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SOME IMPLICATIONS OF ATTACHMENT RESEARCH FOR PSYCHOTHERAPEUTIC PRACTICE

Jeremy Holmes
University of Exeter, UK

Abstract: The implications of current findings in attachment theory for psychoanalytic practice are reviewed. Discussion is divided into three sections: the therapeutic relationship; meaning making; promoting change. It is argued that attachment provides a "meta-perspective" from which the interactions of therapist and client can be viewed. Key themes discussed include: Goal Corrected Empathic Attunement as a stimulator of vitality affects and companionable exploration in therapy; the emergence of narrative competence and meaning in the context of secure attachment to the therapist; the paradoxical nature of therapy as a "positive double bind" aiming to stimulate psychic development and reorganisation. The tripartite rubric is applied to the difficulties of working with borderline clients and how these may be overcome.

Key words: Attachment, Psychoanalysis, Psychotherapy.

INTRODUCTION

The aim of this paper is to illustrate ways in which recent findings from attachment theory (e.g., Fonagy 2006) can help illuminate the therapist-client relationship, especially as it arises in working psychoanalytically with people suffering from borderline personality disorder (BPD). Its justification is what the author sees as a "theory-practice gap" in psychoanalytic psychotherapy—a large body of complex theory, not clearly or necessarily logically linked to psychotherapeutic process.

The components of effective psychotherapy can be classified under three main headings: *therapeutic relationship*, *meaning-making*, and *promoting change* (Castonguay & Beutler, 2006). This division is somewhat artificial in that a good therapeutic alliance in itself promotes, and indeed some argue is a mere proxy for, change (Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998), and no doubt a

Address: Jeremy Holmes, Department of Psychology, University of Exeter, Exeter EX4 4 QG, UK. E-mail: j.a.holmes@btinternet.com

feeling of positive change strengthens the therapeutic bond. Similarly, the exploration of meaning is in itself an aspect of forming a therapeutic alliance, and thinking about that alliance is a central part of the meaning-making process of psychoanalytic therapy. Nevertheless, this tripartite division of the therapeutic symphony into compound time helps identify themes and further structural analysis.

THE THERAPEUTIC RELATIONSHIP

Transference and attachment

Contemporary psychoanalytic theorising provides an increasingly convergent picture of the therapeutic relationship (Gabbard, 2005). The neo-Kleinian approach emphasises the "total transferential situation" (Joseph, 1989), extending what the client brings from the past to encompass the here-and-now therapist's reactions evoked by the client, and the specific constellation thereby created. Interpersonal psychoanalysis (Wallin, 2007) similarly views the therapeutic relationship as a co-creation involving the unconscious desires, defences, and enactments of both participants. Benjamin (2004), Aron (2000) and, from a slightly different perspective, Ogden (1989) write of the "analytic third" as a co-created entity, unique to each therapeutic relationship, with a life of its own that cannot be derived exclusively from either the characteristics of the client or the theoretical models of the therapist.

However, psychoanalysis has struggled to theorise the "real relationship", or the "unobjectionable positive transference" (Gabbard, 2005), a *sine qua non* condition for maintaining treatment. Attachment theory helps here in that it provides a common-sense model of the therapist-client relationship. Distress evokes attachment behaviours. Attachment overrides all other motivations, such as exploratory, playful, sexual, gustatory, etc. (Holmes, 2001). Attachment behaviour involves seeking proximity to an older, wiser figure, able to assuage distress (Holmes, 2001). Once soothed and safe, and only then, is the sufferer able to resume "companionable interaction" (Heard & Lake, 1997) with a co-participant. The architecture of the therapeutic relationship is that of a person in distress, seeking a safe haven, and in search of a secure base, and of a care-giver with the capacity to offer security, soothing, and exploratory companionship.

This relationship is inevitably coloured by *transference* in the sense that the client brings to the relationship largely unconscious expectations, schemata, and internal working models, based on, but not identical with, actual experiences of care-seeking. Shaver and Mikulincer's (2009) hyper-activation/deactivation dichotomy

"No, I don't feel disappointed, sad perhaps. I realise I've made my own choices; what matters to me is my wife and family, the everyday things of life. I feel happy to live by my own lights now, not an impossible dream of my Dad's" he said.

"And you seem to be feeling that the so-called 'wise men', including me, are an illusion, they neglect what really matters to you, the answers lie within yourself", I suggested, adding: "I have to confess that I was thinking about that plant over there; it looks, like you, as if it could do with some tender loving care".

"Well, I suppose I do feel angry with you for not transforming me into the perfect person I thought I wanted to be, but also grateful and loving at the same time for the attention and validation you have offered me" he said.

We negotiated an end-date several sessions later at a natural break, with a follow up appointment after the holidays. As he left he said "I don't need to go to the toilet today!"

I jokingly replied: "but it's pristine, all the cobwebs have been cleared away!". We both laughed; the session seemed to end with a good feeling on both sides.

So here was a rupture: his accurate perception of my less than ideal toilet; our recognition of this and of a narrow career-limited view of his masculinity; repair through acknowledgement. The rupture triggered feelings of neglect and lack of validation from his father which were then played out in his feelings about me. He responded by withdrawal, deciding to end therapy, but perhaps in a more creative and balanced way than the little boy who had to remind himself of his father's name when writing home. He now knows who he is, and is not. He can now turn to his *high-flying* wife with his own manhood more firmly established, less needing to be controlling, or to borrow an idealised masculine identity from his "wise men".

Goal Corrected Empathic Attunement (GCEA)

Bowlby (1988) argued that in the course of effective therapy the therapist assumes some of the properties of a "secure base" in a client's life. However this can only be

in a "virtual" or playful way, in that the therapist's availability is usually highly restricted between sessions. How the occupants of a person's secure-base hierarchy are chosen is not entirely clear (I routinely ask clients at assessment "who would you contact first if there were a crisis in your life?"). Similarly we don't know what turns a professional relationship into a 'secure base', although we do have a good picture of the ways in which deactivating clients avoid this by restricting their neediness and reliance on others (Mallinckrodt et al., 2009) and resisting the pull of therapy.

Clinical experience, with some research backing (Farber & Metzger, 2009), suggests that *care-seeker/ care-giver emotional connectedness* is a key feature of secure base. The capacity of security-providing parents to sooth and assuage their children's freely expressed distress in the strange-situation condition leads to classification as "secure", in contrast to "insecure" children who either restrict (deactivate) or amplify unassuageably (hyper-activate) affect.

Emotional connectedness is thus clearly a feature of psychotherapeutic relationships, and it is possible that this might be one marker of the "secure baseness" of the therapeutic relationship. But what do we mean by emotional connectedness? A number of authors have drawn attention to the importance of positive *interactive sequences* in therapy sessions. Malan (1979) wrote of "leapfrogging" between patient and therapist as the therapist responds to the patient's material with an apposite intervention, which in turn stimulates further discourse from the patient and so on. His marker for a "successful interpretation" was an increase *or decrease* in empathy (the latter denoting a defensive reaction to an intervention that might otherwise "hit the spot"), although how this alteration was measured was not specified, and relied on the retrospective accounts by therapists. His accounts suggest that this empathic shift referred to a change in the *feel* of and *intensity* of the session, together with non-verbal affective markers such as crying, laughter, and/or changes in voice tone or posture on the part of the patient. The clinical example above perhaps illustrates this, especially in the enlivened joking atmosphere at the end of the session.

Gergely and Watson's (1996) landmark paper focuses on affective sequencing between parents and infants. They identified "contingency" and "marking", in the context of intense mutual gaze, as denoting mirroring sequences in which, to use Winnicott's (1971, p. 51) description, the «mother's face is the mirror in which the child first begins to identify himself». Contingent responses denote the way in which the care-giver waits for the infant to initiate affective expression; their response is marked by an exaggerated simulacrum of the infant's expression. The child thereby begins to *see* and *own* his feelings – contingency links them to his own actions and internal feelings – marking enables him to differentiate his mother's mirroring

response from affects of her own. This, in turn, has a soothing/affect-regulating quality.

These interactive sequences thus involve (a) affect expression by the care-seeker; (b) an empathic resonance on the part of the care-giver, who puts her/himself into the shoes of the child; (c) affect regulation in that the parent tends to up-regulate or down-regulate depending on what emotion is communicated (e.g., stimulating a bored child, soothing a distressed one; see example above). The result is (d) mutual pleasure and playfulness, or, to use Stern's (1985) phrase, the evocation of vitality affects, or enlivenment, leading to (e) exploratory play/ companionable interaction (Heard & Lake, 1997) – "exploring in security".

Similar sequences are, arguably, to be found in therapist-client interactions. McCluskey (2005) describes a series of empirical studies in which she films and rates student therapists and simulated clients. She shows that initial attunement (Stage 1), in the sense of an affective response on the part of the therapist, in itself is insufficient to comprise a secure base. Two further steps are needed in order to liberate exploration and companionable interaction. The first (Stage 2) is affect-regulatory and is mainly communicated non-verbally by the therapist's facial expression and tone of voice, often with a *marked* quality: "you did *what*?!"; "that sounds *painful*"; "ouch!!" "it sounds like you might be feeling pretty sad right now", "I wonder if there isn't a lot of rage underneath all this". An historic example comes from Freud's Dora case in which, in a footnote he writes that he took note of the «exact words» that Dora used «because they took me aback» (see Bollas, 2007, p. 31).

The therapist communicates to the patient that he has heard and felt the feeling, and then reflects this back as a 'third' in the room for both to examine. This leads to enlivening on the part of the patient and to Stage 3, companionable exploration of the content or meaning of the topic under discussion. McCluskey (2005) dubs this sequence as 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 or stay on track (both locomotive metaphors).

Empowerment

An important early finding in attachment research (Ainsworth, Blehar, Waters, & Wall, 1978) was that attachment classification in the strange-situation condition was a relational not a temperamental feature, since at one year children could be secure with mother and insecure with father or vice versa (by 30 months the maternal pattern tends to dominate; Ainsworth et al., 1978). Nevertheless the role of fathers in

attachment has been relatively neglected, in the case of disorganised attachment for the obvious reason that many of the children studied come from mother-only families (Lyons-Ruth & Jakobvitz, in press). The Grossman's longitudinal studies (Grossman, Grossman, & Waters, 2005) are an honourable exception, and they have showed that paternal contributions in childhood to eventual security in early adulthood is as important as that of the mother, and that 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, and should perhaps be 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), successful 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 condition fathers operate nearer the fulcrum of the security-exploration *seesaw* than do mothers (Grossman et al., 2005), using distraction and activity as a comforting manoeuvre rather than hugging and gentle soothing.

A relevant recent study comes from Slade (2005) who found that measures of maternal sensitivity were insufficient to capture security-providing functions and that a dimension of "mastery", associated with communicating not just an intimate protectiveness, but also the presence of an adult in charge of the play-space. This links with the often-quoted Vygotskyian notion (see Leiman, 1995) of the "zone of proximal development" where the child is directed to tasks that are neither too easy nor too hard, but also the physical "defensible space" surrounding the child whose security the parent is able to guarantee (cf. Leiman, 1995). There are parallels here with the provision of therapeutic space (which is also a "space of time", cf. Lakoff & Johnson, 1980), and Freud's (1914/1958) injunction that interpretations should be aimed at patients' emergent thoughts, neither too deep nor too superficial.

McCluskey (2005, p. 87), drawing on Heard and Lake (1997), in her construct of GCEA emphasises the *goal*-oriented aspect of exploration which is perhaps downplayed in much of the attachment literature. She sees the outcome of secure attachment through effective assuagement of attachment behaviours as being the:

> ...effective capacity to influence one's environment...What is sought by the care-seeker...is a relationship with someone which puts them in touch with how they might, with or without help, reach their goals for themselves; or if their goals are unrealisable...the interaction promotes that sense of well-being [cf. *vitality affects*] that comes from being in touch with

> another person who can stay with and *name* what one is experiencing rather than denying it, changing it, or fleeing from it.
> (my italics and parenthesis).

From a Lacanian perspective (Lacan, 1977) language is a "paternal" function. "Le no(m) du père" encapsulates the paternal oedipal prohibition which severs the infant's phantasy of merging with the mother, but also the liberating "naming of parts", including the Self (which in Western culture includes the family name). Thus, consideration of the goal-directed empowerment (with its paternal resonance), which secure attachment can facilitate, leads us to the question of language and meaning in psychotherapy.

MEANING-MAKING

Explanatory framework

All effective therapies, including folk remedies and Shamanic rituals, rely on an explanatory framework which brings order to the inchoate experience of illness, whether physical or mental (Holmes & Bateman, 2002). Bateman and Fonagy (2004) argue that a feature of all effective therapies for BPD is a high degree of internal coherence, presumably as a counter-balance to the ever-present threat of chaos and incoherence typical of that condition. An explanatory framework is both anxiety-reducing in itself, and provides the scaffolding for mutual exploration that follows, once attachment anxiety has been assuaged.

This mutual incompatibility between threat-triggered attachment behaviour and exploration is the leitmotiv to which attachment in its clinical guises continually returns. In infants and young children, this is manifest in observable behaviours, that is, pulling into 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 much more subtle, although most adults will have had the experience of "holding on" to some pain, physical or emotional, while in the public arena until they can let go, usually with physical accompaniments such as hugging, hand holding and tearfulness, when with a loved one.

Companionable exploration

In the consulting room, sensitivity to the ebb and flow of attachment and exploration is the hallmark of a skilful therapist. As discussed above, GCEA entails "secure base" responses to client's distress. This is in part a matter of timing and tone of voice, but accurate verbal identification of feelings (i.e., the emergence of shared meanings) is in itself soothing, and the exploration that ensues once feelings are in place is always a *conversation* (Margison, 2002)—often, as we shall see, a "conversation about a conversation".

Highly specific meanings derived from the minutiae of a person's life are co-created by therapist and client. Elaborating this personal vernacular or "idiolect" (Lear, 1993) is a crucial aspect of psychotherapeutic work. When things are going well, as Bollas (2007) describes, the "receptive unconscious" of the analyst is tuned into the "expressive unconscious" of the client, and the task of the ego, or conscious Self is, rather like that of the good-enough mother in Winnicott's model of the child playing "alone in the presence of the mother", merely to guard the space, in a non-intrusive way. The analyst's "explanatory framework" comes into play when there are blocks to this free flow of communication, and here attachment ideas about patterns of insecure attachment and how they manifest themselves in narrative and dialogic style become relevant.

Main is credited with attachment theory's decisive "move to the level of representation" (Main, in press). Clearly *representation* is not exclusively nor necessarily verbal. "Teleological thinking", characteristic of pre-verbal, "pre-mentalising" toddlers (Fonagy, 2006) is both representational and meaningful in the sense that the infant begins to develop a mental map of the interpersonal world based on "if this, then that" logic. However the capacity to represent the Self and Others and their relationship *verbally* is the next vital developmental step, enabling children to negotiate the interpersonal world which will be matrix of all future existence once the "physical matrix" (i.e., mother) is relinquished. Language gives us a Self which becomes both a centre of experience and an object in the world which can be described, discussed and worked on.

Narrative styles

Arising out of its overall theoretical framework, attachment theory has arguably contributed three great empirical discoveries to contemporary developmental psychopathology. First is the establishment of the ubiquity of the hyperactivation/deactivation axis. Second is the discussion on the protective role of reflective function in

the face of developmental difficulty. Third is the establishment of a relationship between childhood attachment patterns and narrative styles in adolescence and young adulthood. *How* we talk about ourselves and our lives, rather than *what* we talk about, is a probe into the inner world, and Main's (in press) development of the Adult Attachment Interview (AAI) was an inspired intuitive, and subsequently empirically validated, guess in this direction (Hesse, in press).

Like the "fluid attentional gaze" (Main, in press) of the secure infant who seamlessly negotiates the transitions between secure base seeking, social referencing and exploratory play, Main characterises secure narratives as "fluid autonomous", neither over- nor under-elaborated, with a balance of affect and cognition appropriate to the topic discussed. In the context of therapy, secure narrative styles are meaningful in the Wittgensteinian sense that they become part of an open-ended "language game" played by therapist and client. By contrast, insecure styles lead to therapeutic conversations that are under-, over-saturated with meaning, or lacking in meaning, depending whether they represent deactivating, hyper-activating or unresolved attachments.

A key part of therapeutic work, far removed from an exclusive preoccupation with making "correct interpretations", consists in moving the client towards the elaboration of mutual meanings, or a more secure narrative style:

> "Can you elaborate on that?", "What exactly do you mean by that?", "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 aspects of the patient's experience (cf., Holmes, in press). This then becomes a shared object or "third" (Benjamin, 2004; Ogden, 1989) which can be "companionably explored" (Heard & Lake, 1997), and in the case of metaphors played with and elaborated.

There is at least some evidence to support the idea that successful therapy is associated with changes in narrative style (Avdi & Georgaca, 2007). However, Eagle and Wolitzky (2009) rightly question whether the notion of "autobiographical competence" (Holmes, 2001) is a valid marker of progress in therapy since it could merely be a manifestation of compliance and/or intellectualisation, or emerge in the consulting room without necessarily denoting generalisation beyond or true structural change in the personality.

Main's (in press) schema contrasts the fluidity of secure styles with the fixity 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 (Loewald, 1980; Rycroft, 1982). Secure narrative styles could be seen as "infinite" – in the Matte-Blanco (1975) sense of the unconscious as an "infinite set" – open-ended systems, always subject to further "vision and revision" (Eliot, 1986), in contrast to the fixed defensive narratives of insecure attachment.

To summarise, attachment theory's contribution to meaning-making in psychotherapy underpins a meta-theoretical perspective in which it is not so much specific interpretations that count, as the restoration or elaboration of the *capacity to make shared meanings*, irrespective of their content. The Boston psychic change group (Lyons-Ruth & the Boston Change Process Study Group, 2001) have similarly focussed on the mutative aspects of "non-interpretive mechanisms" in psychoanalytic work, where therapist and client come together in a meaningful shared "present moment" (Stern, 2004) that emerges from something one or other has said but whose impact lies primarily in the mutuality the meaning creates. Meaning in itself is not mutative, but the *mutuality* of meaning-making. This leads us onto my third theme.

PROMOTING CHANGE

What are the ways in which attachment-informed therapy might, or might not produce benefit to its clients? How can attachment ideas help clarify "therapeutic action"? The latter has been a source of debate and not a little heart-ache, for psychoanalysis. But, as Gabbard and Westen (2003, p. 837) put it (perhaps disingenuously), the issue for contemporary psychoanalysis of «what is therapeutic...is an empirical question which can no more be answered by logic and debate than the question of whether one or another treatment for heart disease is more effective». Attachment theory is now tentatively beginning to make an evidence-informed contribution to this issue.

Mentalisation

It should be noted, however, that there are questions of logic and debate here as well as fact. According to Gustafson (1986), drawing on Bateson (1972; himself basing his ideas on 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 lead clients to seek help. If mentalisation (Jurist &Meehan,

2009) can be characterised as "thinking about thinking" (Holmes, 2006) or "mind-mindedness" (Meins et al., 1998) this brings us immediately to the current interest in the capacity for *reflectiveness* on one's own and others' mental states as focus for therapeutic action in a range of psychotherapies, including psychoanalytic psychotherapy.

Fonagy et al.'s reflexive function scales on the AAI heralded the landmark discovery that prospectively measuring reflexive function in adults predicted their subsequent children's attachment status (Fonagy, Steele, Steele, & Target, 1997). This has subsequently been amply replicated (Van Ijzendoorn, 1995), and led to further experimental and theoretical work. A number of different laboratories and investigative tools have shown that children whose mothers can reflect not just on their own mental states but also those of their offspring are more likely to be secure, despite socio-economic stress, than those whose mother's reflective abilities are compromised (Lyons-Ruth & Jacobvitz, in press). In parallel with these empirical studies, Allen and Fonagy (2006; and other researchers as well) have developed the theoretical concept of mentalisation as a unifying psychotherapeutic concept.[1]

A psychotherapy session, of whatever stripe, provides an arena designed to foster mentalisation. Cognitive therapy tends to focus on the subject's own (and others' presumed) thought processes and the ways in which reality is thereby distorted, so helping sufferers to see painful thoughts, and the emotions derived from them, as "just thoughts". Psychoanalytic psychotherapy goes beyond this in two ways. First, it is inter- as well as intra-psychic, working on the unconscious here-and-now interactions between therapist and client as a primary mentalisation focus. Second, adopting a developmental perspective, it tries to mentalise the states of mind of child and care-giver that form the sufferer's developmental history.

There is some evidence (Fonagy, Leigh, & Steele, 1996) that enhancing reflexive function/ mentalisation is associated with good outcomes in psychotherapy, especially with deactivating clients. As already argued, psychotherapy is a "corrective emotional experience" (Alexander & French, 1946), both in the sense that the client may have for the first time the experience of feeling safe enough to look at his feelings (since they are now mutually regulated via GCEA) and, also, in the pedagogic sense that the skill of mentalisation can be acquired in the course of therapy, both via modelling (listening to the therapist mentalising *out loud* his own and the client's joint emotions and enactments) and by trial and error (the therapist encouraging the client to work on self-understanding at the "zone of proximal development").

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1. The present author remains narcissistically wedded to his own anti-narcissistic definition of mentalisation as the ability to "see ourselves as others see us and others as they see themselves" (Holmes, 2006).

What is it about mentalisation that is associated with psychic health? An evolutionary answer suggests that in a social species such as our own (and all other primates; Suomi, in press), the ability to read and regulate one's own and understand others' minds enhances social skilfulness, thereby enabling the individual to achieve more satisfying and intimate relationships, less likely to be jeopardised by unmodulated affect. To mentalise is to "know thyself", an underlying ethic of psychotherapy, ancient and modern. Eagle and Wolitzky's (2009) caveat, however, applies equally to mentalisation as to "narrative competence": (a) the ability to mentalise in a session may not be generalised outside the consulting room, and (b) mentalisation can easily be confused with intellectualisation, namely, a defence against, rather than an exploration and regulation of, troubling emotions.

Paradox and change in psychotherapy

If, as in classical psychoanalysis, Oedipus lies at the kernel of psychotherapeutic metapsychology, an inherently *paradoxical* view of psychic life is implied: we are often our own worst enemies; perversely we bring about the very dangers and disasters we most wish to avoid; what we want is what we most fear; those we love may also be those we most hate; we are frequently strangers to ourselves. The aim of therapy, in this view, is to replace this tragic vision with an ironic acceptance of our fate and our unruly child-like selves (Schafer, 1983).

Psychoanalysis from its inception to the present day (Caper, 1999) partly no doubt to encourage "brand identity", differentiates itself from therapies based on suggestion. "Suggestion" in its original conception referred to patient-doctor positive transference, or placebo effect, but also encompasses behavioural, cognitive-behavioural and "life coaching" approaches. People tend to turn to the paradoxical promises of psychoanalytic therapy when common sense solutions to their problems have failed.

Psychoanalysis uses paradox to outwit the inherent paradoxes of psychological disturbance. It is paradoxical in that, other than the "fundamental rule" (e.g., "say anything that comes into your mind, however irrelevant embarrassing or trivial it may seem"), no directions are given, and as the presenting symptom decreases in salience, the therapeutic relationship itself assumes the central focus of therapeutic work. Paradoxically also, the intensity of the therapeutic relationship is both *real* (the client may develop an intimacy with his therapist greater than any previously experienced in adult life) and yet *unreal* in that it remains encapsulated within the ethical and physical confines of the contract and the consulting room. As mentioned, the therapist remains a quasi-secure base rather than the real thing.

Other therapeutic modalities also implicitly or explicitly use paradox as thera-

peutic techniques. "*Milan* family therapy" (see Gustafson, 1986) offers families a "no change" message and "prescribe the symptom" (i.e., "we suggest that Caroline go on starving herself since she believes that the family will fall apart if she stops being such a worry and regained normal weight"). This strategy recognises the power of stasis and defence, as well as subtly making therapeutic failure impossible, in that such injunctions either reinforce the influence of the therapist if they are adhered to or stimulate healthy rebelliousness and autonomy. Similarly, dialectical behaviour therapy (Linehan, 1993) gives its borderline clients a poised change/no-change message, simultaneously validating the client's symptomatic behaviours as a way of coping with intolerable mental pain, while encouraging them to find new less self-destructive ways of coping.

Fonagy's account of the mentalisation-fostering aspects of psychotherapy can also be seen as paradoxical. Bleiberg (2006) sees mentalisation as a necessary social skill enabling the mentaliser to read the intentions of the Other—a vital "friend-or-foe" appraisal as small groups of hominids learned to collaborate and compete. However, once the Other is identified as non-threatening, mentalisation is inhibited. The appraiser's guard is put down and psychic energy can be put to other uses. Extreme instances of this are seen in intimate relationships between infants and their mothers and between romantic partners. Brain patterns in both are similar, with inhibition of the neuroanatomical pathways subsuming mentalisation. This releases psychic energy from the appraisal task, and perhaps explains the necessary idealisation (i.e., "my baby/ lover/ mum is the best baby/ lover/ mum in the whole world") in which negative features are ignored or discounted, inherent in such relationships.

Similar process may occur in psychotherapy, as the client begins to imbue the therapist and therapeutic situation with secure base properties, and to relax (literally if lying on the couch) into a comfortable state of held intimacy. However, while encouraging the development of trust, the therapist will also insist that the client direct his attention to the nature of the trusting relationship (i.e., to acquire, activate and extend mentalising pathways). Thus, a psychotherapy session is *recursive* in the sense that it loops back on itself in a way that normal relationships tend not to, except perhaps when repair work (i.e., an everyday form of therapy) is needed. To take a commonplace example, there is often a tussle between therapist and client, especially if deactivating, about reactions to breaks. The client may insist that it is perfectly alright for the therapist to have a holiday (i.e., "everyone needs a break, 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.

This conceptualisation of "therapeutic action" can be seen as a "positive double bind". In Bateson's (1972) classic formulation of the double bind, the potentially

psychotic adolescent is given an approach/avoidance message from his "schizophrenogenic" parent, thereby triggering a psychotic response as the only possible escape from an intolerable crux. While this etiological model no longer holds, it lives on in Main's (1995) approach/avoidance model for disorganised attachment. A positive feedback loop is initiated in which a child feels threatened by the very person (i.e., the parent) to whom he would naturally turn for succour when faced with threat: the more attachment behaviours are activated, the more he seeks out a secure base, as he approaches the "secure base/source" of threat, the more threatened he feels and so on. The bizarre self-soothing manifestations of disorganised attachment, such as furling into oneself, rocking, and head-banging, are seen as attempts to solve or escape from this impossible dilemma.

But because it leads inevitably to change of some sort, a "double bind" can also foster positive developments. Therapy puts the client in a paradoxical "change/no change", "inhibit mentalisation/mentalise" bind forcing the emergence of new structures and extending clients' range of interpersonal skills and resources. This analysis is at least plausible given that attachment and mentalisation are subsumed under distinct neuroanatomical pathways (Jurist & Meehan, 2009).[2]

All this remains speculative, but is consistent with chaos theory (Gleick, 1987), a mathematical approach appropriate to the unstable and fluid world of interpersonal relationships. Chaos theory suggests that injecting energy into closed but unstable systems (i.e., chemical reactants or weather systems) leads to the emergence of new and more complex chemical or meteorological structures. Change in psychotherapy can be thought of in an analogous way (see Scharff & Scharff, 1998).

A clinical approach consistent with this comes from Lear's (1993) extension of the Strachey's classic *mutative interpretation* hypothesis (Strachey, 1934). Lear (1993) sees transformational transference as a three-stage process whereby the therapist first enters the client's pre-existing internal world—with its assumptions and preconceptions and linguistic manifestations (the shared associations and meanings that develop in the course of a therapy, or "idiolect"). Once in, secondly, the therapist begins to disconfirm transferential expectations, neither colluding with the client's preconceptions, nor allowing him/herself to be discounted as alien and irrelevant. The client is thus in a bind. The client's internal world has been "colonised" by therapy; but the therapist neither conforms to nor accepts "decolonialising" expulsion. Thus, thirdly, the patient is forced to revise expectations, assumptions, and schemata. In so doing, as perceptions of him/herself, the therapist,

2. Attachment pathway 'A' involving the middle prefrontal lobes, while 'B', 'theory of mind' route (of which mentalisation is an example) relates to the amygdale.

and their relationship become "de-transference-ised", so the client becomes more realistic in his appraisals and more skilful in doing so.

Returning to the clinical example above, John entered into therapy in a state of transferential idealisation:

> I was to be the "wise man", who, unlike his father, would guide him through life to his "true self". There were sufficient qualities about me and/or my role that allowed for this mis-identification. But I neither enacted this guru-like role, nor did I "allow" him entirely to expel me: "your toilet is just like my father's, dirty and neglected, and I intend to stop therapy immediately".

We negotiated a slow withdrawal from therapy, and were able to laugh about the toilet. Through this he *finds* a more authentic self, no longer in thrall to his father's expectations, playful, exploratory, and self-directed.

At moments of psychic change there may be sudden "flips" from one attachment style to another. This is perhaps most commonly seen when a previously deactivated client suddenly becomes flooded with panic and anxiety and demandingness, and becomes temporarily hyper-activating (Eagle & Wolitzky, 2009). Conversely, from a psychoanalytic perspective, hyper-activation can be seen as a hysterical defence, in which the client estranged from his/her true feelings, displays not the real thing but a simulacrum of emotion, often via envious identification with the parental couple (Britton Feldman, & O'Shaughnessy, 1989). The sudden realisation by the client that, despite *sturm und drang*, "I actually I don't really feel *anything*" may mark the beginning of a less self-estranged inner life. Deactivation/ hyper-activation thus become not immutable traits, but alternative epigenetic pathways, in which one predominates, and which may, if challenged and reorganised via therapeutic paradox, open up to new and less maladaptive neural networks and external relationships.

DISORGANISED ATTACHMENT AND BPD

Attachment perspectives can help understand some of the common therapeutic difficulties presented by people suffering from BPD. Using the heuristic of this paper, difficulties are to be found in each of three of the therapeutic arenas identified.

Prospective studies (Grossman et al., 2005) have established robust links between insecure attachment in childhood and reduced life-satisfaction and less satisfying romantic relationships in early adulthood. But while insecure attachment

may reduce quality of life and compromise intimacy, this remains for the most part outwith the clinical realm. It is reasonable to assume that the majority of people whose attachment styles fall into the "organised insecurity" group are not on direct developmental pathways to psychopathology, even if their vulnerability to depression and anxiety is likely to be higher than those with more favourable attachment experiences in childhood.

By contrast, disorganised attachment both emerges from, and is associated with, high levels of social and individual disturbance (Lyons-Ruth & Jacobvitz, in press), and therefore represents a risk factor for the development of psychiatric disorders. The majority of people suffering from BPD are unresolved or preoccupied in relation to attachment (Westen, Nakash, Thomas, & Bradley, 2007). It is a reasonable, albeit as yet unproven, hypothesis that many of these individuals would have been classified as disorganised in childhood (Holmes, 2003).

In the attachment theory literature, disorganised attachment and its adult equivalent —"unresolved" with respect to trauma— are categories orthogonal to the hyperactivation/deactivation axis. Helping borderline clients to move towards more organised forms of insecurity, or even to secure attachment styles is a major therapeutic challenge.

Therapeutic relationship

As discussed, applying the Main conceptualisation of disorganised attachment to borderline patients, the sufferer, when faced with the possibility of intimate relationship, finds herself in an unresolvable dilemma, leading to various pathological solutions such as dissociation, bizarre experiences or self-injurious behaviour.

This analysis goes some way towards explaining some of the difficulties BPD patients have in forming a therapeutic alliance. Attachment needs in such people are highly aroused, but difficult to assuage. Help is viewed with extreme suspicion, leading either to resisted engagement or excessive dependency. The patient often finds it difficult, particularly in the early stages of treatment, to adapt to the rhythms of attachment and separation inherent in the therapeutic process. In the face of these responses, therapists then often enact one of the two patterns comparable to those identified in mothers of disorganised infants (Lyons-Ruth & Jacobvitz, in press). These are: fearful withdrawal ("this person keeps missing sessions, they're not really motivated and it's a bit or a relief if they drop out; to be honest they scare and confuse me"), or self-referential interpretations ("the patient is projecting his own aggression and despair into me, and insists on extra sessions as a way of controlling me"). Unsurprisingly, therapists are often viewed by their clients as unconcerned, abandoning, hostile or intrusive.

Meaning

Similar difficulties beset the elucidation of *meaning* for BPD patients. Clients are typically invited to think about why they did or felt such and such ("what is going on in relation to the therapist or therapeutic situation or significant other") and/or to listen to the therapist speculating about these issues and their putative developmental origins. For BPD patients such questions, however valid, may be experienced as either persecutory or incomprehensible. The lapses of mentalisation identified as characteristic of the care-giver of a disorganised child mean that the BPD patient lacks the experience of «the fundamental need of every infant to find his mind, his intentional state, in the mind of the other» (Fonagy & Target, 1997, p. 187). Being understood, rather than leading to a sense of relief and deactivation of attachment, and triggering of exploration and companionable exploration, equates to having one's thoughts and feelings invaded, stolen or dictated. Interpretations are experienced as "mad", denigratory or pointless.

Change promotion

Third, the idea of *change* itself is far from straightforward in BPD. Linehan (1993) argues that for such sufferers invitations to change habitual patterns of behaviour, however apparently self-defeating, are likely to be ineffective. Deliberate self-harm, the temporary comforts of substance abuse, the vicissitudes of chaotic relationships, affective oscillations between blissful fusion and feelings of fear and loathing, all serve a psychological purpose. They attempt to reproduce, albeit in pathological and partial form, some of the physiological aspects of a secure base: warmth, oral comfort, being held (Holmes, 2001). There may also be symbolic equivalents in which death or oblivion is sought as an all-accepting safe "bourne", albeit one from which no traveller returns. Less self-defeating, healthy alternatives may appear to offer little more than a void or an impossible dream. Linehan's (1993) "dialectic" involves offering the patient paradoxical "change/no change" messages. This ensures that self-esteem is maintained by praise for having achieved a modicum of psychological survival, while at the same time inviting patients to consider different methods of affect regulation and the development of the self-awareness needed to learn from experience.

Mentalisation-based therapy

In view of the above it is no surprise that conventional psychotherapeutic approaches to BPD are, on the whole, relatively ineffective, or possibly even iatrogenic, when

measured against the natural tendency to remission in BPD (Bateman & Fonagy, 2004). The two best-known evidence-based treatments for BPD, dialectical behaviour therapy (Linehan, 1993) and mentalisation-based therapy (Bateman & Fonagy, 2004) are stand-alone tailored approaches, based on, but markedly different from their parent therapies—behaviour therapy and psychoanalytic psychotherapy, respectively. Both, in different ways attempt to find ways round the difficulties of alliance building and maintenance, of achieving stable *meaningful* meanings, and promoting change without undermining existing methods of survival.

Bateman and Fonagy's (2004) psychoanalytically-informed partial hospitalisation programme has produced impressive results. Characterising itself as mentalisation-based therapy (MBT) this approach has been strongly influenced by attachment theory. Initially it was thought that BPD clients lacked mentalisation skills, and therapy was focussed around the need to foster these, with a strong emphasis on "rupture-repair work" focussing on the therapeutic relationship itself and encouraging clients to think about what may or may not have been happening in their mind and the mind of others in potentially therapeutic "living-learning" incidents (arguments in the day hospital, missing sessions, violent episodes, getting drunk or drugged, risky sexual activity, etc). However, the evidence suggests that disorganised children do not lack mentalisation skills, although their development of them is delayed compared with secure children (Gergely, 2007). As Jurist and Meehan (2009) point out, it seems, rather, that in BPD sufferers, arousal is often so overwhelming that it inhibits fragile mentalisation capacities, underlying much of the relational turbulence so typical of this diagnostic group. Therapeutic strategies therefore need to incorporate not just mentalisation skills training, both formal and opportunistic, but also to help sufferers with self-soothing and other strategies needed to reduce arousal (i.e., "pressing the pause button", mindfulness exercises, etc.).

CONCLUSION

Attachment theory continues to offer a fertile theoretical empirical and clinical resource. It provides descriptive accounts of intimate relationships from the outside consistent with the interior narratives that are the essence of psychoanalysis. Attachment theory started from Bowlby's insistence that security was a basic psychobiological force equal to, and in a sense, preceding sexuality and aggression (Holmes, 2007; Slade, in press). With current interest in mentalisation, attachment theory has now moved its focus from security to the very heart of intimate relationships. Evolutionary theory suggests that flying first evolved in bird-like reptiles as a

means of evading predators. Once established, flight opened up the skies as a whole new ecological niche for its possessors. Similarly, attachment may have first evolved as a way of ensuring infants' survival in a hostile savannah, but physical proximity lead onto emotional closeness; from that has flowed much of what we value about being human. It is hard to imagine either developmental psychopathology or evidence-informed psychotherapy without the continuing contribution of attachment theory. Future developments are awaited.

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