes transférentielles du client et la réponse du thérapeute ; une exploration et une description verbales des émotions générées par ces divergences. Une méta-perspective basée sur la théorie de l'attachement aide à réconcilier les différences apparentes entre des perspectives théoriques psychanalytiques et non-psychanalytiques.

Introduction

The main argument of this article is that psychotherapy process may be best understood by theoretical perspectives – here I shall be making the case for attachment theory – often orthogonal to those espoused by its practitioners. Implicit is the idea that once such an external perspective is adopted, apparent differences between differing psychoanalytic perspectives become less salient.

Let us start with a clinical example, taken from Wachtel (2010).

> Andrew, a man in middle life, presented with difficulties in his marriage. He felt intruded upon by his wife, experiencing her concern and involvement as subtle forms of control, resulting in his withdrawal, covert anger, and diminished feelings of trust and intimacy. The therapist had recently read of Beebe et al.'s work on mother-infant 'tracking' (Beebe & Lachmann, 2002). Here, mothers were asked to follow their infants' vocalisation by singing along with them. Infants were subsequently classified in the Strange Situation as secure or insecurely attached. Compared with the Secure group, Insecure infants

> tended to have care-givers who were either unable to 'track' their babblings, or 'over-tracked' them, following them 'to the letter', but without the jazz-like improvisatory accompaniments of the secure infants. During one session these themes were particularly salient. The therapist suggested that the patient may have felt that his wife was similarly 'over-tracking' him. Andrew immediately took up the word 'over-tracking' – 'that's exactly it. I love that word, over-tracking, that's it'. During the subsequent discussion, Wachtel noticed that Andrew involuntarily turned his head away from the therapist, as though to regulate and diminish the intensity of their conversation, seemingly to forestall 'over-tracking' between therapist and patient. Rather than refer directly to this, which might have run the risk of being an enactment, rather than an interpretation, of over-tracking, the therapist then suggested that perhaps the patient would find talking to his wife easier of she were not directly gazing at him while they conversed.

Here, the therapist is bringing evidence, drawing on a model of child development, to illuminate the minutiae of the consultation.[1] The word 'over-tracking' becomes a nodal point from which radiate out ripples of meaning that help understand not just the patient's presenting problems, but his relationship with the therapist, and points to possible developmental difficulties (the patient may have had a similarly intrusive, non-play-facilitating care-giver). This is evidence-based practice, but also practice-based evidence in that the sensitivity of the therapist feeds back to extend the research-based concept of 'over-tracking' into the clinical encounter.

John Bowlby was fond of quoting Kurt Lewin's aphorism: 'there's nothing so practical as a good theory' (Lewin, 1935). By this, he meant that 'without a reasonably valid theory of psychopathology, therapeutic techniques tend to be blunt and of uncertain benefit' (Bowlby, 1988, p. 42). The example above focuses on theorising implicit procedures rather than specific events or traumata – on *how* things are done rather than *what* is, or has been, done. To reverse Lewin, one could say that the study of good practice is a good way, and maybe the best way, to arrive at a good theory. Beebe's study looks at the underlying 'theories' parents use to bring up their children, more or less successfully. If we can identify and theorise what goes on in successful intimate relationships – whether between care-giver and child, or therapist and patient, we can begin to build well-founded theories about therapeutic work. A theory of psychotherapeutic procedures needs to focus on the interactive processes that lie at the heart of successful and mutative relationships.

I am contrasting here 'theory from above' – the normal use of theory in psychoanalytic work, whether metapsychology – the Unconscious, Infantile Sexuality etc. – or clinical theory – Transference, Countertransference, Projective Identification, etc. – with 'theory from below', the underpinning understanding of intimate relationships which attachment ideas provide. Attachment theory offers a meta-position from which to view psychoanalytic psychotherapy practice (Holmes, 2009). In developing this idea here, I base the discussion around the therapy's three principal components (Castonguay & Beutler, 2006): the therapeutic relationship, meaning-making and change promotion.

The therapeutic relationship

Attachment styles and therapeutic engagement

According to attachment theory, threat or illness triggers attachment behaviours in vulnerable individuals, including people seeking psychotherapeutic help. Once activated, these override all other motivations – exploratory, playful, sexual, gustatory, etc. Attachment behaviour involves seeking proximity to a figure able to assuage distress, in the case of children, one who is older and wiser. Once soothed and safe, and only then, is the sufferer able to explore his or her world, inner or outer, in the context of 'companionable interaction' (Heard & Lake, 1997) with a co-participant.

In this model, threat-triggered attachment behaviour, and exploration, are mutually incompatible. In infants and young children, this is manifest in observable behaviours – pulling 'in' to the secure base figure when threatened, turning 'out' into the world of play and exploration when secure. Inhibitions and compromises of this pattern are the mark of insecurely attached children. In adults, these shifts are usually more subtle, although most will have had the experience of 'holding on to'/'holding in' pain, whether physical or emotional while in the public arena, until the secure presence of a loved one makes 'letting go' possible, usually with physical accompaniments such as holding, hugging and tearfulness.

The basic interpersonal architecture of therapy is (1) a person in distress, seeking a safe haven, in search of a secure base, (2) a care-giver with the capacity to offer security, soothing and exploratory companionship and (3) the resulting relationship, with its own unique qualities. This process applies both to the initiation of therapy itself, to the start of sessions, and to moments of emotional arousal as they occur within each session. Since a central therapeutic aim is eliciting and identifying buried feelings (Malan & Della Selva, 2006), there will, in the course of a session, be an iteration between affect arousal, activation of attachment behaviours, and their assuagement; companionable exploration of the triggering feelings; further affective arousal and so on. This process is inevitably coloured by past experience, especially expectations about how a care-giver will respond to expressed distress. This can be construed as transference in that the client brings to the relationship largely unconscious schemata, or internal working models, based on, but not identical with, previous experiences of care-seeking.

Classifying attachment styles in adults, Shaver and Mikulincer (2008) see insecure attachment as a spectrum ranging from deactivation (corresponding to avoidance in children) of attachment needs at one pole, to hyperactivation (corresponding to ambivalent attachment) at the other. This hyperactivation/deactivation dichotomy captures the relational expectations clients typically bring into the consulting room. Some seem 'switched-off', describing their difficulties in clichéd, minimalist ways, resistant to therapists' probes for feelings. Others overwhelm the therapist and themselves with emotion, seemingly confusing present and past, leaving little space for the therapist to stem the tide of emotion, or assuage distress so that difficulties can be reflectively considered. Blatt and his collaborators (Luyten et al., 2007) capture

this dichotomy in their division of depressed subjects as either 'anaclitic' (i.e. 'dependent or 'leaning on', and so excessively vulnerable to loss) or 'perfectionistic' (people who emphasise autonomy and detachment, and are therefore vulnerable to a sense of failure).

From an attachment perspective, the therapeutic relationship can be seen as the resultant of two opposing sets of forces. On the one hand, the analyst attempts within the limited framework of therapy to provide a secure attachment experience – to identify and assuage attachment needs and to facilitate exploration; on the other, the patient approaches the relationship with prior expectations of sub-optimal care-giving, and, unconsciously assuming an unloving and/or untrustworthy, or narcissistically self-gratifying care-giver, aims mainly for a measure of security. The attachment viewpoint suggests that the therapeutic relationship is shaped both by the dynamic of its actuality and the distorting effects of transference. Secure therapists *redress* their client's attachment insecurities, while insecure ones more likely reinforce them (Dozier et al., 2008). As therapy proceeds, the soothing presence of the analyst enables the client to expose themselves to, tolerate and learn from increasing levels of anxiety – in the case of the anaclitic the anxiety of being alone, in the perfectionistic, the anxiety associated with the unpredictability of life's vicissitudes.

Emotional connectedness

What makes a potential secure base 'secure'? How does an infant 'know' to whom to turn when attachment behaviours are activated? How does an attachment hierarchy, normally with mother at the apex, followed by other kin such as aunts, older siblings, father, grandparents and non-kin 'alloparents' (Hardy, 1999) such as child-minders, become established? When does a therapist move from being a helpful professional to the role of an indispensable attachment figure, and how does this connect with the establishment of an 'analytic process'? Attachment research suggests at least partial answers to some of these questions.

On-going intimate proximity, availability, together with the 'knowing' – the holding in mind through absence and interruption that is integral to parental (and spousal) love – are some of the essential ingredients of a secure base. The mother–infant literature suggests that, among other characteristics, a secure base parent also offers responsiveness and 'mastery' (Slade, 2005); reliability and consistency; 'mind-mindedness' (Meins, 1999); and the ability to repair disruptions of parent–infant emotional connectedness (Tronic, 1998). Each of these are threads that also run through the fabric of successful therapeutic relationships.

Overall, *care-seeker/care-giver emotional connectedness* is the key feature of secure base (Farber & Metzger, 2008).[2] The restriction, exaggeration or uncoupling of such connectedness is what leads to the three varieties of insecure attachment. No less than in secure relationships, in insecure attachments, the attachment figure is present in the mind of the care-seeker as a sought target for attachment behaviours, but there is a discrepancy between what is desired,

and what is available. Transference analysis in therapy attempts to place the minutiae of this disjunction under the therapeutic microscope.

Contingency and marking

Are there analogues of therapeutic intimacy in developmental studies of parent–child interaction? Gergely and Watson's (Gergely, 2007) landmark paper focuses on affective sequencing between parents and infants. They identify 'contingency' and 'marking', in the context of intense mutual gaze, as the basis of mirroring sequences in which, to use Winnicott's (1971, p. 51) phrase, the 'mother's face is the mirror in which the child first begins to find himself'.

'Contingency' describes the way in which the care-giver waits (her response is 'contingent upon') for the infant to initiate affective expression. Her response is then 'marked' by an exaggerated simulacrum of the infant's facial and verbal affective expression. For example, the child might be slightly down-at-mouth; the mother might then, while maintaining intense eye contact with her child, twist her face into a caricature of abject misery, saying, in high-pitched 'motherese', 'Oh, we *are* feeling miserable today, aren't we…'. She thereby offers the child a visual/auditory representation of his own internal affective state. This sets in motion the child's capacity to 'see' and 'own' his feelings.

Contingency gives the child the message that s/he is an actor, a person who can initiate and make a difference to the interpersonal world in which he finds her- or him-self, and introduces him to the dialogic nature of human meanings. Marking links representation (initially in the mother's face, then re-represented in his own mind) to the child's own actions and internal feelings, while 'tagging' that these are his/her's, not the mother's, feelings. This proto-linguistic envelope has a soothing, affect-regulating quality.

These interactive sequences thus involve (1) *affect expression* by the child; (2) *empathic resonance* on the part of the mother, able to put herself into the shoes of the child; (3) *affect regulation* in that the parent tends to up-regulate or down-regulate depending on what emotion is communicated (stimulating a bored child, soothing a distressed one); resultant (4) mutual pleasure and playfulness, or, to use Stern's (1985) phrase, the evocation of 'vitality affects', *enlivenment*, leading to (5) *exploratory play*/companionable interaction (Heard & Lake, 1997).

Similar sequences characterise in-session therapist–client interactions. McCluskey (2005) has shown that initial attunement, a mirroring *affect-identifying* response on the part of the therapist, in itself is insufficient to make up a satisfactory therapeutic interaction. Further steps are needed in order to release exploration and companionable interaction. Step 2 is affect-regulatory, as the therapist 'takes' the communicated feeling and, through facial expression, tone of voice and emphasis, modifies or 'regulates' it: softly expressed sad feelings are amplified, perhaps with a more aggressive edge added; manic excitement soothed; and vagueness of tone sharpened. Mirroring here becomes dialogic.

These moves are comparable to the 'marking' of the Gergely and Watson schema. The therapist might say: 'you did *what*?!'; 'that sounds *painful*'; '*ouch!*!' 'it sounds as though you might be feeling pretty sad *right now*', 'I wonder if there isn't a lot of *rage* underneath all this'. It is interesting to compare this empirical account with Grotstein's (2007, p. 29) account of his analysis with Bion:

> '...virtually every one of the words in my associations was taken up, used, and rephrased so that I was receiving from him in a somewhat altered and deepened version what I had uttered. It was like hearing myself in an echo chamber or sound mirror in which I was being amplified while being edited ...what the classical analyst would point to as a resistance he would point to as a focus of great anxiety...'.

The therapist is a 'sound mirror', representing the analysand's self to himself. The therapist communicates to the patient that he has heard and felt her feelings, regulates their intensity, and implicitly or explicitly adds something, e.g. the sadness that underlies mania, the anger that can be an unacknowledged feature of depression. The security associated with being understood leads to enlivenment on the part of the patient. This in turn opens the way for companionable exploration of the content or meaning of the topic under discussion. McCluskey (2005) dubs this sequence *Goal Corrected Empathic Attunement* (GCEA) in which there is a continuous process of mutual adjustment or 'goal-correction' between client and therapist as they attempt, emotionally and thematically, to entrain the client's affective states and imagine the contexts which engender them. Mentalising can be thought of as an umbrella term covering all aspects of this process.

Rupture and repair

Such sequencing is of course a council of perfection. Like parents and spouses, and indeed anyone whose goal is intimate understanding of another person, therapists regularly 'get it wrong'. Tuckett et al.'s (2008, p. 29) category of therapist actions which they define as *sudden and glaring reactions not easy to relate to the analyst's normal method*, can be seen as ruptures, comparable to the normal and expectable ruptures in parent infant connectedness, which in well-functioning parent–infant couples are 'repaired' as the parent responds to the child's signals of distress.

While being understood reduces anxiety, liberates vitality affects and initiates exploration, being *mis*understood is anxiety-augmenting and aversive, triggering withdrawal and avoidance and/or defensiveness and anger. But just as security-providing mothers are able to repair lapses in attunement with their infants, the capacity to repair therapeutic 'ruptures', a concept developed by Safran and Muran (2000), is associated with good outcomes in therapy.

Using the 'still face' paradigm, attachment researchers have looked at attachment styles in relation to the capacity of mother–infant dyads to resume affective contact following a brief 1-min affective withdrawal on the part of the mother in which she is asked to 'freeze' her expression (Crandell, Patrick, & Hopson, 2003). Securely attached children are least

disrupted by this procedure. Children with organised insecurity resort to self-soothing via looking at their own faces in the mirror when the link with mother is broken, but can generally resume contact once the break is terminated. Disorganised children are least likely to get back on track with their mothers on resumption, and most likely to resort to self-soothing, and fail to link up again with the security of the mother's gaze even when it becomes once more available.

Extrapolating from these findings to adult psychotherapy, therapists need to be highly sensitive to client reactions to 'freezing' or discontinuities of contact both within sessions and in relation to the normal interruptions of holidays and illness. Even though psychoanalytic psychotherapists are trained to focus on manifestations of 'negative transference', the evidence suggests that clients hold back negative feelings from their analysts not less than in other modalities of therapy (Safran & Muran, 2000). An attachment perspective suggests that (a) in any intimate relationship, quotidian misunderstandings are the norm (b) the implications of these depend in part on prior expectations and attachment styles of both participants and (c) the therapeutic issue is not so much to eliminate misunderstandings as to focus on the feelings associated with them and find ways to talk about them.

'Transferential' expectations are brought into play in relation to the regular mistakes, weaknesses and idiosyncrasies applicable to therapies and therapists. Therapist 'enactments' (e.g. starting a session late, drowsiness, inattention or intrusiveness, etc.) need to be non-defensively acknowledged. Such ruptures are understood as 'induced', often outside of awareness of both therapist and client in the unconscious matrix inherent in an attachment relationship. Reflexively thinking about them by therapist and client together strengthens the therapeutic bond, and is itself a change-promoting manoeuvre, enhancing clients' capacity for self-awareness and negotiating skills in intimate relationships.

'Paternal' aspects of the attachment/therapeutic relationship

A key early finding in attachment research was that attachment classification in the Strange Situation was a relational not a temperamental feature, since at 1 year, children could be secure with mother and insecure with father or vice versa, although by 30 months, the maternal pattern tends to dominate, (Ainsworth, Blehar, Waters, & Wall, 1978). Nevertheless, the role of fathers in attachment has been relatively neglected. The Grossman's longitudinal studies (Grossman, Grossman, & Waters, 2005) are an exception, showing that paternal contributions in childhood to eventual security in early adulthood is as important as that of the mother, and that their combined parental impact is greater than the sum of each alone.

The Grossman's delineate the 'paternal' role as somewhat different from the 'maternal' (the sexist implications of this dichotomy are acknowledged, perhaps better reframed as 'security-providing' and 'empowering' parental functions). When asked to perform a brick-building or sporting task

(e.g. teaching a child to swim), security-providing fathers offer their offspring a 'you can do it' message, creating a zone of protection within which sensory-motor development can proceed. In the Strange Situation, as compared with mothers, fathers tend to use short bursts of intense distraction and activity as comforting manoeuvres, in contrast to the more gentle crescendo and diminuendo of hugging and soothing characterising female care-givers.

Comparing parent–child relationships in disorganised and secure children, measures of maternal sensitivity are insufficient to capture security-providing functions. A dimension of 'mastery' also contributes to the variance, communicating not just intimate protectiveness, but also the presence of a competent adult in charge of the play-space (Slade, 2005). The importance of space – physical and metaphorical – links with the Vygotskyian notion of the 'zone of proximal development' where the child is directed to tasks that are neither too easy nor too hard (Leiman, 1995), and the 'defensible space' surrounding the child whose security it is the parent's responsibility to guarantee. Similarly, therapists provide therapeutic space (which is also a 'space of time'), mindful of Freud's (1914/1958) injunction that interpretations should be aimed at patients' emergent thoughts, being neither too 'deep' nor too superficial.

Effective psychotherapy is *both* soothing and empowering. In the Western world, 'naming' is construed as a 'paternal'/masculine function. The famous Lacanian pun – 'le no(m) du pere' (the name of the father; the *no* of the father) encapsulates the 'negative' paternal oedipal prohibition which severs the infant's phantasy of merging with the mother, but also the 'positive' liberating, linguistic function which enables one to stand outside, think about, and manipulate, experience, and, ultimately to understand one's self (expressed in the patronymic). In order to alleviate client anxiety, the therapist needs not just to be empathic, but also to communicate 'mastery' (with its 'paternal' resonance) – a sense that she knows what she is doing, is in control of the therapy and its boundaries (without being controlling), and is relaxed enough to mentalise her own feelings, and to put them into words. Mastery and empathy are not mutually exclusive, but denote a good 'primal marriage' of sensitivity and power from which the client can begin to tackle his difficulties.

The 'fundamental rule'

A feature of secure relationships, whether parent–infant or spousal, is open communication ('I can say anything to my mum/husband and know she/he will listen without judging me'). Freud's 'fundamental rule' (inviting the patient to say anything that comes into her/his mind, however irrelevant or embarrassing), could be seen as an attempt to establish a similar culture within the consulting room. Much of the work of psychoanalytic psychotherapy revolves around identifying and removing barriers to unfettered communication. 'Free association' typically requires a contingent interactive culture in which the therapist awaits and follows the client's lead. The flow of communication becomes possible once an atmosphere of security is established, often following

the identification of, and challenge to, the myriad ways in which clients habitually avoid emotional intimacy in the service of security.

Bollas (2007) bemoans the attrition of free association in current psychoanalytic practice, which he sees as having been driven out by an excessive preoccupation with transference interpretation. For him, a mark of good analysis is one that liberates the flow of free association. But there is no inherent opposition between transference interpretation and free association. Indeed, Freud viewed transference interpretations as necessary only when the flow of free associations was interrupted. Interpretations can be seen as means of identifying ways in which the patient feels insecure in the presence of the analyst. An interpretation, which acknowledges and helps understand a painful affect – if transferential in relation to the therapist – facilitates exploration, once greater security/intimacy is re-established. Here, we see the two ways in which theory underpins what goes on in the consulting room. An 'interpretation' is likely to draw on aspects of explicit psychoanalytic theory – Oedipal, Paranoid-Schizoid/Depressive position dichotomy, Infantile Sexuality, etc. Free association is at first sight a-theoretical, but its parameters and justification can be understood in terms of the bottom-up theory of intimate relationships based on attachment ideas I am proposing here (cf. Holmes, 2011).

Meaning

Meaning-making is intrinsic to all therapies. An explanatory framework brings order to the intrinsically inchoate experience of illness, whether physical or mental (Holmes & Bateman, 2002). A theoretical 'formulation' is both anxiety-reducing in itself, and provides a scaffolding for the mutual exploration that follows once attachment anxiety has been assuaged. A symptom or troublesome experience is 'reframed' via an explanatory system, which helps make sense of the sufferer's mental (or physical) pain. The use of the word 'sense' here acknowledges that meaning transcends mere cognition and ultimately derives from bodily experiences.

Language

New meanings emerge in the cut and thrust of psychoanalytic work in part through the analyst's close attention to language. Freud saw the inherent ambiguity of language as an entrée to the unconscious, viewing words as 'switches' or junction points between conscious and unconscious thoughts, or to use a contemporary metaphor, nodal points in neural networks.

In the attempt by Tuckett et al.'s (2008) to categorise psychoanalytic interventions, one group of comments is described as 'unsaturated' or 'polysemic'. 'Unsaturation' is Bion's (1970) chemical metaphor. An unsaturated solution is one that can always accept more without precipitation; an unsaturated compound is one capable of further reactions. Polysemism means 'many meanings'; so it and unsaturation refer to the possibility of multiple

(or arguably infinite) meanings. As the literary critic Eagleton (2007, p. 22) puts it, 'language is always what there is more of'. Therapist and patient co-create a space from which to look at feelings, behaviours and speech-acts from all possible perspectives and angles – concrete, metaphorical, sexual, adult, child-like, coercive, intimidated, anxiety-influenced and so on. The analyst is ever alert to the polyphony of the words and phrases used by the client, ready to explore the many meanings thereby revealed and concealed.

As in any intimate relationship – spousal, parent–child, sibling, close friendship – highly specific meanings derived from the minutiae of a person's life are co-created by therapist and client. Elaborating this personal vernacular or 'ideolect' (Lear, 1993, 2009) is a crucial aspect of psychotherapeutic work. In the terminology of Bollas's (2007), the 'receptive unconscious' of the analyst is tuned into the 'expressive unconscious' of the client; the task of the analyst's conscious ego, like that of the good-enough mother in Winnicott's (1971) model of the child playing 'alone in the presence of the mother', is to guard the therapeutic space in a non-intrusive way.

Dominated by 'theory from above', psychoanalysis tends to be over-concerned with single rather than multiple meanings. An example of this comes from Jung (1964), in which he discusses the contrast between his own and Freud's interpretation of Jung's dream of his 'house' with its many stories, and the stairs leading down to a cellar containing two skulls. Freud saw this in terms of Jung's murderous wishes towards members of his family – the bedrock of aggression and sexuality which Jung with his theological leanings denied. Jung maintains that Freud was wrong and that the dream represented the 'story' of his life as it ascended from the primitive religious impulses to his mature world-view. From the perspective of this article, both were right – and neither. The key issue, deriving from the 'day's residue' of Jung's feelings of intimidation by Freud, was rivalry between the two men, an oedipal father–son struggle to the death. The freer either had been, the more able they would have been to entertain many meanings, and the more open they would be to putting their ideas to the test in the crucible of their current here-and-now relationship. The more anxious, the more they would cling to their own particular limited interpretation. The aim of therapy is not to arrive at specific meanings but to free the capacity to explore a range of possible meanings.

Narrative styles and the meaning of meaning

The Adult Attachment Interview suggests that *how* we talk about ourselves and our lives, as much as *what* we talk about, reveals the architecture of the inner world. Like the 'fluid attentional gaze' (Main, 1995) of the secure infant who seamlessly negotiates transitions between secure base-seeking, social referencing and exploratory play, Main characterises secure narratives as 'fluid autonomous' – neither over-, nor under-elaborated, and able to balance affect and cognition in ways appropriate to the topic discussed.

There is evidence to support the idea that successful therapy is associated with the replacement of insecure by more secure narrative styles (Avdi &

Georgaca, 2007) towards the acquisition of what I have called 'autobiographical competence' (Holmes, 2001). Main's schema contrasts the fluidity of secure styles with either the fixity, prolixity or incoherence of the insecure. Psychic health is characterised by some psychoanalytic writers in terms of a harmonious and creative collaboration between unconscious and conscious parts of the mind (Rycroft, 1985). Secure narrative styles are open-ended, 'polysemic' systems, 'infinite' (in Matte-Blanco's (1975) sense of the unconscious as an 'infinite set'), always subject to further 'vision and revision' (Eliot, 1986), in contrast to the fixed, overwhelming or inchoate narratives of insecure attachment.

A key part of therapeutic work is not so much about making 'correct' interpretations as moving the client towards the exploration of mutual meanings, based on a more secure narrative style. 'Can you elaborate on that?'; 'what exactly did you mean then?'; 'I can't quite visualise what you are talking about here; can you help?'; 'what did that feel like to you?'; 'I'm getting a bit confused here, can you slow down a bit'; 'there seems to be something missing in what you're saying; I wonder if there is some part of the story we haven't quite heard about?'. The therapist is probing in this kind of dialogue for specificity, visual imagery and metaphor which enable her to conjure up, in her mind's eye and ear, aspects of the patient's experience. This then becomes a shared object or 'third' (Benjamin, 2004; Ogden, 1989) which can be 'companionably explored' (Heard & Lake, 1997), often a metaphor to be played with and extended.

Finding the right meaning

As therapists we are continuously struggling to find the 'real', 'right' or 'true' meaning of our client's communications, verbal and non-verbal. The client will in turn respond by telling us whether a particular comment on the part of the analyst, or idea they have generated themselves, 'feels right'. Implicit in Cavell's (2006) notion of 'triangulation' is the idea that a child cross-checks the veracity and validity of their perceptions of the outside world with those of the care-giver, and so begins to build up a picture of the real world distinct from his or her perception of it. The Winnicottian ideas of mirroring, contingency/marking and empathic attunement suggest that we learn about our inner world in a comparable way, using the *care-giver's understanding* to develop our own *self*-knowledge. In psychotherapy sessions, the analyst makes guesses or suggestions about how clients may be feeling; clients then compare this proffered empathic understanding with what their introspection tells them. Exploring whether there is a near-match or a misalignment (empathy is never an exact match, more a 'rhyme' leading to further informed guesses), therapy helps the client to gradually know himself or herself better.

In his neurophysiological critique of Cartesian dualism, Damacio (1994) suggests that mind and body work in tandem to let us know when our cognitive and intellectual faculties are on track. Attachment and empathy, apparently

abstract concepts, are ultimately psycho-physical phenomena. Proximity is sought – tactile (hugging, sitting on a lap), auditory (via a telephone) or visual (a picture, which may be in the 'mind's eye'). This lowers arousal – slows heart rate, causes less sweating, releases oxytocin (Zeki, 2009). A mentalising conversation (e.g. a therapy session) may also be seen in those terms. The physical posture and tone of voice of the client reveals his or her emotional state. The therapist imaginatively or even actually (via contingently marking and so altering their own physical posture) mirrors this state, which, in turn, via 'mirror neurones' triggers a version of the client's emotional state in the therapist's receptive apparatus (Hobson, 2002). This can then be introspected, identified and verbalised. In doing so, change is set in train.

Finding the 'right' meaning emerges from a three-stage process. First, in a state of 'reverie' (Ogden, 1989), the therapist 'tunes into' her own affective and corporeal sensory-affective world, i.e. her 'counter-transference'. Describing such sensations in words constitutes stage two, an attempt at verbal description, transforming 'preconceptions' into 'conceptions' (Bion, 1970). Stage 3, the full expression of meaning-making, is the therapist's attempt to weave (a) her own affective reactions, (b) knowledge about the client's history (c) and relevant understanding of developmental/psychoanalytic theory into a pattern that captures the internal world of the client in the context of the interpersonal situation generated in the *in vitro* atmosphere of the session.

To summarise, Attachment theory's contribution to meaning-making underpins a 'bottom-up' meta-theoretical perspective in which it is not so much specific interpretations that count, as the restoration or fostering of the *capacity to find/make shared meanings*, irrespective of their content. The Boston psychic change group (Lyons-Ruth et al., 2001) have similarly focused on the mutative aspects of 'non-interpretive mechanisms' in psychoanalytic work. Therapist and client come together in a meaningful shared 'present moment' (Stern, 2004). Meaning in itself is not mutative; it is the *mutuality* of meaning-*making* that matters which brings us to the third leg of the psychotherapy tripod – promoting change.

Promoting change

Psychoanalysis is inherently ironic (cf. Lear, 1993) in that it avoids explicit efforts to produce change, yet its implicit aims are no less 'mutative' than any other therapy. This paradox follows logically from psychoanalysis's theoretical base. People get into psychological trouble because of conflict between the conscious and unconscious mind. Direct appeals on the part of therapy to the sufferer's consciousness will therefore merely activate resistance of the unconscious to change in the status quo and be counter-productive. The unconscious must be approached by stealth, and taken unawares. Theories of psychic change that fail to take account of this paradoxical aspect are unlikely to gain much purchase.

Mentalising

According to Gustafson (1986; drawing on Bateson (1972), who based his ideas on Bertrand Russell's 'theory of logical types'), psychic change invariably entails taking a perspective at a *meta-level*, *or higher logical type* from the problematic behaviours or experience which has led the sufferer to seek help. 'Mentalising' – 'thinking about thinking' or 'mind-mindedness' (Meins, 1999) – clearly fulfils the Gutafson criterion. Moving from action and impulse to reflecting on one's own and others' mental states is crucial to therapeutic action in psychoanalytic psychotherapy, and perhaps the psychotherapies generally (Allen, 2003).

Bleiberg (2006) suggests that mentalising is an essential social skill for group living. Being able to mentalise or to read the intentions of the other became a vital 'friend-or-foe' appraisal as small groups of hominids learned to collaborate and to cope with competition. However, once the other is identified as unthreatening, mentalising is inhibited.

A similar sequence may apply in psychotherapy, as the client begins to imbue the therapist and therapeutic situation with secure base properties, and to relax into a comfortable state of held intimacy. However, while encouraging the development of trust, the therapist will simultaneously insist that clients examine their feelings about the therapist and the therapeutic relationship – aiming to activate and extend mentalising skills. A psychotherapy session is *recursive* in the sense that it loops back on itself in ways that normal relationships tend not to, except perhaps when repair (which can be thought of as an everyday form of 'therapy') is needed. To take a commonplace example, there is often a tussle between therapist and client about reactions to breaks. The client may insist that it is perfectly alright for the therapist to have a holiday, ('everyone needs time off, especially in your sort of work'), while the therapist relentlessly probes for signs of disappointment, rejection and anger, sometimes much to the client's irritation. Therapy here aims to help the client mentalise avoided affect in the service of therapeutic change.

The 'benign bind'

Seen this way, psychoanalytic therapy puts the client in a 'benign bind'. Therapy puts the client in a paradoxical 'change/no change', 'inhibit mentalising/mentalise' bind, forcing the emergence of new structures, and extending clients' range of interpersonal skills and resources. Clients have no choice but to think about feelings and identity in ways that would normally be dealt with by repression, avoidance, acting out or projection.

A psychoanalytic formulation consistent with this comes from Lear's (1993) extension of the Strachey's classic 'mutative interpretation' hypothesis (Strachey, 1934). Lear sees transformational transference as a three-stage process whereby the therapist first enters the client's pre-existing internal world with its unique assumptions and preconceptions and linguistic manifestations or 'ideolect' – the shared associations and meanings that develop in the course or a therapy. Once 'in', secondly, the therapist begins to *dis*confirm

transferential expectations, neither colluding with the client's preconceptions, nor allowing herself to be discounted as alien, irrelevant and expellable. The client is now in a bind. The therapist has gained admittance to his internal world; but the therapist neither conforms to transferential expectations, *nor* easily allows himself to be expelled. This is often most manifest around therapeutic 'ruptures' where an idealised therapist is suddenly seen as failing, or a denigrated one as in fact sympathetic and loving. Moments of discrepancy, disappointment or confusion arising out of the therapeutic relationship, if they can be expressed and fully experienced, and then thought about and discussed, now become productive points for psychic growth (Safran & Muran, 2000). Thus, thirdly, the patient is forced to revise his expectations, assumptions and schemata about intimate relationships. In so doing, as his perceptions of himself, the therapist and their relationship become 'de-transference-ised', he becomes more realistic in his appraisals and more skilful in managing them (cf. Holmes, 2011).

Conclusion

We know *that* psychotherapy, including psychoanalytic psychotherapy, 'works' (Shedler, 2010) – but not *how* it manages to produce benefit. It may well be that psychoanalytic therapists are blind to what it is they do that gets their patients better. Attending to the pull and push of the attachment dynamic, and freeing oneself from dogma (including, of course, dogmatic views on Attachment) may lead to better therapy, productive research questions and a theoretical perspective – both within and without psychoanalysis – that transcends both petty rivalries and superficial compromise.

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Notes

1. It should be acknowledged that I am using the term 'evidence' here in a somewhat tendentious way. The parallels between mother–infant relationship and the therapeutic relationship is assumed, as it often is in psychoanalytic thinking,

rather than justified. It could be argued indeed that there is an implicit infantilising aspect in psychoanalytic theorising, that 'reduces' the client to babyhood.

2. But note that Cortina and Liotti (2010) convincingly argue that attachment and interpersonal sensitivity are distinct, albeit-related dimensions.

References

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Allen, J.G. (2003). Mentalizing. *Bulletin of the Menninger Clinic, 67*, 87–108.

Avdi, E., & Georgaca, E. (2007). Narrative research in psychotherapy: A critical review. *Psychology and Psychotherapy: Research and Practice, 78*, 1–14.

Bateson, G. (1972). *Steps towards an ecology of mind*. New York: Ballentine.

Beebe, B., & Lachmann, F. (2002). *Infant research & adult treatment*. Hillsdale, NJ: Analytic Press.

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly, 73*, 5–46.

Bion, W. (1970). *Attention and interpretation*. London: Tavistock.

Bleiberg, E. (2006). Enhancing mentalisation through psycho-education. In J. Allen & P. Fonagy (Eds.), *Handbook of mentalisation-based treatment* (pp. 233–248). Chichester: Wiley.

Bollas, C. (2007). *The Freudian moment*. London: Karnac.

Bowlby, J. (1988). *A secure base*. London: Routledge.

Castonguay, L., & Beutler, L. (2006). *Principles of therapeutic change that work*. Oxford: Oxford University Press.

Cavell, M. (2006). *Becoming a subject*. Oxford: Oxford University Press.

Cortina, M., & Liotti, G. (2010). Attachment is about safety and protection, intersubjectivity is about sharing and social understanding. *Psychoanalytic Psychology, 27*, 410–441.

Crandell, L., Patrick, M., & Hobson, P. (2003). 'Still face' interactions between mothers with borderline personality disorder and their 2-month infants. *British Journal of Psychiatry, 183*, 239–249.

Damacio, A. (1994). *Descartes' error*. New York: Jason Aronson.

Dozier, M., Stovall, K., & Albus, S. (2008). Attachment and psychopathology in adulthood. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment* (2nd ed., pp. 718–744). New York: Guilford.

Eagleton, T. (2007). *How to read a poem*. London: Blackwell.

Eliot, T.S. (1986). *Collected poems*. London: Faber.

Farber, B., & Metzger, J. (2008). The therapist as secure base. In J. Obegi & E. Berant (Eds.), *Clinical applications of adult psychotherpy and research* (pp. 46–70). New York: Guilford.

Freud, S. (1914/1958). Remembering, repeating, and working through. In J. Strachey (Ed.), *Standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 157–173). London: Hogarth.

Gergely, G. (2007). The social construction of the subjective self. In L. Mayes, P. Fonagy, & M. Target (Eds.), *Developmental Science and psychoanalysis* (pp. 39–63). London: Karnac.

Grossman, K., Grossman, K., & Waters, E. (2005). *Attachment from infancy to adulthood: The major longitudinal studies*. New York: Guildford.

Grostein, J. (2007). *A beam of intense darkness*. London: Karnac.

Gustafson, J. (1986). *The complex secret of brief psychotherapy*. New York: Norton.
Hardy, S. (1999). *Mother nature*. London: Penguin.
Heard, D., & Lake, B. (1997). *The challenge of attachment for care-giving*. London: Routledge.
Hobson, P. (2002). *The cradle of thought*. London: Macmillan.
Holmes, J. (2001). *The search for the secure base*. London: Routledge.
Holmes, J. (2009). *Exploring in security: Towards and attachment-informed psychoanalytic psychotherapy*. London: Routledge.
Holmes, J. (2011). Superego: Attachment perspectives. *International Journal of Pyschoanalysis* (in press).
Holmes, J., & Bateman, A. (2002). *Psychotherapy integration: Models and methods*. Oxford: Oxford University Press.
Jung, C. (1964). *Man and his symbols*. London: Aldus Books.
Lear, J. (1993). An interpretation of transference. *International Journal of Psychoanalysis, 74*, 739–755.
Lear, J. (2009). Technique and final cause in psychoanalysis: Four ways of looking at one moment. *International Journal of Psychoanalysis, 90*, 1299–1317.
Leiman, M. (1995). Early development. In A. Ryle (Ed.), *Cognitive analytic therapy: Developments in theory and practice*. Chichester: Wiley.
Lewin, K. (1935). *A dynamic theory of personality*. New York: McGraw-Hill.
Luyten, P., Sabbe, B., Blatt, S.J., Meganck, S., Jansen, B., De Grave, C., . . . , Corveleyn, J. (2007). Dependency and self-criticism: Relationship with major depressive disorder, severity of depression and clinical presentation. *Depression and Anxiety, 24*, 586–596.
Lyons-Ruth, K., & the Boston Change Process Study Group (2001). The emergence of new experiences: Relational improvisation, recognition process and non-linear change in psychoanalytic psychotherapy. *Psychologist/Psychoanalyst, 21*, 13–17.
Main, M. (1995). Recent studies in attachment: overview with selected implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental and clinical perspectives* (pp. 276–289). Hillsdale, NJ: Analytic Press.
Main, M. (1999). Epilogue. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment* (pp. 832–869). New York: Guilford.
Malan, D., & Della Selva, P. (2006). *Lives transformed: A revolutionary method of dynamic psychotherapy*. London: Karnac.
Matte-Blanco, I. (1975). *The Unconscious as infinite sets*. London: Routledge.
McCluskey, U. (2005). *To be met as a person*. London: Karnac.
Meins, E. (1999). Sensitivity, security and internal working models: Bridging the transmission gap. *Attachment and Human Development, 3*, 325–342.
Ogden, T. (1987). *The matrix of the mind*. Northvale, NJ: Aronson.
Rycroft, C. (1985). *Psychoanalysis and beyond*. London: Chatto.
Safran, J., & Muran, J. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford.
Shaver, P., & Mikulincer, M. (2008). An overview of attachment theory. In J. Obegi & E. Berant (Eds.), *Clinical applications of adult psychotherapy and research* (pp. 17–45). New York: Guilford.
Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65*, 98–109.
Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment and Human Development, 7*, 269–282.
Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Stern, D. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.

Strachey, J. (1934). The nature of the therapeutic action of psychoanalysis. *International Journal of Psychoanalysis, 50*, 275–292.

Tronic, E. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal, 19*, 290–299.

Tuckett, D., Basile, R., Birkstead-Breen, D., Böhm, T., Denis, P., Ferro, A., . . . , Schubert, J. (2008). *Psychoanalysis comparable and incomparable*. London: Routledge.

Wachtel, P. (2010). One-person and two-person conceptions of attachment and their implications for psychoanalytic thought. *International Journal of Psychoanalysis, 91*, 561–581.

Winnicott, D. (1971). *Playing and reality*. London: Penguin.

Zeki, S. (2009). *The splendours and mysteries of the brain*. Chichester: Wiley-Blackwell.