ATTACHMENT THEORY, THE THERAPEUTIC RELATIONSHIP AND THE PROCESS OF CHANGE: AN INTEGRATIONIST PERSPECTIVE

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Abstract: Research in the fields of developmental psychology, neurobiology and cognitive neuroscience are helping to deepen our understanding of the therapeutic relationship and the process of change. In my paper, I illuminate the way in which attachment theory and research can be integrated with data from related disciplines and applied to our clinical work. I argue that a key aspect of therapeutic action consists in the modification of implicit memories that motivate the procedures underpinning habitual ways of experiencing self with other. I illustrate this therapeutic process with a clinical vignette.

Key words: attachment – therapeutic relationship - integration – therapeutic action – implicit memory - representational model – moment of meeting

Introduction

John Bowlby launched attachment theory in the late 1950s in response to what he saw as questionable ideas about childhood development and a lack of scientific rigor in psychoanalytic thinking in the 1930s and 40s (Holmes, 1996). Despite the ethological and biological dimensions of attachment theory, the genesis of Bowlby’s work was psychoanalysis, and he acknowledged his debt to Freud, Klein and the British object relations school. Bowlby was particularly influenced by Fairbairn’s account of separation anxiety and the way in which the infant’s actual experiences with others structures his or her representational world of object relations.
When conceptualizing the inner world from an attachment theory perspective, Bowlby (1973, 1980) looked to cognitive psychology, drawing specifically on episodic and semantic memory (Tulving, 1983), and the concept of the internal working model or IWM (Craik, 1943), which he came to view as integral components of the attachment behavioural system. Following Tulving (1983), Bowlby drew attention to the ways in which information is encoded in distinct systems of memory. Episodic memory consists of information that is stored in the form of autobiographical details. Each remembered event has its own distinctive place in the person’s life history. By contrast, semantic memory consists of generalized information about the world and the person’s sense of self in relation to significant others. Bowlby postulated that such generalized information is encoded in IWMs and mediates the person’s attachment-related thoughts, feelings and behaviour in a largely nonconscious way. However, semantic information may be at great variance with information stored in explicit memory. This gives rise to cognitive and emotional conflict and to gross inconsistencies between the generalizations a person makes about his or her parents and what is explicitly implied or actually recalled in terms of specific episodes. Such conflict and inconsistencies indicate the operation of parallel memory systems and the dissociation of painful affect.

The Adult Attachment Interview is designed to ‘surprise the unconscious’, and to detect conflict and inconsistencies in the discourse style of the interviewee. The researcher shifts attention from the content of autobiographical memory to the form of discourse, coherent or incoherent, in which those memories are presented. For example, the mother’s state of mind in respect of her attachment history may be classified as
secure, and her child as securely attached, despite her having experienced early trauma in the form of separation, loss and/or abuse. Such findings indicate the resolution of trauma and the attainment of ‘earned security’ via subsequent secure attachment experiences which, of course, may include a therapeutic relationship (Hesse, 1999; Main, 1991). AAI classifications, then, reveal differences in discourse style, in access to attachment memories, and in ability to coherently discuss past attachment experience.

Bowlby’s theorizing about different memory systems occurred before the discovery of implicit memory. His description of the operation of semantic memory may now be seen as having certain features in common with the functioning of implicit memory. This form of memory is principally perceptual, non conscious, and non reflective. It’s automatic in operation and not accessible to verbal report. It incorporates procedural memory which we rely on in everyday life to learn new skills, such as learning to play a musical instrument or ride a bicycle, and to acquire habitual ways of relating outside of conscious awareness. Thus, our thoughts, feelings and behaviour in our current attachment relationships are influenced by previous interpersonal experiences that are encoded and stored in implicit/procedural memory.

More generally, attachment theory posits the existence of a number of innate behavioural systems, which include the attachment, exploratory, fear, caregiving, affiliative, and sexual systems. These systems motivate our behaviour in any given social situation, as mediated by sets of non conscious expectations and characteristic ways of regulating affect that are implicitly encoded in representational models of self-other
relationships developed in early life. Attachment theory, then, holds that cumulative experiences are internalized to form IWMs which guide expectations and perceptions, thereby serving as templates for future relationships. Although resistant to change, IWMs are open systems and may be updated and revised in the light of new experience (Bowlby, 1973, 1980; Fonagy, 1999b; Peterfreund, 1983).

Contrasting attachment patterns and states of mind are captured in attachment research utilizing the Strange Situation procedure and the AAI. Adults who have developed a dismissing attachment state of mind avoid intimacy and exploration of painful thoughts and feelings. By contrast, those whose early relationships have created a preoccupied attachment state of mind are angrily enmeshed with their past and current attachment figures. Adults with an unresolved state of mind in respect of trauma cannot maintain affective continuity in their inner worlds and become disorganized and disoriented when re-experiencing a stressful event. Findings show that while the avoidant child and dismissing adult develop a state of mind that values emotional self-reliance and separateness, the ambivalent-resistant child and preoccupied adult develop a state of mind that is angry, frightened and anxious about being separate and autonomous. The disorganized child and unresolved adult dissociate from the immediate environment and develop either a helpless or hostile/controlling state of mind (Lyons-Ruth, Bronfman & Atwood, 1999; Lyons-Ruth et al., 2005). These states of mind give rise to non-conscious attachment procedures and phenomena that are communicated, in part, via the patient’s particular discourse style and interaction with the therapist and with key others in everyday life (Renn, 2006, 2008, 2012; Wachtel, 2008). Being aware of our own
predominant attachment state of mind and implicit procedures may help us, as therapists, to recognize and understand the enactments that we inescapably get drawn into with our clients, and inform how best to repair such inevitable ruptures to the attachment relationship or therapeutic alliance (Schore, 2011; Wallin, 2007).

**Attachment and Sexuality**

It’s often overlooked that the genesis of attachment theory is rooted in Bowlby’s interest in understanding the origins of delinquent behaviour in young children, as set out in his early study into the character and home life of 44 juvenile thieves (Bowlby, 1944; Renn, 2007). Indeed, Bowlby went on to theorize the aetiology of aggression, seeing this as a secondary response to a perceived threat to the psychological self in an attachment matrix characterized by trauma and abuse, rather than innate, as in the death instinct (Black, 2001; Bowlby, 1984, 1988; Freud, 1920g; Klein, 1933; Renn, 2012; Schwartz, 2001). However, attachment theory may legitimately be criticized for omitting the importance of sexuality as a motivating factor in human behaviour.

Attempts to rectify this omission have been made in recent years, most notably by Lichtenberg (2007, 2008) and Target (2007) respectively. Target (2007) found that mothers tended to ignore or avoid mirroring and marking their infants’ affective state of sexual excitement. She argues that this unmentalized aspect of the child’s attachment experience becomes split-off, forming part of an “alien self-structure”. Such dissociated sexual dynamics may be enacted in subsequent attachment relationships and in the transference-countertransference matrix. Although the mother-infant relationship is the
focus of such research, my clinical experience strongly suggests that the father’s influence on the developing child’s sexuality is also highly significant and, therefore, likely to be enacted in the therapeutic relationship (Renn, in press). Preliminary findings reported respectively by Eagle (2007) and Lichtenberg (2007, 2008) support the ubiquitous influence of early attachment bonds on sexual relations in adulthood. Such findings provide compelling evidence that attachment strategies and implicitly encoded procedures formed in infancy influence the playing out of the sexual system in adult romantic relationships (Mikulincer & Shaver, 2007).

Also writing from an attachment perspective, Liotti (1999) contends that the person may defensively inhibit the attachment system by choosing, consciously or unconsciously, to activate a competing motivational system. He posits the existence of three basic motivational systems that compete with the attachment system: the agonistic, caregiving, and sexual systems. The activation of the agonistic system leads the person to experience a high level of rage and aggression, while the defensive activation of the caregiving system may lead to a form of compulsive, controlling caregiving behaviour. Alternatively, the person may choose to interact with other people on the basis of his or her sexual motivational system. The activation of this system creates “the basis for promiscuity and for the construction of any significant relationships according to the roles of seducer and the seduced” (p. 771).

Liotti (1999) argues that the choice of the sexual system is facilitated if the person has been sexually abused by an attachment figure in childhood. He contends that the
three patterns of interpersonal relationships, based on the abnormal activation of the agonistic, caregiving, and sexual systems, are selected in the service of avoiding painful attachment experiences associated with loss, rejection, and abandonment. He suggests that these non optimal systems may readily be observed in clinical practice in the treatment of people suffering from dissociative processes. Similarly, Litowitz (2002) argues that sexuality is manifested in treatment as affects in need of regulation, and in attachment behaviours and procedural memories communicated directly between therapist and client.

In clinical practice, then, attachment theory is used to conceptualize the developmental antecedents and interpersonal features of the client’s difficulties in living, particularly his or her implicitly encoded procedures for managing closeness and distance and separations and reunions in intimate relationships, and the influence of these phenomena on the formation of the therapeutic alliance (Lopez & Brennan 2000). Attachment theory and research provide both a particular way of listening to the client’s story and of understanding the clinical process (Slade 1999). An aspect of this process involves identifying similarities in the complex dynamic interplay between the client’s early relational matrix and his or her current intimate relationships, including that with the therapist (Renn, 2003, 2006, 2008, 2012; Wachtel, 2008). This facilitates an understanding of the way in which archaic, non conscious cognitive-affective mental models are being perpetuated in the here and now, actively mediating and distorting the person’s attachment-related thoughts, feelings and behaviour, particularly at times of
heightened emotional stress – how the silent relational past lives on in invisible ways in the interpersonal present (Renn, 2008, 2012).

**Attachment and Neuroscience**

Empirical research supports the view that mental models deriving from actual relationships are internalized and generalized as representations of past experience (Bowlby, 1973, 1988; Bucci, 1997; Schacter, 1996; Stern, 1985). It also shows that adaptive responses to repetitive caregiving patterns in early life reinforce particular neural networks that form the neurological substrate of representational models. As previously noted, a salient aspect of these mental models consists of generalized beliefs and expectations about relationships between the self and key attachment figures, not the least of which concerns one’s worthiness to receive love and care (Bowlby, 1973, 1988). Secure attachment is facilitated when the caregiver-infant coordination is neither too low (avoidant) nor too high (enmeshed). Mid-range coordination that is contingent and predictable, yet flexible and variable, is optimal as it promotes a sense of felt security and thus the capacity to experience new information and relationship transformations (Beebe et al., 2000).

Research using the Strange Situation procedure (Ainsworth et al., 1978) and the AAI (George, Kaplan & Main, 1985) is designed to induce a degree of stress and thereby activate the attachment system and concomitant representational models. In effect, this research taps into implicit/procedural memory, the dynamics of which are manifested in infant attachment behaviour and adult discourse style (Crittenden, 1990; Fonagy, 1998,
1999b; Goldwyn & Hugh-Jones, 2011; Slade, 2004). Informed by these findings, and as previously noted, contemporary psychoanalysis holds that representational models of self-other relationships are stored in implicit/procedural memory and organize interpersonal behaviour largely outside of conscious awareness (Bruschweiler-Stern et al., 2002, 2007; Fonagy, 1998, 1999; Fonagy & Target, 1998; Stern et al., 1998b).

From an attachment perspective, psychopathology is seen as arising from an accumulation of non-optimal interactive patterns that result in enduring personality traits characterized by a compromised capacity for affect regulation and mentalization, and concomitant difficulties in interpersonal relationships (Bradley, 2003; Grigsby & Hartlaub, 1994; Mitchell, 1988; Spezzano, 1993; Stern, 1985, 1998). In neurobiological terms, these findings reflect a trauma-induced deficit in the brain’s right orbitofrontal systems, as a result of which affective information implicitly processed in the right hemisphere is inefficiently transmitted to the left for semantic processing (Schore, 1994, 2001). Thus the psychological meaning of problematic emotional experience does not become organized into an explicit, coherent narrative and sense of self (Boulanger, 2007; Holmes, 1999; Main, Kaplan & Cassidy, 1985; Main, 1991; Roberts, 1999; Terr, 1981; van der Kolk, 1994; van der Kolk & Fisler, 1995). The resultant representational models of the self as bad and endangered are indelibly held in mind (LeDoux et al., 1989) and may be enacted at the procedural level in subsequent interpersonal contexts that cue the retrieval of traumatic memories (Ginot, 2007; Mancia, 2006; Schacter, 1996; Schore, 2011). The triggering event may be subtle and seemingly relatively minor, such as a
raised voice or angry face, but the response may be excessive and disproportionate (Renn, 2003, 2006, 2010, 2012).

Attachment theory, then, holds that representational models developed in early life mediate and distort experience of actual relationships and guide and direct feelings, behaviour, attention, memory and cognition out of conscious awareness. Nonverbal, implicit processes may therefore be viewed as providing a measure of continuity from childhood to adulthood, and as organizing transference expectations in everyday life, as well as in the therapeutic encounter (Beebe & Lachmann, 2002; Beebe et al., 2005; Clyman, 1991; Divino & Moore, 2010; Mancia, 2006; Sander & Sander, 1997; Schore, 2011). Moreover, early childhood experiences in the form of cumulative developmental trauma have life-long effects on our functioning at the implicit, nonverbal level of behaviour, emotion, and arousal (Beebe, et al., 2005; Damasio, 2000; Lyons-Ruth & Block, 1996; Lyons-Ruth et al., 2005; Mancia, 2006; Pally, 2005; Perry et al., 1995; Renn, 2012; Schore, 1994, 2001; van der Kolk & Fisler, 1995). Indeed, findings indicate that once patterns of interpersonal interaction are established they tend to become actively self-perpetuating because potentially disruptive signals are countered by the deployment of perceptual and behavioural control mechanisms. Thus, non optimal representational models are resistant to change because error-correcting information is being defensively and selectively excluded from consciousness (Main, Kaplan, & Cassidy, 1985). This non conscious process may be equated with the perceptual filtering mechanism described by Rose (2003) from a neuroscience perspective. It may also be seen to partly account for the stability of character and the perseverance of maladaptive
ways of experiencing and relating that are maintained by the procedural component of implicit memory (Beebe & Lachmann, 2002; Beebe et al., 2005; Fonagy, 1999; Grigsby & Hartlaub, 1994; Knox, 1999, 2003; Lyons-Ruth, et al., 1998; Mancia, 2006; Stem, et al., 1998a, 1998b; Wilkinson, 2010).

**The Mirror Neuron System**

Gallese (2009) links these implicit processes to the recent discovery of the mirror neuron system, emphasizing that our natural tendency is to experience our interpersonal relations first and foremost at the implicit level of bodily interaction. Indeed, preliminary research suggests that the neurobiological substrate for the innate capacity to read and empathically share emotions, intentions and sensations with others is the mirror neuron circuitry, the systems of which are present at birth (Rizzolatti, Fogassi & Gallese, 2006). It is thought that the mirror neuron system is activated when we observe the other’s actions, intentions and emotions, taking the form of what Gallese (2009) terms “embodied simulation”. In essence, the same neurons fire in the brain of the person observing the actions or emotional display of another as if he or she was performing the observed action or experiencing the same feelings (Cozolino, 2002). Mirror neurons, then, permit us to participate in the other’s actions without having to imitate them (BCPSG, 2008), and help to elucidate the complex process by which nonverbal emotional communication occurs (Cozolino, 2002, 2006; Divino & Moore, 2010). Given this, the mirror neuron system would seem to be linked to the capacity for mentalization (Fonagy et al., 2004; Fonagy, 2008), as well as to the capacity for experiencing shared, intersubjective states of mind in our attachment relationships (Balbernie, 2007).
Awareness of the impact of the other on the self, for good or for ill, is, of course, nothing new. Searles (in Laing, 1961) speaks of our ability to drive one another crazy, as, indeed, do Laing and Esterson (1964) in their study of sanity and madness in the family. Herman (1992), for her part, draws attention to the traumatic or vicarious countertransference that may be experienced in working with traumatized people. Understanding these interpersonal processes of transmission from the vantage point of neuroscience in general, and the mirror neuron system in particular, may not only enhance our understanding of the therapeutic process, but also help to protect the therapist from the risk of burnout that is attendant in our work with severely traumatized people.

**Therapeutic Action**

In terms of therapeutic action, it may be argued that implicit modes of interaction become a central focus of the therapeutic process. This is particularly the case if we also accept that such non-conscious experience is enacted in our most intimate relationships, and is most readily accessed in the context of those relationships (Fonagy 1998; Stern et al. 1998a; Renn, 2010, 2012; Ringstrom, 2008; Shimmerlik 2008; Wachtel, 2008). The Boston Change Process Study Group (2010) applies a developmental perspective, informed by attachment theory, to clinical work with adults, arguing that findings from attachment research and cognitive psychology can, when harnessed to dynamic systems theory, help us to understand and model change processes in psychodynamic treatment. Therapeutic action consists of meaningful emotional connection between the therapist and client in the form of “now moments” and “moments of meeting” that transforms
“implicit relational knowing” and facilitates a changed state of “intersubjective consciousness”.

Implicit relational knowing is a non symbolic, non conscious form of “knowledge” that operates outside of focal attention and conscious experience. It’s a form of “knowing” that “has never been put into words, has never had to be, or never could be (BCPSG, 2008, p. 129). The group point out that non-language-based knowing “is the only form of knowing in infancy by developmental default” (ibid). Moreover, Stern (2004) argues that implicit relational knowing consists of “active, preformed past patterns that seek expression and thus determine behaviour”, and that “each successive present moment in life is a different instantiation of the past acting on the present” (Stern, 2004, p. 205). Indeed, he argues that: “Implicit regulatory memories and representations play a constant role in shaping the transference and the therapeutic relationship, in general, as well as in making up much of our lived past and symptomatic present” (p. 119). He emphasizes that anxiety on the part of the therapist may preclude engagement in “now moments” with the result that the opportunity for change at a key moment is lost.

Whereas the BCPSG argues that change in the implicit domain may come about without the necessity of interpreting the experience in the explicit “verbal-reflective” domain, in line with Beebe and Lachmann (2002) they emphasize the interaction between the implicit, nonverbal domain and the explicit, verbal domain, arguing that exchanges on the verbal level are continually altering the dyad’s timing, spatial organization, affect, and arousal on a moment-to-moment basis in the implicit domain.
From this perspective, then, the process of change is conceptualized as the unfolding of an emergent intersubjective process characterized by the movement towards self-organization in a context of destabilization and perturbation. The model emphasizes the fact that our experience is mediated by implicit, nonverbal representational models (Bowlby, 1973, 1988; Fonagy & Target, 1997; Fonagy, 1999; Shimmerlik, 2008). Therefore, accessing and making explicit invisible procedural ways of experiencing and relating so that implicit memories can be subtly changed and encoded within second order representational models becomes a crucial aspect of therapeutic action. In this conceptual framework, pre-symbolic encounters in the implicit domain form the basis of intersubjective relatedness and promote the establishment of a secure-enough base from which to explore, express and elaborate new forms of agency and shared experiences (Lyons-Ruth, et al., 1998; Stern et al., 1998b). In this sense, psychoanalysis may be seen as the active co-construction of a new way of experiencing self with other (Fonagy & Target, 1998; Fonagy, 1999; Wachtel, 2008), and as identifying problematic patterns of organization (Fosshage, 2011; Wachtel, 2008).

**An Integrated Therapeutic Model**

More generally, attachment theory and infant research demonstrate that psychological organization is an adaptation aimed at preserving critical, life-sustaining relationships. As Slade (2004) points out, attachment classifications used for research purposes are simply ways of describing and organizing implicitly encoded attachment phenomena. These silent phenomena, and the invisible processes and relational procedures they represent, are the focus of clinical work, not the classifications *per se*. A
basic understanding of attachment theory and research sensitizes the therapist to the nature and functioning of the attachment system and aids in the observation and recognition of attachment phenomena, as revealed in the client’s speech and behaviour (Slade, 2004). The initial interview provides an ideal opportunity to begin to listen for attachment phenomena, as manifested in the client’s talk about his or her relationships with parents, partners and children.

**Clinical Illustration**

The following case vignette of the first two sessions that I had with a new client, “Patricia”, illustrates the way in which the ideas emanating from attachment theory, narrative theory, mentalization, affect regulation, neuroscience, implicit memory and nonverbal communication can be applied to our clinical work and help us to understand what is being subtly enacted in the therapeutic relationship (Renn, 2012).

Patricia, an attractive single woman in her early 30s, had self-referred. During the first session she spoke in considerable detail about her reasons for seeking therapy. She told a story of a fragmented family, losing contact with her father when she was six years old following her parents’ separation and divorce. She had an unhappy school and home life, being bullied by a group of girls at school, and feeling excluded by the close alliance between her mother and older sister at home. She has an ongoing difficult relationship with her mother who, herself, was abandoned by her parents as a child and separated from her sister, whom she never saw again after being adopted.
Patricia had been diagnosed with depression in her early 20s, and was currently being treated with anti-depressants. She spoke of feeling emotionally dead and disconnected from herself and from others. Although in employment, everyday tasks were experienced as a huge burden weighing her down. She feared that her moods and behaviour were intractable and that change would not be possible because of an imbalance in her brain chemistry. She had tried therapy once before, speaking in a dejected way of a failed short-lived therapy with a female therapist some two years previously. She described feeling angry, confused and persecuted by the inconsiderate behaviour of family, friends and work colleagues who, she believed, treated her in a dismissive and unfair way. She was plagued by guilt whenever she tried to assert herself, and so, instead, would ingratiate herself with others by putting their needs before her own, despite feeling a smouldering sense of injustice. All of this made matters worse, as it left her feeling that she was over-controlling of herself and manipulative of others.

A major reason for Patricia wanting therapy was a problem in sustaining intimate, sexual relationships with men. She said that she felt like a child in relation to men, and that she allowed herself to be sexually used and emotionally abused by the men in her life. Despite this, she felt unable to leave the abusive relationships. More generally, Patricia spoke of feeling socially shy, inept and impulsive, physically ugly, morally prim, and sexually undesirable.
Although I trust that I have set out Patricia’s many and various difficulties in living in a relatively coherent way, her discourse style in telling me her story, as informed by research using the AAI, was characterized by unfinished sentences, story lines that suddenly disappeared, only to merge with unrelated situations and expressions of hurt and injustice, and a pronounced difficulty in reflecting upon her experience in a collaborative way with me. There was an angry and excessive preoccupation with her past and present attachment relationships, with the boundaries between the two often seeming confused and diffuse. I had considerable difficulty in getting a word in edgewise to bring her back to focus on a particular aspect of her life that she had started to tell me about, before she again wandered off at a tangent, starting a new thread and leaving the previous story unfinished and dangling in the air.

Patricia seemed to be reliving in the here-and-now the emotional experiences that she was relating from the past, and to have little consciousness of me as a person to be connected with. Indeed, apart from gently guiding her back to the point of her story from time to time, I felt largely superfluous. However, I noted that whenever I shifted position in my seat, she would abruptly stop the flow of her monologue. This, I think, indicated that Patricia’s attachment system was in a state of hyper-activation and that she was anxiously hyper-vigilant, monitoring my every move. Indeed, an informal benchmark for the establishment of a sense of safety and security with some patients is when they continue to speak during any movements that I might make. Moreover, a certain body-symmetry often develops, in that the client’s and my own shifts in position tend to mirror
or mimic each other’s. This may indicate the operation of the mirror neuron system and reflect the establishment of a bodily form of intersubjectivity.

I think it fair to assume that at a first meeting the client is likely to feel somewhat vulnerable and to experience a degree of stress in the presence of a stranger, no matter how well disguised this state might appear. This very stress tends to activate an archaic representational model and a discrete discourse style that communicates implicitly stored information to the therapist about the client’s current attachment expectations, early intersubjective experiences, and developmental trauma. Although much of this could be discerned from the content of Patricia’s story, the form of discourse in which she told it indicated a lack of “earned security” and an ongoing preoccupied state of mind in respect of attachment, together with a concomitant difficulty in managing her feelings and making sense of her own and other people’s behaviour and mental states.

Preoccupied attachment is the adult corollary of infant ambivalent-resistant attachment organization. It indicates an under-controlled emotion regulation system, as manifested by the hyper-activation of the attachment system, by an exaggerated style of emotion regulation, and by attempts to dramatically heighten emotional experience. The person’s representational model tends to be characterized by dysregulated anger and an ever-present fear of rejection and abandonment. While there is conscious awareness of attachment affect, there is a cognitive disconnection between the affect and its cause and source. This creates confusion, anxiety, and a persistent sense of dread and foreboding.
Research indicates that this attachment state of mind develops in a relational matrix in which the preoccupied caregiver is inconsistently available and uncontingently responsive, or has an attachment need to keep the infant emotionally dependent on him or herself. Thus, the caregiver focuses on negative affect to the exclusion of helping the child to regulate his or her emotions. The failure to respond to attachment needs in ways that are consistent, contingent and congruent with the infant’s psychobiological state serves to keep the child intensely focused on the attachment relationship. This, in turn, reduces the chances of the child becoming emotionally independent of the caregiver. In such infant-caregiver dyads the child is likely to develop an ambivalent-resistant pattern of attachment organization that matches the caregiver’s preoccupied state of mind, together with a style of regulating emotion that is preoccupied and under-regulated (Main, et al., 1985; Peck, 2003). The initial indications were that Patricia’s early attachment and intersubjective experiences had shaped and structured her inner world in these ways, as reflected in the attachment phenomena that I had observed and experienced at our first meeting.

Patricia began the second session in similar vein to the first, listing, in a rather hopeless and desultory way, the various problems she has in her relationships. Midway through the session she told me that she had gone out for a drink with work colleagues the previous evening. She described feeling sad and socially inept with her colleagues, hiding these feelings with a “smiley” exterior, and anxiously filling any gaps in the conversation with “empty words”. In a rather heavy, defeated and despairing way, she said, “I expect I’ll do the same here, so
the therapy won’t work”. Uncharacteristically, she left an interpersonal pause, and for the first time I felt invited to engage with her in a more direct way. I said in a quiet, soft voice: “But I might choose not to respond to your ‘empty words’ and leave a silence instead”.

Patricia looked at me sharply with an anxious, startled expression. I gazed back with bright eyes, smiled warmly, tilted my head to the left and, with a slightly quizzical, yet challenging, expression, raised my eyebrows and waited. Patricia stared back, looking a bit panicky. I held her gaze and she started to laugh, shyly at first, covering her eyes with her left hand in embarrassment and peeping at me through her fingers. But she then seemed to surrender herself to the experience. Her laughter was prolonged and so delightful and infectious, that I found myself involuntarily joining in. In between bouts of gurgling laughter she asked, “What have you done to me? I’m always the one that makes people laugh. No one ever makes me laugh. How did you do this? It’s your training, isn’t it?”

Patricia went on to describe a “tingling feeling” in her throat, saying, “I know this therapy is going to work, I can feel it”, adding, “I haven’t felt so alive in years”. However, she also said that her joy and pleasure were tinged with fear and trepidation, and that part of her wanted to flee from the room. In a playful tone of mock rebuke, and with bright smiling eyes, she said, “You’re dangerous, you are!”
For someone like Patricia, who has been depressed for years and apparently habitually false and inauthentic in her relationships, to suddenly feel alive and emotionally connected must, indeed, have felt dangerous and alarming, the more so, perhaps, because of my gender. In terms of the BCPSG’s model, Patricia and I shared a ‘now moment’ that emerged in a rather sudden, dramatic and unpredictable way, catching us both by surprise and leading to a “moment of meeting” in the implicit/enactive domain. Initially, the mutual experience was predominantly body-based and nonverbal, and brought our implicit relational knowing into a changed state of ‘intersubjective consciousness’.

From an attachment perspective, I would say that my implicit coordinated interactions with Patricia during the ‘now moment’ experience were in the mid-range, that is, they were neither avoidant nor enmeshed but contingent and congruent to her state at that particular moment. Thus, there was also a degree of flexibility and variability which, given the way the interaction developed, seemed to have promoted a good enough sense of felt security in Patricia that she could risk experiencing a relationship transformation in the here-and-now of the therapeutic encounter (Beebe et al., 2000).

The opportunity for this shared, intersubjective moment and new way of experiencing one another to emerge would, I think, have been lost had I chosen to interpret Patricia’s expectation that the therapy would fail because of her “empty words”. Could her very use of this phrase have implicitly influenced me to avoid using empty words of my own? No matter how clever and creative, an interpretation at that point
would likely have deadened Patricia’s lived experience and confirmed her expectation that spontaneous emotional connection is all but impossible for her. I think that this would also have been the case in the first session had I chosen to make a transference interpretation about her difficulty in leaving abusive relationships with men. Although I was not consciously aware of the implicit, nonverbal aspects of mutual influence occurring moment-to-moment in the first session (Beebe & Lachmann, 2002), I think that procedural/emotional aspects of the encounter paved the way for the ‘moment of meeting’ to emerge in the second. This would seem to confirm Stern’s (2004) contention that “making narratives involves not only words, but also direct experiences that are in the implicit domain” (p. 192).

On a more general point, I often find with clients like Patricia who carry a diagnosis of depression, and who tend to self-pathologize in such a way, that they are not globally depressed. Rather, their depressed state appears to be context-dependent, in that it comes and goes, depending on the social situation that they are in and the representational model or self-state that emerges in a given social context. The key factor here is emotional connectedness or intersubjective relatedness. Whenever the client feels emotionally and authentically connected with another, the depression tends to lift, however temporarily. By contrast, feeling isolated and alone in the context of the ongoing absence of a companionable, intersubjective relationship is often accompanied by feelings of low mood and depression. Helping the client to recognize these shifts in mood, mental models or self-states can, itself, be therapeutic, bringing a sense of hope to counter despair. In this sense, the dramatic shift in Patricia’s state of mind in the second
session would suggest that the ‘now moment’ experience constituted a transition from an archaic representational model to one that is actually available to her, but which needs to be strengthened and consolidated so that it becomes a more consistent aspect of her lived experience. My thinking in this regard accords with Wachtel’s (2008) suggestion that paying attention to the client’s healthier, more adaptive ways of being, and examining the contextual nature of their moods and behaviour, “can greatly enhance our clinical work” (p. 73).

**The Integration of Attachment Theory and a Sensorimotor Perspective**

The therapeutic benefit of integrating a sensorimotor perspective with the emotional and cognitive aspects of clinical work with traumatized individuals has been elaborated by Pat Ogden and her colleagues (Ogden, Minton, & Pain, 2006). The following example consists of the thoughts and associations I had after reading a clinical vignette by Wallin (2007) of his work with “Ellen”. Wallin writes:

I’m feeling calm, quietly taking in her presence without experiencing the familiar internal pressure to quickly respond. Staying with her, I’m also turning my attention to my breathing and my body. I have the not unfamiliar sense that I’m “knowing” her through my belly: My “gut sense” is that, as I’m relinquishing the lead, she’s taking it (Wallin, 2007, p. 321).

Wallin (2007) is working from an attachment perspective, and also bringing a ‘mindfulness’ approach to bear on his experience of being with Ellen. For me, his sense
of “knowing” Ellen through his belly and of allowing his “gut sense” to inform the interaction (allowing Ellen to take the lead) may be seen as an example of body countertransference. From my reading of the neuroscience literature, my particular understanding of body countertransference is informed by the knowledge that there is an entire nervous system in the gut – the enteric nervous system – with nigh on as many billions of neurons as the brain (Rose, 2005). Given this, Rose (2005) suggests that we do, indeed, often feel with our bowels!

To my mind, the existence of the enteric nervous system adds credence to Damasio’s (2000) assertion that the source of feelings lie in the internal milieu and viscera of the body – that the body is the main stage for the emotions and for what Damasio calls ‘background feelings’. Moreover, I would suggest that the experience of ‘embodied simulation’ that occurs when the mirror neuron system is activated has a part to play in understanding body countertransference (Gallese, 2009). As Wallin’s (2007) example suggests, bringing focal attention to bear on our bodies in a mindfulness way may help us to become consciously aware of such background moods and feelings in ourselves, and inform what is occurring between therapist and client in the implicit/enactive mode of experiencing (Bruschweiler et al., 2002, 2007; Lyons-Ruth et al., 1998; Stern et al., 1998a, 1998b).

Similarly, I often find that when the dialogue in a session has touched upon an issue that is too painful, threatening or overwhelming for the client to think about and symbolize, there may, instead, be a motoric discharge of the dissociated affect. A
A common example of the bodily discharge of a state of mind that cannot be mentalized is the vigorous shaking of a leg. Other examples are facial contortions, the rapid crossing/uncrossing of legs, the ringing of hands, becoming suddenly fidgety, blushing and/or the appearance of red blotches on the throat and upper chest, and attempts at self-soothing such as stroking the face or hair (Renn, 2012). Following Janet (1913) and Freud (1914g) respectively, neuroscience findings indicate that the somatization and behavioural manifestation of traumatic experience is itself a form of memory expressed by the body (van der Kolk, 1989, 1994).

In my own clinical practice, if the timing feels right and I sense that the client will not feel shamed, persecuted or impinged upon, I might well draw attention to his or her bodily behaviour, linking this to what we were discussing at the specific point in the session that such behaviour became manifest. I might also share my own bodily experience in the context of our interaction and of what I had observed in the client’s expressive bodily display. I’ve found that developing mutual awareness of this kind, and sharing bodily, as well as emotional experiences, can facilitate the process of transforming right brain, body-based experience into left brain, subjective states of consciousness. Via this process, visceral-somatic experiences may become available for verbal reflection and elaboration (Schore, 1994). This aspect of therapeutic action is also informed by my familiarity with van der Kolk’s research into the psychobiology of trauma, and the finding that traumatic experience gets locked into the body (van der Kolk, 1989, 1994).
More generally, in a given context I might ask the client to describe what he or she is experiencing bodily – tightness in the chest, constriction of the throat, tension in the neck or shoulders, restriction in breathing, butterflies in the stomach, and so on. We would then wonder together what such bodily states might represent in emotional terms – anxiety, fear, shame, hate, anger, disgust, sadness, despair. Not infrequently, a client whose childhood productions were routinely squashed as inadequate or shameful may, paradoxically, become dysregulated by positive experiences associated with pride, joy and interest-excitement. Clients who, for reasons of cumulative attachment trauma or dramatic abuse, have developed alexithymia or dissociation may, when asked what they are feeling, routinely respond with a thought – for such clients thoughts are habitually equated with feelings. These clients often have difficulty in linking emotions to a given interpersonal context, particularly when in a stressed psychobiological state. This may, in turn, leave them feeling confused about what other people’s behaviour really means – the capacity to mentalize is compromised by the dysregulation of bodily and emotional states. Introducing the language of emotions into the therapy, and helping the client to appraise what he or she is feeling, can be powerfully transformative, enhancing the capacity to regulate bodily and affective states and thus mentalize one’s own and the other’s emotional and intentional states of mind under increased levels of stress (Renn, 2012).

**Conclusion**

From the foregoing, it may be accepted that memory is important not as an account of history, but as a means of communicating the nature of internal
representations of self-other relationships. As we have seen, representational models are the invisible psychic structures that organize behaviour and experience in the present, mediating our expectations and predictions of self-other relationships deriving from the silent past (Bowlby, 1973, 1988; Fonagy & Target, 1997; Fonagy & Target, 1998; Fonagy, 1999b; Fosshage, 2011; Renn, 2012; Stern, 2004; Wachtel, 2008). This being so, it is these structures themselves that need to be the focus of psychoanalytic work and not the events that might have contributed to their development. In the light of these findings, therapeutic work needs to focus on helping the client to identify, and thus make visible, repetitive patterns of behaviour for which explicit memory can provide no explanation. Therefore a key aspect of therapeutic action consists of the modification of implicit memories and the expression of dissociated emotions that motivate the procedures underpinning habitual ways of experiencing self with other (Fonagy & Target, 1998; Fonagy, 1999; Wachtel, 2008). Many of these procedures may be highly dysfunctional but be based on powerful, yet outdated and largely nonconscious expectations generated by past experience of a cumulatively traumatic nature (Knox, 2003; Renn, 2003, 2006, 2008b; Wachtel, 2008; Wilkinson, 2010). Given that such emotional procedures are not readily accessible for verbal report they may only become explicitly knowable when enacted in the implicit realm (Fonagy, 1999; Lyons-Ruth, et al., 1998; Pally, 2005; Reis, 2009a, 2009b; Renn, 2012; Ringstrom, 2008; Shimmerlik 2008; Stern et al., 1998b; Teicholz, 2009).

From a clinical perspective, then, engaging focal attention and bringing the consciousness system to bear on implicit/procedural expectations and patterns of
interaction is a vital therapeutic tool. Consciousness of previously non conscious procedures, expectations, emotions and predictions facilitates choice, enhances behavioural and emotional regulation, and promotes therapeutic change (Fonagy & Target, 1998; Fonagy, 1999; Fosshage, 2011; Pally, 2005; Schore, 1994; Renn, 2012; Shimmerlik 2008; Wachtel, 2008). In time, consciousness of the beliefs and expectations generated by emotional memories leads to changes in procedural rules and to the creation of a second-order representational model of their inner experience (Eagle, 2003; Fonagy, 1999b; Sandler & Sandler, 1997). From a contemporary perspective, then, psychoanalysis works by modifying procedural mental models and the accompanying emotions that are generated and enacted in particular self-other relationships (Bowlby, 1988). Therefore, bringing implicit/procedural structures into conscious focus in an emotionally meaningful way is a critical component of therapeutic action (Eagle, 2003; Fonagy, 1999; Fosshage, 2011; Orange, 1995; Pally, 2005; Renn, 2012; Schore, 1994; Sandler & Sandler, 1997; Shimmerlik 2008; Wachtel, 2008).

Given the implicit and explicit dimensions of therapeutic action, it is, of course, important that the therapist becomes aware of the implicit/procedural aspects of his or her own affect and behaviour, as well as that of the client, so that implicit/enactive aspects of the exchange can be spoken about and reflected on. This dual aspect of therapeutic action suggests that the therapist functions both to enact and to reflect on the interaction (Fosshage, 2011; Pally, 2005; Reis, 2009a, 2009b; Renn, 2012; Wallin, 2007). From a neuroscience perspective, utilizing the explicit, declarative system of the hippocampus allows optimal implicit/procedural interactions between client and therapist to become
more strongly encoded in the client’s amygdala and basal ganglia of the implicit memory system with the outcome that these more optimal procedures are activated automatically and habitually (Pally, 2005). As previously noted, this process links the nonverbal and verbal representational domains of the brain, thereby facilitating the transfer of implicit/procedural information in the right hemisphere to explicit or declarative systems in the left. Thus, body-based visceral-somatic experience is symbolically transformed into emotional and intentional states of mind that then become available for reflection and regulation (Damasio 2000; Schore 1994). From an attachment theory perspective, these new forms of agency and shared experiences become encoded in the systems of implicit/procedural memory as second-order representational models (Fonagy, 1999).

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Books.


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Psychotherapy Relationships through an Attachment Theory Lens. From the perspective of interpersonal psychotherapy, the process of building a secure attachment and productive alliance is the central goal of the therapeutic work with clients who begin with a limited capacity for this type of relationship (Teyber & McClure, 2011). For these clients, a fully secure attachment to therapist with all five critical features in place is not a starting point for the work, but rather a marker that it is nearing its conclusion (Mallinckrodt, 2010). A qualitative study of experienced therapists presented a detailed picture of how they approach working with hypera. Attachment theory has been applied to a wide variety of existing therapeutic approaches, such as psychodynamic, cognitive-behavioral, and dialectic-behavioral therapies. Attachment security mediates the relationship between abuse and later psychopathology in children and can therefore be regarded as a risk buffer (Alink, Cicchetti, Kim, & Rogosch, 2009). According to this theory, the child develops a bond with his or her primary attachment figure (usually a mother) and is able to use that person as a source of comfort and reassurance during times of stress and distress (Ainsworth, Blehar, Waters, & Wall, 1978). In the words of attachment theorists, the child is able to use the attachment figure as a secure base from which to explore his or her environment. Therapeutic Attachment Relationships: Interaction Structures and the Processes of Therapeutic Change. Geoff Goodman. The 75 years that span the writings of Sigmund Freud and John Bowlby-two minds that have significantly shaped thinking about the processes of change in psychotherapy and psychoanalysis-have yielded dramatic changes in the ways in which we conceptualize human relationship as curative. Attachment theory and research have begun to specify the variety of therapist-patient interactions and the relation between the quality of these interactions and patient outcomes. The goal of this book is to contribute to our understanding of these interaction structures and their influence on therapeutic changes in the patient. Key words: attachment, therapeutic relationship - integration, therapeutic action, implicit memory - representational model, moment of meeting. Introduction. From this perspective, then, the process of change is conceptualised as the unfolding of an emergent intersubjective process characterised by the movement towards self-organisation in a context of destabilisation and perturbation. The model emphasises the fact that our experience is mediated by implicit, nonverbal representational models (Bowlby, 1973, 1988; Fonagy & Target, 1997; Fonagy, 1999; Shimmerlik, 2008).