CHAPTER 1

Attachment, Mentalizing, and Trauma

This chapter lays the foundation for the rest of the book. To cement the book's developmental perspective, I start at the beginning: reviewing attachment in childhood. Through a wealth of research, we can see starkly the basic prototypes of secure and insecure attachment that establish a foundation for ways of relying on others—or not—to manage distress. In the chapter's second section, I recapitulate these secure and insecure attachment patterns as they play out in adulthood; the parallels to early childhood are dramatic and instructive. Of course, attachments change dramatically over a person's lifetime, but the basic functions of attachment pertinent to infancy do not change, and this makes the comparison of adulthood and childhood worthwhile.

The third section of this chapter elucidates what I consider to be the psychological glue that bonds attachment relationships: Mary Ainsworth (Ainsworth et al. 1978) called it sensitive responsiveness, Peter Fonagy (Fonagy et al. 2002) refined it as mentalizing, and I will mix it with mindfulness. With attachment and mentalizing in mind, the reader is prepared for the section on attachment trauma. I propose simply that traumatic attachments stem from mentalizing failure, wherein relationships become unglued. Plain old therapy restores connections.

Childhood

We should start with some basic concepts in attachment theory, all of which revolve around the main function of attachment: *emotion regulation*. These concepts set the stage for discussing three prototypical attachment patterns. In short, sensitive responsiveness promotes secure attachment. Correspondingly, in the face of limited responsiveness, the child has two basic options: to try harder (ambivalent attachment) or to go it alone (avoidant attachment). In this section, I elaborate these patterns and describe some ways that caregivers might contribute to them. I also consider the role of the child's temperament and the environmental context of care, which contributes to stability and change in attachment. The section concludes with a summary of the developmental advantages of attachment security.

Key Concepts

Attachment relationships are like other close relationships that involve *affectional bonds* (Ainsworth 1989), which are evident in a desire for closeness, distress upon separation, joy upon reunion, and grief upon loss. Yet attachment relationships are distinct in providing *security and comfort in the face of distress*—hence their fundamental role in trauma. Beginning in infancy, attachment develops in the context of a *goal-corrected partnership* (Bowlby 1982) in which two behavioral systems become coordinated: infant attachment and parental caregiving. The infant attaches to the parent, and the parent bonds with the infant. Infants' attachment security and strategies to cope with insecurity are tied closely to the quality of parental caregiving. Notably, although parents must establish affectional bonds with their children, parental *attachment* to children is anomalous inasmuch as parental reliance on children for security and comfort is problematic.

Attachment relationships are patterned on the basis of *internal working models* (Bowlby 1982)—that is, relatively stable *mental representations* built up from repeated child-caregiver interactions. These mental models include not only representations of the caregiver (e.g., as loving and dependable) but also self-representations (e.g., as lovable and worthy of care). Like any other representations—maps, for example—these internal working models can be more or less accurate or distorted. Yet John Bowlby (1973) asserted that working models are predominantly realistic: "the varied expectations of the accessibility and responsiveness of attachment figures that different individuals develop during the years of immaturity are *tolerably accurate* reflections of the experiences those individuals have actually had" (p. 202, emphasis added).

Internal working models are implicit as well as explicit. *Explicit* models are conscious and thus can be thought about and talked about: "My mother could be cruel and sometimes glared at me with such contempt that I felt as low as a cockroach." *Implicit* models are nonconscious; they become automatic procedures for interacting that guide behavior without awareness. These models are based on procedural learning and memory, akin to learning to ride a bicycle. Thus, the child might learn, without thinking about it, to avoid the mother's contempt by means of ingratiating behavior, always striving to please. Bowlby's (1982) concept of *working* models is crucial: such models are potentially employed flexibly and are subject to modification. Explicating implicit models in psychotherapy is one route to change, for example as ingratiating behavior in the patient-therapist relationship is identified, discussed, and surmounted. Yet, more pervasively, working models also are modified implicitly, without awareness, in the course of relationship changes (e.g., mother becoming less irascible and more consistently affectionate) or new relationships (e.g., with an even-tempered partner).

The universal prototype of attachment is a mother lovingly cradling a frightened or distressed infant in her arms. This prototype exemplifies the fundamental function of attachment: providing the infant a *safe haven* that offers protection from harm. Bowlby (1958) proposed that attachment evolved in a wide range of species—mammals prototypically—to provide protection from predation: mothers are naturally motivated to remain close to their infants, as infants are motivated to stay close to their mothers; when separated, for example, a mother and infant are reunited by the infant's cries of distress. Although physical protection remains a crucial function of caregiving, attachment research has come to give greater weight to the value of restoring a *feeling of security* (Sroufe and Waters 1977), which relates to the previously mentioned cardinal function of attachment: emotion regulation. As I discuss further in the context of mentalizing (see section Mentalizing in Attachment Relationships), the prolonged period of dependency in humans is now more fully appreciated not only as providing needed protection and felt security but also as constituting the foundation for social learning—nothing less than learning to be a person in relation to other persons (Fonagy et al. 2002).

Although the safe-haven function of attachment is intuitively evident, those who are unfamiliar with attachment theory are less likely to appreciate its complementary function: attachment provides a *secure base for exploration*. Bowlby (1988) asserted, "No concept within the attachment framework is more central to developmental psychiatry than that of the secure base" (p. 202). One needs merely to picture the toddler and his mother at the playground: Checking back periodically to make sure his

mother is available, the toddler explores the playground confidently. Losing sight of his mother, the toddler stops playing, perhaps crying and searching for her. Or the toddler may play enthusiastically until a barking dog approaches. In either case, the toddler will seek the safe haven of maternal comfort to restore a feeling of security and relief from distress. Conjointly, the safe haven and secure base afford *psychological security*—that is, security in attachment and security in exploration, confidence in others, and self-confidence (Grossman et al. 2008).

Ingeniously, based on her extensive in-home observations of mother-infant interactions from Uganda to Baltimore, Mary Ainsworth (Ainsworth et al. 1978) developed a 20-minute laboratory procedure to assess attachment security in infancy. This procedure is the experimental analogue to the playground. Ainsworth designed the Strange Situation to be moderately stressful to the infant by scripting two brief separations in a playroom environment that includes a stranger and a set of toys (see Table 1–1). The infant's responses to the mother's departure play some role in the evaluation of attachment security, but the most crucial question relates to the reunions: how do these interactions affect the infant's distress? The assessment involves the partnership—that is, the infant's behavior in relation to the mother's behavior. In the Strange Situation, trained investigators can discern the three fundamental attachment patterns. I present these patterns in idealized forms; readers should keep in mind that reality is messier than the following neat categorizations.

Secure Attachment

Introduced to the playroom with his mother present, the securely attached infant explores the toys and engages in play, sometimes with assistance from his mother and perhaps in interaction with the stranger. Left alone with the stranger, the secure infant will show varying degrees of distress, likely in conjunction with diminished interest in play. The infant might seek comfort from the stranger to some extent but will strongly prefer his mother's comfort when she returns. Left completely alone in the second separation, the infant is liable to become more intensely distressed and to be in even greater need of comfort. Upon reunion in relation to either separation, the secure infant seeks proximity to his mother, typically desiring close bodily contact. His mother effectively provides comforting and reassurance, such that the infant settles down and returns to exploration and play.

Extensive research confirms Ainsworth's original observation that sensitive responsiveness on the part of the caregiver is conducive to secure attachment in the infant (Weinfield et al. 2008). Sensitive responsiveness

TABLE 1–1. Strange Situation episodes

1. The infant and the mother are brought into an unfamiliar but comfortable room filled with toys.
2. The infant is given the opportunity to play with the toys, potentially with the mother's assistance.
3. A stranger enters the room and plays with the infant.
4. The mother departs, leaving the infant with the stranger and the toys.
5. The mother returns, pausing to give the infant a chance to respond to her return, and the stranger leaves the room.
6. The mother leaves the infant alone in the room.
7. The stranger comes back into the room and interacts with the infant.
8. Then the mother returns, and the stranger leaves the room.

is the basis of the safe haven insofar as the mother is warm and affectionate as well as attuned to the infant's signals of distress, interpreting them accurately and responding to them promptly and appropriately. In addition, sensitive responsiveness provides a secure base for exploration insofar as the mother is engaged in the infant's activities in a way that is cooperative and helpful without interfering with her infant's intentions.

Ambivalent-Resistant Attachment

The ambivalently attached infant clings to the (insufficiently) safe haven, with attachment predominating over exploration. The ambivalent infant finds separations extremely distressing; upon reunion, he demands care yet angrily resists comforting. As he rejects the care he desperately needs, his ambivalence may be blatant: he may demand to be picked up and then push his mother away, squirm out of her grasp, yet continue to cling to her. Hence, he is distressed but his frustration renders him inconsolable.

Ainsworth and colleagues (1978) observed ambivalent infant attachment in conjunction with chronically unresponsive or inconsistent care. Thus, the infant's intensification of distress and angry protests (e.g., tantrums) are implicit strategies learned to command attention and to force more responsiveness from caregivers who are lacking in psychological attunement. Ambivalent infants thus *hyperactivate* their attachment needs—in effect, turning up the dial to elicit care. To the extent that it is (intermittently) effective in evoking responsiveness, this hyperactivating strategy is rewarded. Yet the attachment remains ambivalent: the desire for care is intermingled with feelings of deprivation and frustration, and the coercive behavior infuses the relationship with resentment.

Avoidant Attachment

Whereas ambivalent infants cling ineffectively to the safe haven, avoidant infants are stuck in exploration—in effect, on their own in the playground. Thus, in the Strange Situation, the avoidant infant may appear precociously independent as he plays and ostensibly ignores his mother. In contrast to the securely attached infant, who involves his mother in play, the avoidant infant is more likely to engage in solitary play. In contrast to the ambivalent infant, he shows no overt distress in response to his mother's departure; when she returns, he shows little desire for contact. If she picks him up, he is unresponsive, preferring to be put down so he can return to play.

Ainsworth observed mothers of avoidant infants to be subtly rejecting, averse to bodily contact, perhaps irritated by their infant but suppressing their anger. She also found the mothers to be rigid and compulsive, not wanting the infant to interrupt their activities and becoming frustrated quickly when the infant didn't comply immediately with their wishes. Avoidance appears to be a reasonable strategy for managing distress in relation to a consistently emotionally unavailable and subtly irritable caregiver who is communicating, "Don't bother me with your needs or distress." The infant strives to avoid bothering the mother, *deactivating* his attachment needs, turning down the dial, and attempting to manage his emotional distress as best he can on his own.

Child Temperament

The early attachment research elicited intense debate about the likely influence of infant temperament on the research findings (Karen 1998). Intuitively, for example, one would expect the infant or child who is temperamentally anxious, distress prone, or "difficult" to be a likely candidate for developing ambivalent attachment. This controversy about the relative contribution of temperament and caregiving to attachment patterns has inspired extensive research with surprising results: the patterns of caregiving just described exert a far stronger influence on attachment classification than do a child's genetic or temperamental factors.

Yet this broad conclusion obscures complexity (Vaughn et al. 2008). Temperament, although rooted in genetic and physiological characteristics, is not immutable. On the contrary, temperament is subject to environmental influence, prominently including caregiving. Moreover, the infant's temperament may influence the parent's caregiving behavior. For example, a more distress-prone infant could evoke a stressed-out parent's irritability or inconsistency. To add a further layer of complexity, owing to genetic differences, some children are more responsive than others to patterns of caregiving (Belsky and Fearon 2008). For those children who are genetically predisposed to be more responsive to caregiving, the relations I just summarized will be more evident than for those children who are less responsive to variations in caregiving.

Environmental Influences on Caregiving

Attachment researchers have been criticized for blaming parents—mothers in particular—who would be better served by compassionate understanding that takes into account the environmental context of caregiving. Sensitive responsiveness—or lack of responsiveness—doesn't occur in a vacuum. Many factors have been found to influence caregiving and attachment: parental age, education, and socioeconomic status; parental psychiatric disorders; and stressful life circumstances. Moreover, underscoring the importance of attachment, the mother's attachment security influences her caregiving: the child is likely to be more insecure with a mother who is a single parent, struggling with marital conflict, or relatively lacking in other sources of social support (Belsky and Fearon 2008). Plainly, an accumulation of vulnerabilities is most likely to be detrimental to attachment security (Belsky 2005), as would be true, for example, of a mother without any confidants who is living in poverty and raising a temperamentally difficult infant along with a number of siblings while embroiled in a turbulent marriage.

Thus, as I elaborate in this chapter, we therapists must remain mindful of the context of care. The capacity of humans for attachment (and for mentalizing) evolved in the context of communal caregiving (Hrdy 2009), in which multiple caregivers were available to assist the mother. Thus, in our culture, the mother (or other caregiver) who raises a child single-handedly will be challenged to provide consistent sensitive responsiveness. For better or for worse, marriage plays a critical role: parents might support each other and compensate for each other's limitations, or they might undermine each other and exacerbate each other's limitations (George and Solomon 2008).

Stability and Change

Stability warrants our interest in attachment patterns, and potential for change justifies our interventions. Longitudinal research on stability of attachment from infancy into early adulthood (Grossman et al. 2005) shows substantial continuity as well as lawful patterns of change (Thompson 2008). One key factor is that stability and change in attachment patterns will occur in tandem with stability and change in environmental influences.

I consider it nothing short of astounding that *any* correspondence—no matter how modest—can be found between infant attachment behavior in a 20-minute laboratory observation and security of attachment measured by an interview many years later. Yet Strange Situation attachment classifications at 12 months have been found to correspond to interview-based attachment assessments at ages 19 (Main et al. 2005), 21–22 (Crowell and Waters 2005), and 26 (Sroufe et al. 2005). On the flip side of this coin, less than perfect correspondence between infant and later attachment classifications in these studies attests to evidence for change. For example, detrimental changes in attachment security are associated with trauma, stressful life events, divorce, parental death, and serious illness in the child or parent. Fortunately, parent-infant interventions (Belsky and Fearon 2008) as well as psychotherapy (Sroufe et al. 2005) have the potential to enhance attachment security, sooner or later.

Developmental Benefits of Attachment Security

On the basis of their longitudinal research on the developmental impact of infant attachment, Alan Sroufe and colleagues (2005) made the strong claim that "nothing is more important in children's development than how they are treated by their parents, beginning in the early years of life" (p. 288). The subsequent benefits of infant attachment security have been studied in toddlers, in preschoolers, and in middle childhood.

Secure attachment is associated with multiple forms of adaptation (Berlin et al. 2008). In comparison with those who are insecurely attached, securely attached children are more capable of regulating emotional distress with the help of caregivers and on their own; are relatively easygoing; and are more socially competent, empathic, and caring. Therefore, they form more positive relationships with siblings, peers, friends, and teachers. Given their security in exploration, they are relatively curious and persistent in problem solving, while also able to seek help when they need it. Accordingly, their security promotes cognitive and academic development.

We naturally associate security with independence, but this association is misleading. Secure attachment is associated with *effective dependence,* which also promotes effective independence. In comparison with their secure counterparts, ambivalent children are more anxious and easily frustrated; more passively helpless and excessively dependent; and less able to perform well in novel and cognitively challenging situations that call for active mastery. Notwithstanding their relative immaturity and passivity, they are less socially isolated than avoidant children, who tend to be more hostile and aggressive as well as emotionally insulated. Avoidant children are likely to bully and victimize ambivalent children, and classmates and teachers single out avoidant children as being disliked. Hence, just as secure attachment broadly enhances development, insecurity compromises it.

Adulthood

While delineating substantial developmental changes, Bowlby (1988) maintained that "attachment behaviour...is characteristic of human nature throughout our lives—*from the cradle to the grave*" (p. 82, emphasis added). Although attachment phenomena can be observed in a range of relationships, parent-child relationships are paradigmatic of attachment in childhood, and romantic relationships are their prototypical adulthood counterparts. I start there. But we adults maintain internal working models of our childhood attachments to our parents, and these working models influence our romantic relationships as well as our patterns of caregiving with our children. Accordingly, there are two main domains of adult attachment research: attachment to romantic partners and attachment to parents. Both domains are central to treating attachment trauma, and I distinguish research methods in each. With this foundation, I explicate the three basic patterns of attachment (secure, ambivalent, and avoidant) in each of the two domains (romantic partners and parents).

At this point, readers should be alerted to two complications. First, we have three main domains paired with different methods for assessing attachment security: infant attachment using the Strange Situation, adult attachment to romantic partners using questionnaires, and adult attachment to parents using the Adult Attachment Interview. The terminology for the different attachment patterns varies from one domain and method to another. Second, as I discuss later in conjunction with attachment trauma, a fourth pattern of profoundly insecure (disorganized) attachment was discovered belatedly in conjunction with maltreatment. Table 1–2 summarizes the variations in methods and terminology.

After reviewing the three basic patterns of attachment, I consider the extent to which adult attachment is relationship specific, the import of matches and mismatches in attachment patterns between romantic partners, and evidence for stability and change in attachment patterns in adulthood.

Attachment in Romantic Relationships

Debra Zeifman and Cindy Hazan (2008) developed an interview to assess the four defining characteristics of attachment relationships: seeking

proximity at times of distress, feeling distressed upon separation, using the relationship as a safe haven for comfort, and relying on the relationship as a secure base for exploration. They found that children showed clear-cut attachment (i.e., all four features) only in relation to parents, whereas adolescents showed clear-cut attachment in relation to peers, almost invariably a boyfriend or girlfriend. Interviews of adults ranging in age from 18 to 82 years showed that full-blown attachment was most characteristic of romantic relationships lasting 2 or more years. We can become enamored quickly, but we become attached far more slowly.

As just implied, attachment is only one facet of adult romantic relationships, which also involve sex and caregiving along with much else. We humans are a relatively monogamous species, and thus sex, attachment, and caregiving often are combined in a partnership; however, romantic relationships also are characterized by great diversity, as these three facets also are somewhat independent (e.g., a person could be attached to a spouse yet engage in casual sex with others). This diversity also encompasses same-sex romantic relationships, which are similar to heterosexual relationships with respect to attachment (Mohr 2008).

Measuring Adult Attachments to Romantic Partners

In collaboration with Phil Shaver, Hazan developed what I consider a do-it-yourself approach to attachment classification. They wrote the following brief descriptions of the romantic counterparts of Ainsworth's categories (Hazan and Shaver 1987, p. 515):

- *Secure:* I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don't often worry about being abandoned or about someone getting too close to me.
- *Ambivalent:* I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't want to stay with me. I want to merge completely with another person, and this desire sometimes scares people away.
- *Avoidant:* I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, love partners want me to be more intimate than I feel comfortable being.

Hazan and Shaver published these descriptions as a "love quiz" in a local newspaper and invited readers to indicate which description best fit their most important relationship and to mail in their answers. In so doing, they launched what has become a prolific and informative self-report tradition of adult attachment research (Mikulincer and Shaver 2007a).

TABLE 1–2. Variations in terminology for attachment classifications

Method; domain	Terminology			
Strange Situation; infant with parent	Secure	Ambivalent-resistant	Avoidant	Disorganized-disoriented
Questionnaire; adult with romantic partner	Secure	Ambivalent-anxious	Avoidant	Fearful
Adult Attachment Interview; adult with parents	Secure-autonomous	Preoccupied	Dismissing	Unresolved-disorganized

Subsequent self-report assessments of adult romantic attachment have become more refined (Crowell et al. 2008), consisting of many questions that permit the assessment of attachment security in degrees. Such questionnaires can be scored on two dimensions: anxiety and avoidance (Brennan et al. 1998). I use Figure 1–1 to depict such a scheme in educating patients about attachment. Secure attachment is evident in low scores on anxiety and avoidance (i.e., comfort with closeness); ambivalent attachment is associated with high scores on anxiety and low scores on avoidance (i.e., anxiety with closeness); and avoidant attachment is associated with low scores on anxiety and high scores on avoidance (i.e., comfort with distance). This depiction also yields a fourth category called *fearful* attachment, characterized by high anxiety and avoidance. This plight of feeling afraid and alone epitomizes attachment trauma, as I elaborate later in this chapter in the Attachment Trauma section.

The diagram shown in Figure 1–1 helps patients to understand the differences among the various attachment categories and to appreciate the differences in degrees of security and insecurity. The diagram also illustrates the potential for differences in security between relationships as well as the possibility for shifts over time within relationships. To take one example, in our psychoeducational group on attachment and mentalizing in the Professionals in Crisis program at The Menninger Clinic, we frequently discuss how patients who have functioned at high levels of success in the upper-right quadrant (avoidant) collapse into the lower-right quadrant (fearful) in the face of extreme stress. In part, such collapses

result from the lack of support that secure attachment would provide. We also use the diagram to highlight pathways to security (e.g., as illustrated by the dotted line). We propose in the group that movement from avoidant or fearful to secure attachment entails a pathway through ambivalence, given that avoidance stems from painful prior attachment experiences and that moving closer inevitably evokes anxiety.

Measuring Adult Attachments to Parents

In contrast to the questionnaire assessment of attachment in romantic relationships, which initiated a line of research in social and personality psychology, Mary Main and colleagues developed a clinical interview to assess adults' experiences of attachment with their parents (Hesse 2008). This hour-long Adult Attachment Interview is intended to be emotionally evocative, potentially stimulating painful memories and strong feelings. The interview begins with an orientation toward the participant's family constellation and asks for five adjectives characterizing mother and father (e.g., *affectionate, distant, controlling*). For each adjective and each parent, the participant is asked for concrete examples—that is, detailed early memories of events exemplifying the adjective (e.g., an incident in which the parent was "controlling"). In addition, participants are asked about feelings of closeness to their parents; the ways their parents responded to distress or illness; experiences of separation; and feelings of being rejected or threatened by their parents. The interview asks about childhood attachments with other adults as well as experiences of significant loss throughout the lifetime. As would be the case in psychotherapy, all experiences are explored in detail, drawing on specific memories.

The Adult Attachment Interview also asks participants to reflect on the meaning of early experiences and their long-term influences. For example, they are asked for their understanding of the reasons for their parents' behavior; the influence of their early attachment experiences on their personality; and changes in their relationships over the course of development. The interview also inquires about relationships with children, actual or anticipated. In addition, the interview inquires about traumatic experiences—not only regarding losses but also related to neglect and abuse. Although the interview includes an estimation of the quality of actual relationships (e.g., the extent to which each parent was loving), assessments are made not on the basis of these estimates but rather on the basis of the participant's *current overall state of mind with respect to attachment*. Hence, some participants with a history of abuse and neglect are able to demonstrate secure attachment in their valuing of attachment and the capacity to give an emotionally rich and coherent account of their at-

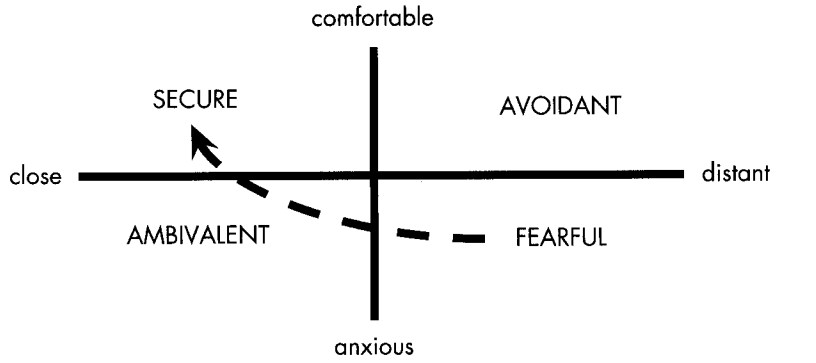

FIGURE 1–1. Dimensional view of attachment categories for patient education.

Dotted line indicates movement from fearful attachment through anxious ambivalence to secure attachment.

tachment relationships despite their history of trauma—a state of mind we therapists aim to achieve through psychotherapy. In parallel with the infant attachment research, attachment classifications are assigned, albeit with the slightly different terminology indicated in Table 1–2: secure-autonomous, preoccupied with attachment (corresponding to *ambivalent*), and dismissing of attachment (corresponding to *avoidant*).

As I hope to have made clear, these two traditions—questionnaires regarding romantic attachments and clinical interviews for state of mind regarding attachments to parents—were developed to measure adult counterparts to Ainsworth's three attachment categories. Despite their overlapping aim to arrive at attachment classifications, these two research traditions involve different methods (questionnaires versus interviews) and different relationships (romantic partners versus parents). Moreover, they were developed for fundamentally different purposes: the questionnaires were developed to relate attachment security to other facets of adult romantic relationships and general adjustment, whereas the Adult Attachment Interview was developed specifically to establish correspondence between parents' discussions of their childhood attachments and their infants' security of attachment with them in the Strange Situation. Thus, albeit to varying degrees, children's attachment classifications match their parents' attachment classifications in the Adult Attachment Interview.

Given the different methods, targets, and purposes of the questionnaire assessments and the Adult Attachment Interview, it's not surprising

that researchers have found limited agreement among the attachment classifications (Mikulincer and Shaver 2007a). Notwithstanding this limited agreement between these two parallel traditions, I find it instructive to juxtapose research findings for each of them with respect to the major attachment classifications. Again, in the following section, I present idealizations—pure types; reality is rarely so neat. I begin each attachment category with a review of romantic relationships, followed by a discussion of interview findings regarding adults' attachment to their parents. We therapists need to have a clear image of secure attachment relationships in adulthood inasmuch as a cardinal goal of trauma treatment is increasing the capacity for secure attachment, often in all domains—with parents, partners, and children—and predicated partly on establishing security in the patient-therapist relationship.

Secure Attachment in Adults

Case Example

Aaron sought hospitalization in his mid-40s after he became severely depressed for the first time in his life. He felt blindsided by his depression, characterizing himself as generally outgoing and upbeat. But he had experienced a series of losses, and his wife's sudden illness was the proverbial last straw that culminated in a depression so severe that he withdrew from all his social activities and ultimately was unable to continue working in his highly successful real estate business.

Aaron had grown up in a close and loving family, but he moved far away from his parents and two sisters when he went to college, met his wife, and established his career. His parents both died young—his father when Aaron was in his late 20s and his mother when he was in his 30s. In hindsight, he traced the beginning of his depression to the death of his business partner, who had a fatal heart attack 2 years prior to Aaron's hospitalization. His partner, several years his senior, had been like an older brother to him, a mentor and confidant on whom he had come to rely after his father died.

Aaron was active in his community and had a substantial social network, but he began to lose his "verve" after his partner died; then he began spending more time at home. He had a close and loving relationship with his wife, and their active family life with their two adolescent children kept him from being too withdrawn and inactive. Three months prior to his hospitalization, however, his wife had a stroke, which he said "pulled the rug out" from under him. With the loss of his parents in the background and his partner's death from a heart condition in the foreground, Aaron became "petrified" that he would lose his wife, even though she was recovering from the stroke.

Aaron faced a dilemma, because he had always confided in his wife and drawn comfort from her, particularly with the deaths of his parents and then his partner. But he felt unable to confide in her regarding his fear about her death, believing that he needed to "be strong" for her. His hospitalization provided a refuge for Aaron because he was accustomed to relying on others for support, and there were no barriers to his talking openly about his losses and his fears. He relied on individual and group psychotherapy as well as informal contacts with his fellow patients to overcome his isolation and to regain an appreciation for the value of social activities in his life.

With the help of marital counseling, Aaron discovered that his wife had been distressed by his withdrawal from her, which resulted from his deepening depression and reluctance to talk with her about his fears about death. He came to realize that his wife also could "be strong" and that she was able to accept his fears as well as to talk with him openly about her own fears. At the same time, he reached out to two close friends, letting them know about his depression and hospitalization, and he found them to be understanding and eager to help him become reconnected to his social network. Thus, his lifelong capacity to form emotionally supportive connections enabled him to rebound from his severe depression over the course of several weeks, at which point he said he could "reclaim" his life.

With images of secure attachment in childhood in mind, the adulthood counterparts are unsurprising. Moreover, as Aaron's experience attests, the adaptive benefits of secure attachment are as evident in adulthood as they are throughout childhood.

Secure romantic relationships are characterized by trust, commitment, and stability; emotionally open communication; empathy and emotional availability conducive to providing comfort for the partner's distress; sexual intimacy and monogamy; reciprocity and interdependence; and high levels of satisfaction with the relationship. Secure relationships are not free of conflict but rather entail a level of trust that fosters communication, negotiation, and a propensity to forgive; accordingly, attachment security fosters confidence that relationship problems can be addressed and resolved, thus promoting stability in the relationship. Although attachment theory distinguishes sex, love, exploration, and caregiving from attachment, attachment security tends to glue all these facets together in romantic relationships. Of course, security doesn't provide immunity to breakups, but it does foster resilience, in part by enabling a person to make use of emotional support in other relationships.

Jim Coan and colleagues (2006) conducted a remarkable experiment that I use to impress upon patients and colleagues the centrality of attachment in distress regulation. These researchers recruited couples who were satisfied with their marriages, and they exposed the wife in each couple to the threat of shock, reinforced by administering shock in a minority of trials. The wives experienced the threat under three conditions while their brain activity was monitored: 1) holding their husband's hand, 2) holding a stranger's hand, and 3) not holding anyone's hand. Broadly speaking,

threat activates two processes in the brain: stress responses and corresponding efforts to dampen distress. The researchers found that both patterns of brain activity were lowest while wives were holding their husband's hand and highest while they were not holding anyone's hand. Moreover, the greater the satisfaction in the marital relationship, the lower the level of brain activity while holding the husband's hand. Coan (2008) thus makes a compelling case that secure attachment is the most efficient way to regulate stress; as I view it simplistically, attachment gives the brain a break from the strain of experiencing and managing stress.

Implicitly and explicitly, secure attachment is associated with working models of others as benevolent and trustworthy. For securely attached persons, such models not only apply to romantic relationships but also extend to a more generalized positive view of human nature. Expectations that partners are well-intentioned, dependable, and forgiving are conducive to problem solving in the relationship. As in childhood, secure attachment in adulthood is associated with a model of self as being worthy and lovable. Secure attachment doesn't entail viewing relationships through rose-colored glasses; on the contrary, security allows room for criticism and self-criticism, making for a balanced view of others and oneself, a capacity to tolerate the negative as well as the positive, and thus openness to influence and change.

Those who report security in their romantic attachments also are likely to characterize their relationships with parents as being warm and supportive in questionnaire studies. As I noted earlier, however, the Adult Attachment Interview focuses not on the actual history but rather on the participant's manner of recounting that history in the interview. More specifically, the hallmark of secure-autonomous attachment is *narrative coherence*, a concept that applies directly to psychotherapy. Main and colleagues (2008) examine interviews for several core characteristics: truthfulness backed by specific evidence, succinctness, completeness, relevance, clarity, and organization. Accordingly, secure interviews are marked by emotionally authentic and convincing accounts of childhood experience, and they have a quality of freshness: participants are actively reflecting, thinking on their feet, sometimes coming up with new perspectives and realizations—a process we strive to achieve in psychotherapy. The antithesis of freshness is a stale account, full of generalizations or clichés, likely to be boring to hear—a sign in therapy of distance and insecurity.

More generally, persons demonstrating attachment security convey a positive attitude toward attachment; that is, regardless of the nature of their early history, they value attachment relationships. As it was intended to do, secure-autonomous attachment as evidenced in the Adult

Attachment Interview predicts infant attachment security in the Strange Situation, exemplifying the intergenerational transmission of attachment patterns (see Table 1–3). I discuss the reasons for the relation between parental and infant attachment security later in this chapter in the context of mentalizing (see section Mentalizing in Attachment Relationships).

Ambivalent-Preoccupied Attachment in Adults

Case Example

Bruce had become "crippled" with anxiety and depression in the context of escalating conflict in his second marriage. He traced his emotional instability back to high school when his parents' tumultuous marriage ended in divorce. Bruce said he'd been shy and socially "insecure" as long as he could remember, and he said he was just like his mother, who'd "fly off the handle at the drop of a hat."

In his senior year of high school, Bruce developed his first serious romantic relationship with Clarissa, a girl who was struggling with a similarly tumultuous household in which her parents' marriage was disrupted by her father's alcoholism. Bruce said they clung to each other "like Velcro." Bruce and Clarissa went away to the same college and married before graduation. Their marriage deteriorated when Clarissa gave birth to their son, and Bruce complained that he'd been "replaced." Two years later, they divorced, and Clarissa took custody of their son.

TABLE 1–3. Prototypical developmental pathway: secure attachment

Parent's discussion of childhood attachment experience	Coherent, at ease, open, free to explore, comfortable discussing painful emotions and experiences, balanced in views of self and others
Parent's behavior with infant	Sensitively responsive, consistently emotionally available
Infant's behavior with parent	Explores environment and checks back with parent; focuses on parent around separation; misses parent; initiates contact on reunion; gives flexible attention to parent and environment
Developmental outcomes	Is accepting of dependency; is effectively dependent *and* independent; has feelings of self-worth and self-confidence; is empathic and caring toward others; has capacity for trust and intimacy; is open to positive and negative emotions; is skillful in emotion regulation; has comforting memories of attachment relationships

Bruce started drinking more heavily after the divorce and, within a few months, he met Donna at a bar. She was a "soul mate" who easily matched all his resentments with resentments of her own. He said it was "us against the world." Bruce and Donna married "on the rebound" after a few months. But their marriage went downhill after Bruce was terminated from his job and despaired of finding alternative work. Whereas Bruce felt increasingly helpless, he characterized Donna as a "fighter," and she took a second job to make ends meet. While she worked, Bruce would just "veg" around the house, watching TV and half-heartedly applying for jobs. Although they needed the money, Bruce increasingly resented Donna's being out at work so much, especially on evenings and weekends. He pleaded with her to take time off from work, recognizing that he tried to cling to her "like Velcro," as he'd done with Clarissa. But Donna's absences just kept "ripping" them apart.

At one point when he grabbed her arm as she was going out to work, Donna blurted out that she wished she had three jobs so she'd never have to see Bruce's "sorry ass." At that point, Bruce's anxiety and despair became so unbearable that he started thinking about suicide and ultimately started downing a bottle of pills in Donna's presence. Thus, he was propelled into treatment in desperation.

As Bruce's experience attests, ambivalent attachment in romantic relationships is associated with a fast pace: falling in love quickly, passionately, and perhaps indiscriminately. This fast pace includes a high level of emotional openness and self-disclosure—too much too fast, potentially including rapid sexual intimacy. Minimizing differences and idealizing the partner—having found the perfect love—is a setup for disillusionment. As it is in childhood, the need for closeness is driven by the fear of abandonment. Yet, coupled with possessive and controlling behavior, the demand for closeness is liable to push the partner away. Vicious circles ensue as the partner's distancing fuels intensified anxious clinging.

As it is in childhood, ambivalent attachment in adulthood is associated with anxiety, feelings of deprivation, and frustration. My colleague Helen Stein calls it the *kick-and-cling* pattern. The ambivalent partner is liable to suppress the direct expression of anger, thereby building up resentment, which may be expressed indirectly (e.g., in sullen withdrawal) and in periodic angry outbursts. Such outbursts serve the same function in adulthood as they do in childhood: protesting unresponsiveness to force attentiveness. Of course, such strategies might be effective in the short run but are likely to alienate the partner in the long run, leading to increasing mutual resentment. Furthermore, the dependent-helpless stance that characterizes ambivalent attachment undermines the development of autonomy and competence, thereby cementing dependency and adding fuel to fears of abandonment and inability to manage on one's own.

Ambivalent attachment is predicated on working models of attachment figures as being capable of providing care yet undependable. Thus,

ambivalence intermingles hope with expectations of disappointment. Also inherent in the concept of ambivalence is conflict and contradiction, expecting the partner to be both loving and rejecting. The anxiety inherent in ambivalence leads to wariness and hypervigilance; the ambivalent partner is continually on the lookout for hints of rejection and potential abandonment. Such hypersensitivity leads to misperceptions or overreactions to ordinary failures in attunement or responsiveness that are ubiquitous in relationships (e.g., interpreting preoccupation as disinterest). Self-fulfilling prophecies ensue as minor problems escalate into major conflicts, reinforcing the ambivalent working models. These models entail a high level of self-criticism, including feelings of being inadequate, unworthy, weak, and unlovable. Such feelings fuel sensitivity to rejection and criticism, thereby contributing to conflict and further self-fulfilling prophecies. Feelings of inadequacy fuel dependency and failure to develop competence and self-reliance; these failures block successes that would be needed to develop more positive working models of self.

Although I've painted a rather unattractive picture of ambivalent attachment, there is a positive side to it: a high level of persistence in seeking and maintaining attachment relationships. Thus, ambivalence entails a level of engagement that keeps the door open to developing secure attachments. As I noted earlier, in the subsection Measuring Adult Attachments to Romantic Partners, ambivalence is likely to be on the pathway from avoidance to security.

As the label implies, preoccupied attachment as demonstrated in the Adult Attachment Interview entails an inability to move beyond conflict and frustration with early attachments, as shown in ongoing entanglement in attachment-related distress. Preoccupied interviews lack coherence and are rambling, vague, overly detailed, tangential, and thus hard to follow. These interviews are infused with continuing resentment, as evident in complaints about parental failures as well as blame—not only blaming parents but also self-blame. As these interview findings attest, merely thinking about childhood attachment relationships is emotionally distressing, thus activating attachment needs as well as the frustration associated with unmet needs.

As is the case with security, the child's insecure attachment classification is likely to match the parent's. Thus, parental attachment preoccupation in the Adult Attachment Interview is associated with infant ambivalence in the Strange Situation in the prototypical intergenerational pattern summarized in Table 1–4. The infant's distress and attachment needs are liable to evoke the preoccupied parent's ongoing problems with attachment and emotion regulation, thereby interfering with the parent's capacity to respond sensitively and consistently to the infant's distress.

TABLE 1–4. Prototypical developmental pathway: preoccupied-ambivalent attachment

Parent's discussion of childhood attachment experience	Poor capacity to focus, long-winded, vague, tangential, preoccupied with anger toward parents, blaming and self-blaming
Parent's behavior with infant	Inconsistent, unavailable, unresponsive, under-involved
Infant's behavior with parent	Wary and distressed; focuses attention on parent to the exclusion of play; is difficult to soothe or comfort on reunion; shows anger mixed with effort to maintain contact
Developmental outcomes	Anxious, hypervigilant, worried about attachment figure's availability and responsiveness; exaggerates threat and fear to elicit care; seeks reassurance; has negative beliefs about self and world; punishes attachment figure to discourage unresponsiveness

The positive side of ambivalence, however, also is evident in parenting as it is in romantic relationships: albeit inconsistently, the parent is likely to remain emotionally engaged with the infant.

Avoidant-Dismissing Attachment in Adults

Case Example

Elaine, a bright and attractive woman in her early 30s, sought treatment when her alcohol abuse escalated to the point that she was arrested at 2:00 A.M. and jailed overnight for driving under the influence after a night of barhopping. This incident was humiliating, especially because she was a "rising star" in a law firm.

Recognizing that her life was "out of control," Elaine sought psychotherapy. But she started every session presenting herself as bubbly and cheerful, routinely saying with a smile that everything was "rosy." Without a hint of distress, she talked about what seemed to be a painful history of emotional isolation—inside and outside her family. She said she admired her father from afar. Although she "walked in his footsteps," she hardly knew him. He was a "high-powered" attorney who was rarely at home, and he was emotionally disengaged from the family when he was there. Thus, she was left at the mercy of her mother, whom she flatly characterized as a "cold bitch" who was demanding and perfectionistic.

Elaine was socially isolated throughout her school years, with the exception of having one friendship with a girl her age who was a "kindred spirit." She said the two were alike in being equally "mean and cruel," taking pleasure in the "pranks" they played on their peers. But they were both ostracized socially. Elaine was able to get by on her intelligence, however, and she graduated high school near the top of her class. She said she'd learned to "suck up" to her teachers to "stay out of trouble."

Relying on "wits and charm," Elaine excelled in college and law school. She said that, regarding romantic relationships, she was content with a series of exciting "flings" that didn't involve any commitment. She surprised herself in one therapy session, however, when she was blindsided by tearfulness as she talked about one romance that "got out of hand." Contrary to her usual "flings," she dated Fred for 3 years, although the relationship was "on again, off again." When they were together, she started to "open up" to him, but then she would distance herself. She acknowledged that she'd even started to fantasize about having children, but then she said with disdain that she considered this a "house-with-a-white-picket-fence pipe dream." She became tearful when she talked about spending a weekend away with Fred at the end of which he brought out an engagement ring and proposed marriage. She "panicked" and cut off the relationship, at which point her drinking escalated.

As Elaine's experience illustrates, low levels of intimacy, closeness, affection, commitment, and emotional dependence characterize avoidant attachment; the prototype is the self-sufficient loner. This is not to say that avoidant persons are asocial; on the contrary, they may be extroverted—downright charming and witty. Yet their relationships are superficial, devoid of emotional confiding and comforting. Avoidant attachment is conducive to sex without love—that is, associated with positive attitudes toward casual sex concomitant with promiscuity, sex with strangers, and one-night stands. Sex may serve the purpose of bolstering the self-image, as evident in bragging about sexual exploits and conquests. Moreover, avoidance is antithetical to providing care and nurturance; avoidant persons are likely to be emotionally unavailable in the face of their partner's distress or even to respond to distress with hostility.

In adulthood, as in infancy, avoidance is an *attachment strategy*—that is, a way of maintaining *attachment at a distance*, or a strategy to maintain connection while minimizing rejection. As stated earlier, avoidant children acquiesce to the implicit command, "Don't bother me with your unhappiness." In adulthood, this strategy goes both ways: "I won't bother you, and I don't want you to bother me." Moreover, given repeated experience of unmet attachment needs, the avoidant person suppresses not only the *expression* of distress but also the *experience* of distress. Distress is associated with a feeling of weakness, vulnerability, and inferiority; hence, the avoidant person blocks awareness of the full range of distressing emotions, including anxiety, fear, shame, guilt, loneliness, and sadness. Irritation and anger may be the exception to this general rule.

Plainly, avoidant attachment is associated with negative working models of others—that is, expecting others consistently to be rejecting or

unavailable. More generally, avoidance is likely to be associated with suspiciousness and distrust, which is conducive to hostility. Such negative attributions of others' intentions can reflect sheer projection of one's negativity onto others. Of course, such attributions contribute to self-fulfilling prophecies: hostility and suspiciousness beget rejection. Avoidant attachment is patently defensive in being self-protective, and defensiveness also may be evident in the avoidant person's sense of self. That is, avoidance is associated with defensive self-inflation, coupled with a penchant for externalization—namely, casting blame for problems onto others. In contrast to ambivalence, which is likely to be associated with feeling one-down in relationships, avoidance is associated with an effort to remain in control, one-up in relationships.

In the Adult Attachment Interview, dismissing attachment makes for a short story—literally, because interviews tend to be brief (i.e., the opposite of preoccupied interviews). Attachment is devalued, memories are sparse, and descriptions of relationships are abstract; thus, descriptive adjectives are not backed up with convincing evidence. Some dismissing interviews are marked by idealizing parents as being "wonderful" or "the best," without evidence. Sometimes idealizations are blatantly contradicted by the ostensibly supportive evidence: "Yeah, he used to hit me with a board when I got out of hand, but that was just his way of showing love, doing it for my own good."

Parents who are dismissing in the Adult Attachment Interview are likely to have infants who are avoidant in the Strange Situation, the prototypical intergenerational pattern summarized in Table 1–5. Children are likely to adapt to their parents' attachment pattern. Dismissing parents aspire to downplay, suppress, and reject emotional distress; to reiterate, the dismissing parent conveys "Don't bother me," and the avoidant infant acquiesces, for example, by directing attention to the toys.

Relationship Specificity of Adult Attachments

The Adult Attachment Interview yields a single classification intended to capture the individual's overall state of mind in relation to attachment. Similarly, questionnaires about adult attachment generally yield an overall classification. We have reason to rely on generality: these assessments of overall attachment patterns have shown enormous predictive power in research (e.g., most impressively, predicting an infant's attachment behavior from a parent's attachment classification). As the evidence reviewed here implies, working models stemming from earlier relationships influence the development of later relationships, generalizing from one relationship to

TABLE 1–5. Prototypical developmental pathway: dismissing-avoidant attachment

Parent's discussion of childhood attachment experience	Poor memory for childhood; downplays negative experiences; idealizes or devalues attachments; presents self as strong and independent
Parent's behavior with infant	Rejects infant's bids for comfort when distressed; unemotional with infant; intrusive, controlling, overstimulating
Infant's behavior with parent	Directs attention toward environment and away from parent, whether parent is present, departing, or returning; unemotional with parent
Developmental outcomes	Downplays threat, worry, vulnerability, need for comfort; rejects help; shows lack of emotional awareness, sometimes coupled with physiological reactivity; shows defensive self-inflation; is unwilling to provide comfort and support; shows outward emotional health but collapse of defenses with extreme stress

another. As also implied, these models are likely to be self-perpetuating, for better or for worse: securely attached persons anticipate benevolence and demonstrate caring and empathy, and thus others are likely to respond positively to them; ambivalently attached persons bring anxiety and resentment into relationships in a way that evokes conflict; and avoidant persons tend to maintain distance, which blocks engagement altogether.

Yet, being relational, attachment also is relationship specific to a considerable degree, based on the history of interactions between individuals. The most compelling evidence for relationship specificity is the finding that an infant may be securely attached to one parent and insecurely attached to the other (Steele et al. 1996). These differences within a family make sense in light of the fact that attachment strategies are responses to patterns of caregiving: if one parent is sensitively responsive and the other is inconsistently responsive or consistently rejecting, the infant will demonstrate security in one of these relationships and insecurity in the other. Such relationship specificity is conducive to flexibility in attachments, and we must count on it in conducting psychotherapy: to use Ainsworth's language, plain old therapy requires a level of sensitive responsiveness that promotes patients' security in the relationship. Also counting on generality, we hope that such enhanced security will generalize to other relationships, and we aspire to help this process along by examining and potentially modifying insecure working models in these other relationships. Yet, as I'll emphasize repeatedly throughout the book, individual psychotherapy has its

limits, and we therapists also rely on couples and family therapy to promote relationship-specific changes in attachment security.

Matches and Mismatches

Given that attachment is relational and to some degree relationship specific, attachment researchers have investigated the occurrence and impact of matches and mismatches of attachment patterns in romantic partners (Feeney 2008). The complexity in these findings is considerable in light of the number of possible combinations. Unsurprisingly, securely attached persons are likely to pair up with one another, and their relationships are associated with better adjustment and higher levels of satisfaction. There is also some evidence for greater than chance levels of partner matching between insecure individuals (i.e., ambivalent-ambivalent and avoidant-avoidant). Mismatches can be advantageous if one partner is secure: the security of one may buffer the insecurity of the other, and this particular mismatch offers a crucial pathway to positive change (e.g., as might occur in a good romantic relationship or in an effective psychotherapy relationship). Ideally, each partner relies on the level of security the other partner shows, and this allows them to ratchet up their conjoint security.

Of course, insecurity also can beget insecurity: ambivalence begets ambivalence, and avoidance begets avoidance. As hinted earlier, the pairing of ambivalence with avoidance is liable to lead to escalating conflict in vicious circles. The avoidant partner's distancing stokes the ambivalent partner's anxiety and resentment; anxious clinging and angry protests on the part of the ambivalent partner promote further withdrawal and stonewalling on the part of the avoidant partner. Not uncommonly, ambivalent wives are dissatisfied with avoidant husbands. In contrast, two avoidant spouses are liable to have an emotionally distant marriage—at worst characterized by an emotional divorce.

Stability and Change

As in childhood, attachment patterns show a mixture of stability and change over the course of adulthood, and the stability of a relationship will depend on the stability of many other factors. Perhaps supporting the idea of self-perpetuation, studies of stability in adult attachment over periods ranging from 1 week to 25 years show consistency in 70% of participants on average (Feeney 2008). As in childhood, instability is associated with lawful discontinuity (Mikulincer and Shaver 2007a). Secure attachment can be destabilized by experiences of rejection or betrayal, as well as by separations and losses. Conversely, insecure attachment can be ameliorated by the formation of positive and stable relationships—entering

into a good marriage, becoming a loving parent, or engaging in psychotherapy. For better or worse, experiences that disconfirm working models are associated with change in attachment security. We cannot avoid one brute fact: disconfirming insecure models requires a trustworthy partner.

Mentalizing in Attachment Relationships

Thus far, I have adopted Ainsworth's concept of sensitive responsiveness as the linchpin for secure attachment. We easily appreciate how a mother's sensitive responsiveness to her child's distress will give the child confidence in turning to her for solace. And we need only make a short leap to imagining that we adults will turn to sensitively responsive persons when we need comfort and understanding. Fonagy and Target (2005) have refined Ainsworth's insights in relating parental mentalizing capacity to children's attachment security as well as relating impaired mentalizing to attachment trauma. *Mentalizing* is not an easy word to adopt, as Jeremy Holmes (2010) contends: "When I first encountered the term 'mentalising' I found it off-putting, with its abstract pseudo-technical ring." Yet he adds, "I have come round to the view that mentalising captures a crucial aspect of psychological health, and psychotherapists' efforts to promote it" (p. 9).

I agree with Holmes on both counts and, sensitive to the potentially jarring sound of *mentalizing*, I like to introduce the concept to patients and colleagues alongside *mindfulness*, which is intuitively meaningful and user friendly. Yet I'm more interested in substance than semantics in this regard; mentalizing and mindfulness are overlapping concepts, and we can learn something about mentalizing from mindfulness research. Thus, I start this section with a discussion of mindfulness, then move on to review mentalizing, and conclude by summarizing the overlap and differences between mindfulness and mentalizing.

Mindfulness

In brief, mindfulness refers to *attentiveness to present experience* coupled with an *accepting attitude* toward experience—including emotionally painful and traumatic experience. Acceptance of emotionally painful experience, as contrasted with strategies to diminish emotional pain, has led to a significant shift in contemporary cognitive-behavioral therapies. Steven Hayes and colleagues (1999) contrast *experiential acceptance* with two forms of avoidance, each of which is pertinent to trauma. *Situational avoidance* encompasses avoiding situations that evoke painful emotions

(e.g., a person who was assaulted in a parking garage might avoid parking garages). *Experiential avoidance* entails avoiding distressing thoughts and feelings, in effect, trying to avoid one's own mind—a futile endeavor. Mindfulness practice (e.g., through meditation) can promote experiential acceptance by demonstrating that mental states, including painful thoughts and feelings, are transient phenomena and not inherently toxic if one can adopt a nonjudgmental attitude of curiosity toward them. This attitude requires a complex amalgam of engagement (attentiveness) and detachment (i.e., observing one's thoughts and feelings, not taking them too seriously, and allowing them to pass through one's mind).

I find the mindfulness literature appealing, in part because of its explicit ethical foundation. Although many therapists approach mindfulness from a secular perspective, mindfulness has roots in Buddhism and hence in spirituality. The mindfulness tradition advocates compassion toward all beings, including the self. The practice of self-compassion has garnered increasing attention (Neff 2011), and compassion toward oneself is conducive to experiential acceptance. For example, you can bear emotional pain more easily if you empathize with yourself rather than berating yourself for your feelings.

Mindfulness took hold in the clinical research literature with Jon Kabat-Zinn's (1990) development of an 8-week group intervention, Mindfulness-Based Stress Reduction. Kabat-Zinn designed this program to help patients with general medical conditions (e.g., heart disease and chronic pain) who did not respond fully to standard medical care. Mindfulness practice has since become a mainstream intervention incorporated into contemporary cognitive-behavioral therapies for a wide range of symptoms and disorders (Roemer and Orsillo 2009). A review of nearly 40 studies with over 1,000 patients showed significant decreases of anxiety and depression with mindfulness interventions, and a substantial subset of these studies showed enduring benefit in follow-up assessments (Hoffmann et al. 2010). This research suggests that, paradoxically, accepting emotional distress rather than aspiring to suppress it is a helpful strategy for emotion regulation. This suggestion appears less paradoxical, however, in light of research on attachment security: sensitive responsiveness implicitly entails mindfulness—attentiveness and acceptance—and sensitive responsiveness ameliorates distress by enhancing feelings of security.

Mentalizing

Mentalizing entails mindfulness in the context of *attentiveness to mental states* in oneself and others—in short, holding mind in mind. The technical sound of the word *mentalizing* is misleading in implying something esoteric. On the contrary, mentalizing is a natural human capacity that we typically take for granted. Barring autism, we all become natural psychologists, inclined to make sense of ourselves and others.

Yet, as summarized in Table 1–6, mentalizing is complex in that the term encompasses many facets (Fonagy et al. 2012). Most fundamentally, we distinguish between self and others; knowing one's own mind is not the same as knowing the mind of another person. In addition, we distinguish explicit (controlled) from implicit (automatic) mentalizing. Explicit mentalizing is conscious and deliberate, typically involving language (e.g., putting feelings into words) and narrative (e.g., constructing a story to explain a problematic action). Implicit mentalizing is intuitive and nonconscious (e.g., as in turn-taking in conversations and automatically adjusting one's posture and voice quality in the process of empathizing with a friend's discouragement). We also distinguish an external focus (e.g., on a coworker's scowling face) from an internal focus (e.g., on the reasons for her scowl). In addition, we distinguish between mentalizing cognitive processes and affective processes (i.e., mentalizing thoughts versus emotions). Moreover, the time frame of mentalizing can vary: one can mentalize in relation to the present (e.g., a current desire), the future (e.g., anticipating the impact of a planned confrontation), or the past (e.g., reconstructing the basis of a misunderstanding). Finally, the scope of mentalizing may be narrow (e.g., a current thought) or broad (e.g., as in constructing an autobiographical narrative).

Understanding the development of our mentalizing capacity is tantamount to fathoming how we come to have a full-fledged human mind—no small feat (Fonagy et al. 2002). My colleagues and I have reviewed pertinent developmental research elsewhere (Allen et al. 2008); here, I focus merely on the contribution of secure attachment to the development of mentalizing. As a prelude, however, you must understand a fundamental and counterintuitive principle: the mind develops from the outside in. That is, you develop a sense of a self and come to know your own mind by virtue of others—caregivers most prominently—relating to you as a person with a mind.

TABLE 1–6. Different facets of mentalizing

- Focus on self versus others
- Explicit (deliberate, verbal) versus implicit (automatic, intuitive, nonverbal)
- External focus (observable behavior) versus internal focus (mental states)
- Thoughts versus feelings
- Present versus past and future
- Narrow (present state) versus broad (autobiographical)

Consider the process of coming to learn what you feel, beginning in the first year of life. Fonagy and colleagues (2002) explained how infants come to recognize their feelings by virtue of caregivers mirroring their emotional states in a complex fashion. The caregiver is not a simple mirror: it won't help the crying infant for his mother to cry just as hard; the infant will not be soothed! Rather, the mother shows the infant that she appreciates how he feels and empathizes: she integrates compassion and caring into her expression of sadness, using a soothing voice. Thus, she represents the infant's emotion to him. Similarly, if the infant is frustrated, the mother doesn't express her frustration with the infant but rather imitates his frustration in conjunction with an attitude of sympathy; she shows what *he* feels, not what *she* feels. Through this process, he comes to learn what he feels. This emotional learning process is the crucible for the development of subsequently more refined mentalizing, which, ultimately, enables a person to label feelings, understand the reasons for them, and put them into an autobiographical narrative.

As I noted in the section on adulthood, Main and colleagues (1985) demonstrated correspondence between parents' Adult Attachment Interview classifications and their infants' Strange Situation classifications. Extending this research, Fonagy and colleagues (1991a) conducted a remarkable study. They administered the Adult Attachment Interview to 100 mothers who were pregnant with their first child, and then they observed the mother-infant interactions in the laboratory when their infants were 12 months old. They found significant concordances between mothers' attachment classifications and infants' classifications. They subsequently replicated these results for fathers (Steele et al. 1996). The way the parent talked about attachment before the child was born predicted the way the child would interact with the parent in the lab 1 year after being born. This finding calls for explanation.

How does parental security of attachment lead to infant attachment security? Although the research is complex and arduous to conduct, the developmental principle is simple: mentalizing begets mentalizing. Fonagy and colleagues (1991b) demonstrated, for example, that parental mentalizing in the adult interview was the strongest predictor of infant attachment security. This finding makes sense if we suppose that parents who are able to mentalize in relation to their own attachment history (i.e., to reflect in a coherent and emotionally engaged manner) are likely to be more capable of mentalizing in relation to their infant's attachment needs and emotions. Subsequent research bears out this supposition. Securely attached parents mentalize their infants. They engage in what Elizabeth Meins (Meins et al. 2006) called *mind-minded commentary* on their infants' behavior, spontaneously commenting on what the infants might

be thinking, feeling, and intending to do. Secure parents also talk about their infants in a psychologically attuned way, attentive to their feelings, desires, and needs (Slade et al. 2005). Naturally, intuitively anticipating a mentalizing response, infants turn to them for help when distressed; they're securely attached. Moreover, securely attached infants develop better mentalizing capacities in childhood; for example, they're able to appreciate what other children are thinking and feeling.

These research findings relating mentalizing to secure attachment constitute substantial refinements to Ainsworth's pioneering discovery of the importance of sensitive responsiveness (Fonagy and Target 2005). To reiterate the commonsensical story foretold in the book's Introduction, we would expect that infants would seek and find comfort from parents who are attuned to their emotional states, and we shouldn't be surprised that children learn to mentalize by virtue of engaging in mentalizing interactions, just as children learn to speak by virtue of being spoken to.

Integrating Mindfulness and Mentalizing

I find the overlap between the concepts of mindfulness and mentalizing remarkable inasmuch as they come from such diverse traditions: mindfulness has roots in Buddhism, philosophy, and ethics, whereas mentalizing derives from psychoanalysis and developmental psychopathology. Research on both has been motivated by the desire to relieve suffering (see Figure 1–2). Hence, each has a place in psychotherapy. I cannot imagine a psychotherapy that does not entail mindful attention to mental states. Moreover, mindfulness and mentalizing entail a stance of curiosity toward mental states as well as an accepting attitude toward experience. In sum, mindfulness, mentalizing, and acceptance exemplify sensitive responsiveness; all three are essential to security in parent-child relationships, friendships, love relationships, and plain old therapy.

Yet mentalizing is not equivalent to mindfulness. Five differences stand out. First, mindfulness is not restricted to mental states (e.g., you can be mindful of a flower or your breath); hence, I construe mentalizing as *mindfulness of mind*. Second, mentalizing is more social than mindfulness in two senses: mentalizing includes attention to mental states in others as well as in oneself; more fundamentally, mentalizing is intrinsically social insofar at it comes into being in the context of social interactions. Third, our understanding of mentalizing, related to its social nature, comes from developmental research. Thanks to this research, we now understand how mindfulness of mind comes into being and how we might enhance its development. Fourth, whereas mindfulness entails *bare attention*, mentalizing also involves *reflection* and narrative—that is, elaboration

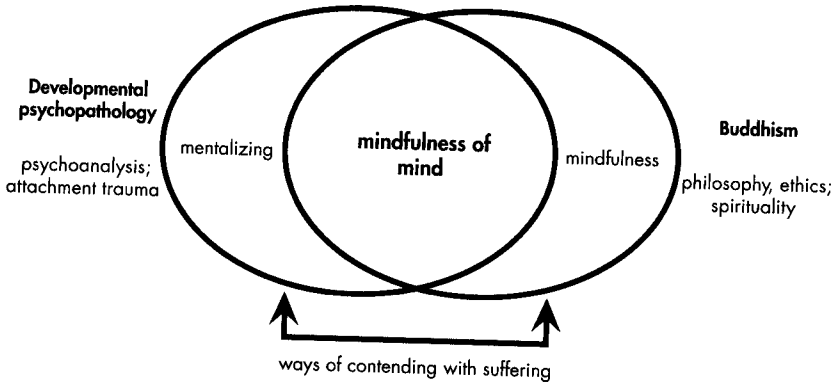

FIGURE 1–2. Overlap between mentalizing and mindfulness.

and interpretation of mental states. Fifth, short of being stripped down to its bare bones in secular applications, an ethical perspective is explicit in mindfulness while remaining implicit in mentalizing.

Finally, there is a seeming contradiction between the mindfulness and mentalizing literatures: the Buddhist tradition advocates nonattachment, whereas the mentalizing literature emphasizes attachment. In the Buddhist literature, attachment connotes grasping, clinging, and possessiveness; yet these inclinations are characteristic of insecure attachment. Accordingly, research by Shaver and colleagues (2007) has shown that mindfulness is associated with secure attachment—that is, lower levels of anxiety and avoidance. This finding makes sense, because secure attachment is conducive to acceptance of emotional experience—neither being anxious about it nor pushing it aside. Accordingly, if somewhat ironically, secure attachment also relates positively to measures of nonattachment as construed in the Buddhist literature (Sahdra et al. 2010). For example, securely attached persons are nonattached in the sense that they are able to accept the flow of events and experiences (without obsessing about them or avoiding them) and are less encumbered by possessiveness. Hence, these two views of attachment are complementary rather than contradictory.

Attachment Trauma

I use the term *attachment trauma* in two senses: first, to refer to trauma that takes place in attachment relationships; second, to refer to the adverse impact of such trauma on the capacity to develop secure attachment relationships. Attachment trauma creates a *dual liability* (Fonagy

and Target 1997): it simultaneously evokes emotional distress and undermines the development of the capacity to regulate distress. I've been building the case in this chapter that mentalizing in secure attachment relationships is the foundation of emotion regulation. Hence, my main thesis about attachment trauma that provides the fundamental rationale for plain old therapy is as follows:

> The experience of being left psychologically alone in unbearable emotional states repeatedly for prolonged periods is potentially traumatic owing in part to the absence of mentalizing. Treatment entails creating a secure attachment context conducive to mentalizing in which previously unbearable emotional states can be experienced, expressed, understood, and reflected upon—and thereby rendered meaningful and bearable.

To confirm this proposition, we therapists merely need to be attentive to all the ways in which traumatized patients express their core experience of feeling *invisible*—ignored, overlooked, dismissed, misunderstood, unheard, unseen—in the present as well as the past.

Thus, consistent with its profound and pervasive adverse developmental impact (Strathearn 2011), I place neglect—lack of psychological attunement—at the center of attachment trauma. From this perspective, neglect is inherent in abuse. Mentalizing failure—psychological unavailability—lies at the core of emotional neglect. But mentalizing failure, and neglect in this sense, also lies at the core of every form of abuse—physical, sexual, and psychological. Abusing a child, or an adult, for that matter, is incompatible with mentalizing—that is, mindful attentiveness to the child's (or adult's) experience. Accordingly, mentalizing puts the brakes on violence, and being violent requires releasing the mentalizing brakes (Fonagy 2004).

Our understanding of attachment trauma comes from Main and colleagues' (Main and Solomon 1990) recognition of a fourth attachment category in conjunction with seemingly anomalous infant behavior in the Strange Situation. Main classified this anomalous pattern as *disorganized* attachment, and this atypical pattern was discovered to originate in maltreatment. After reviewing the research on the organized patterns of attachment (secure, ambivalent, and avoidant), I have established a conceptual template for understanding attachment trauma. Here, too, an intergenerational pattern emerged: parents' unresolved-disorganized attachment in the Adult Attachment Interview predicts infants' disorganized attachment in the Strange Situation (Main and Hesse 1990). Trauma begets trauma. This groundbreaking discovery spawned two decades of research that has refined our understanding of attachment trauma and its development, including its roots in mentalizing failures.

Infant Disorganization in the Strange Situation

Classifying infants as being disorganized in the Strange Situation requires careful observation and clinical sensitivity, because disorganized behavior often is short-lived—potentially occurring in bouts as brief as 10–30 seconds (Main et al. 2005). Hence, the disorganized classification is superimposed on the predominant pattern (i.e., secure, ambivalent, or avoidant) rather than substituting for it. Notwithstanding their brevity and subtlety, indications of disorganization portend significant developmental problems, potentially extending into psychiatric disturbance in adulthood.

Disorganized behavior is seemingly inexplicable in lacking an obvious intention or goal. Main and colleagues realized that the reason for this confusing behavioral pattern was the infant's irresolvable conflict: in the most glaring instances, the abusive attachment figure is frightening, and the infant's primary strategy for reducing fear—seeking proximity—only exacerbates the fear. Hence, Main construed disorganized attachment as stemming from *fright without solution*. Here is a painful example: When the mother leaves the room in the Strange Situation, the infant runs after her, screaming and pounding on the door through which she has exited. When the mother returns, the infant becomes frightened and runs to the opposite side of the room. Thus, despite the infant's extreme distress, there is no reunion and no solace. Other examples of disorganized behavior include a cheerful greeting followed by a frozen, dazed expression; clinging to the parent while turning away and averting gaze; extended rocking or automaton-like movements; direct expressions of fear of the parent, such as jerking back with a frightened expression; aimless wandering; sudden eruptions of fear or anger into otherwise contented play; and prolonged, trancelike states.

Notably, some of these observations suggest that *dissociative states*, a common trauma-related symptom, have origins in infancy. Thus, I touch on dissociation in this chapter before considering it at more length in the next. In brief, dissociation entails either *alterations* in consciousness (e.g., detached, dazed, trancelike states) or *alternations* in consciousness (e.g., contradictory and seemingly compartmentalized behavioral states, such as the sudden intrusion of fear). In either form, painful experience is dissociated in the sense of being disconnected or kept separate from ordinary consciousness.

Disabled Caregiving and Infant Disorganization

Infant disorganization is relationship specific; rarely does an infant show disorganized behavior with more than one parent (Lyons-Ruth and Jacobvitz 2008). Extensive research links disorganization to maltreatment (van IJzendoorn et al. 1999). For example, in Sroufe and colleagues' meticulous longitudinal study (Carlson 1998), disorganization was associated with physical abuse (e.g., intense and frequent spanking, angry parental outbursts resulting in serious injuries), psychological unavailability (e.g., parental unresponsiveness or detachment), and neglect (e.g., failure to provide physical care or protection).

Plainly, maltreatment exemplifies the infant's plight of fright without solution. Yet Main and colleagues' (2005) research also has shown more subtle contributors to disorganized attachment. Indeed, it is now clear that a wide range of parental behavior beyond blatant maltreatment is conducive to infant disorganization. That is, the parent may be directly *frightening* (e.g., abusive) or *frightened* (e.g., in a traumatized state). In either case, the parent is psychologically unavailable. In a related vein, Karlen Lyons-Ruth and colleagues (2005) have identified two patterns of misattunement conducive to infant disorganization: hostile intrusiveness and helpless withdrawal. More generally, Lyons-Ruth (Lyons-Ruth and Jacobvitz 2008) linked disorganization with *disrupted emotional communication*, which takes many forms: negative-intrusive behavior (e.g., mocking the infant), withdrawal (e.g., silence), communication errors (e.g., giving contradictory cues such as encouraging closeness while physically withdrawing), and disorientation (e.g., unusual and perplexing voice changes). The crucial discovery was that even in the absence of directly abusive or frightening behavior, signs of disrupted emotional communication predict infant disorganization. This is what I had in mind when I commented earlier that relationships have become unglued in attachment trauma.

More than any other study I have seen, Beatrice Beebe and colleagues' (2010) study of mother-infant interactions highlights the role of psychological disconnection in attachment trauma. In contemplating her research, one should keep in mind my basic proposition that being left psychologically alone in distressed states lies at the heart of attachment trauma. Beebe studied 150 seconds of mother-infant interactions in a free play situation, coding second-by-second segments. These interactions occurred when the infants were 4 months old, and the codings subsequently were found to be related to infants' Strange Situation classifications at age 12 months. Lack of maternal emotional attunement characterized interactions predictive of attachment disorganization: in the face of their infant's distress, a misattuned mother would look away, show a lack of facial responsiveness, or display discordant emotion (e.g., smiling while the infant cried). In addition to stonewalling, these mothers might show intrusiveness or loom unpredictably into the infant's space. When we consider the adverse implications of disorganized attachment, to be described

later, it is no exaggeration to construe such misattunement to infant distress as potentially traumatic. In considering the import of these findings, one should keep in mind that the misattunement was evident in a brief laboratory interaction when mothers were instructed to attend to their infants (i.e., to play with them), and they were being observed. Presumably, such instances in the lab are indicative of more pervasive misattunement or psychological unavailability in the child's natural environment.

In work consistent with recent research findings, Judith Solomon and Carol George (2011) have construed infant disorganization as resulting from a disabled caregiving system, including helplessness in the caregiver, which results in an abdication of care. They describe mothers of disorganized infants as being emotionally flooded and overwhelmed by feelings of inadequacy that impair their capacity to engage emotionally with their infant's distress and thereby to provide comfort. In addition, caregiving can be disabled by pervasive emotional constriction (e.g., as might occur with severe depression or emotional detachment), with the same result. I discussed the importance of the environmental context of caregiving earlier in this chapter (see section Environmental Influences on Caregiving), and it shouldn't be overlooked here. As Solomon and George contend, abdication of care is associated with assaults to the caregiving system, which can include perinatal loss of a previous child; parental psychiatric disorders and substance abuse; divorce; and living in a violent environment, including in the midst of terrorism or a war zone.

Notably, disorganized attachment appears to be the exception to the rule that infant genetic factors play a limited role in attachment behavior (Spangler 2011). Yet genetic factors exert their influence on disorganization in interaction with the caregiving environment. That is, some genetic anomalies appear to be risk factors in combination with unresponsive care; conversely, different genetic factors appear to be protective (i.e., lowering the risk of disorganization in the face of unresponsive care). In addition, the wider developmental context of care needs to be considered: as discussed next, the parent's history of trauma and loss can contribute to infant disorganization in an intergenerational process.

Disorganization in Adulthood

Analogous to their infants' disorganized behavior demonstrated in the Strange Situation, parents' disorganized thinking can be evident in the Adult Attachment Interview (Hesse 2008). Just as secure attachment is marked by narrative coherence in the interview, disorganized attachment is evident in narrative incoherence. Such disorganization is liable to occur when parents are invited to think and talk about their history of attachment trauma and loss. Such lapses in coherence may take the form of brief dissociative states, as the parent seems momentarily detached or disoriented, perhaps lost in the past. These interviews are coded as unresolved-disorganized (i.e., unresolved with respect to past trauma or loss). As little as a few sentences of disrupted coherence can lead the researcher to code the interview as unresolved-disorganized. Hence, as in infant classifications, the disorganized coding is assigned alongside the best-fitting organized classification (i.e., secure, preoccupied, or dismissing). Alternatively, some parental interviews are coded as "cannot classify" on the basis of intermingling of contradictory patterns (e.g., dismissing and preoccupied) or pervasive incoherence that renders interviews relatively incomprehensible. Like the unresolved-disorganized classification, these unclassifiable interviews are predictive of infant disorganization.

Many studies have confirmed the relation between parents' unresolved trauma and loss as evident in the Adult Attachment Interview and infant disorganization in the Strange Situation (van IJzendoorn et al. 1999). As just noted, these parental interviews are coded on the basis of momentary disruptions in narrative coherence. However, Lyons-Ruth and colleagues (Melnick et al. 2008) also found more pervasive signs of disturbance in the interviews to be predictive of infant disorganization—that is, disturbance evident beyond discussions of trauma and loss. Recall that hostile-helpless parental behavior in the Strange Situation is associated with infant disorganization in that situation. These researchers found that hostile-helpless states of mind with respect to attachment in the adult interview also are associated with infant disorganization in the Strange Situation. These hostile-helpless states of mind reflect identifications with hostile or helpless childhood attachment figures, based on a history of traumatic attachment relationships. For example, persons in the hostile subtype might describe themselves as acting just like a terrorizing parent; those in the helpless subtype are likely to be more passive and fearful, identifying with a parent who was disengaged from the caregiving role.

All these findings are connected: the parents' hostile-helpless stance in the Adult Attachment Interview is related to their hostile-helpless interactions with their infants in the Strange Situation; in turn, these hostile-helpless interactions are related to infant disorganized behavior. This prototypical intergenerational pattern of unresolved-disorganized attachment is summarized in Table 1–7. Presumably, if these hostile-helpless states are evident in clinical interviews and laboratory observations, they also occur routinely in the natural environment, potentially pervasively disrupting the kind of attunement and communication needed for emotional support and secure attachment.

TABLE 1–7. Prototypical developmental pathway: unresolved-disorganized attachment

Parent's discussion of childhood attachment experience	Unresolved with respect to trauma or loss; shows momentary lapses in attention and dissociative states or alteration in consciousness; incoherent; unclassifiable
Parent's behavior with infant	Frightened/frightening behavior; dissociative states; hostile intrusiveness or fearful withdrawal; emotionally overwhelmed in response to infant's distress; disrupted communication; role confusion; disabled caregiving or abdication of care
Infant's behavior with parent	Fright without solution: fear; trancelike and dissociative states; disorientation; dramatically contradictory behavior
Developmental outcomes	In childhood, is controlling (punitive or caregiving) with parents; in adulthood, shows continuing disorganization or is vulnerable to dissociation and other psychiatric disorders

Impaired Mentalizing in Disorganized Attachment

With your thinking about mentalizing now well primed, I hope that you've been connecting the dots while reading about this research on disorganized attachment in parents and infants. To make the connections explicit, the disruption in narrative coherence in the Adult Attachment Interviews of parents whose infants become disorganized can be construed as evidence of impaired mentalizing (Fonagy et al. 1991b). For parents classified as unresolved-disorganized, mentalizing is compromised when the interview evokes a history of attachment trauma or loss. For those in the "cannot classify" category, mentalizing is more pervasively compromised during the interview inasmuch as they are unable to present a coherent picture of their attachment history. Similarly, hostile or helpless states of mind that pervade the interview exemplify impaired mentalizing. In all these instances, evoking memories and feelings associated with attachment derails mentalizing.

Paralleling what happens in the parent's interview, the infant's attachment needs expressed in Strange Situation reunions are liable to evoke distress in the parent (e.g., at the extreme, evoking memories of attachment trauma, such as neglect or abuse); hence, by evoking memories and feelings associated with past trauma, such interactions may undermine parental mentalizing, resulting in misattunement to the child's distress.

Such misattunement is evident in parents' frightening or frightened behavior, their hostile or helpless behavior, or their more pervasively disrupted emotional communication. In stark form, as Beebe and colleagues (2010) demonstrated, the parent may simply turn her attention away from her infant's distress. All such behavior is the antithesis of mindfully holding the infant's mind in mind.

Research supports the chain of reasoning I've just outlined. For example, Arietta Slade and colleagues (2005) directly assessed parents' capacities to mentalize their infant in the 90-minute Parent Development Interview. The interview covers the mother's perception of her infant; her experience of separations from her infant; her view of herself as a parent; and her understanding of the influence of her parents on her way of parenting. As anticipated, the researchers found that parental unresolved-disorganized attachment was associated with relatively poor mentalizing of the infant in the Parent Development Interview and, in turn, with infant disorganization in the Strange Situation. Moreover, poor maternal mentalizing in the interview also was associated with disrupted parent-infant communication in the Strange Situation, and disrupted communication was associated with infant disorganization (Grienenberger et al. 2005).

Disorganized attachment has two prominent adverse consequences. First, the infant is unable to find solace when distressed and thus experiences repeated emotional dysregulation—distress without respite. Second, because a person learns to mentalize by virtue of being mentalized, the disorganized infant's development of mentalizing capacity is compromised. Just as mentalizing begets mentalizing, nonmentalizing begets nonmentalizing. Accordingly, Fonagy and colleagues (2007) reviewed research showing multiple impairments in children's mentalizing in conjunction with a traumatic attachment history: difficulty appreciating what others are thinking and feeling, limited capacity to talk about mental states, difficulty understanding emotions, failure to empathize with other children's distress, and difficulty managing emotional distress. These mentalizing impairments can contribute to problems in a wide range of relationships—not only with parents, but also with siblings, peers, and teachers.

This research shows the sheer extent of the dual liability associated with early attachment trauma that I mentioned at the beginning of this section. The trauma evokes distress and undermines the development of capacities to regulate distress. Children learn to regulate distress through mentalizing interactions; moreover, they learn to identify what they feel through these interactions, setting the stage for them to manage feelings on their own as well as with the help of others. Without the capacity to

mentalize, they can be relatively helpless in regulating their distress. We easily imagine vicious circles in which impaired mentalizing contributes to interpersonal conflicts, interpersonal conflicts evoke distress, impaired emotion regulation escalates distress and conflicts, and so on.

Nonmentalizing Modes of Experience

Fonagy and colleagues (2002) delineated three prominent nonmentalizing modes of experience stemming from attachment trauma that lay the foundation for further developmental adversity. I will be referring back to these modes in later discussions of psychiatric disorders.

Psychic equivalence is the most fundamental failure of mentalizing: mental states are equated with reality. Dreaming is the prototype: the dreamer believes the dreamed events are really happening. Posttraumatic flashbacks are another example: a memory is experienced as a current reality—a "daymare" as one patient described it. Paranoid delusions also reflect psychic equivalence: the deluded individual is convinced of the truth of his beliefs, not considering that they could be false. He has no doubts that people really are conspiring against him. Understanding psychic equivalence helps one to understand mentalizing: the crux of mentalizing (and mindfulness) is awareness of the distinction between mental states and reality. Beliefs can be false, and feelings can be unwarranted. Mentalizing is fundamental in coping with traumatic flashbacks; people with posttraumatic stress disorder (PTSD) must learn to recognize that they are remembering trauma, not reliving it.

The *pretend* mode represents the opposite of psychic equivalence: rather than mental states being too real (i.e., equated with reality), they're too disconnected from reality. Dissociatively detached states have a pretend quality—and are commonly associated with trauma. At the extreme, these states are evident in feelings of unreality (e.g., feeling as if one were an actor in a play). Most commonly, the pretend mode is evident in the disconnection between thoughts and feelings; conversation in the pretend mode carries no emotional weight or conviction. Thus, functioning in the pretend mode is a significant threat to psychotherapy in that the illusion of collaboration is maintained without any serious work being done. For example, the pretend mode is evident in speech riddled with clichés or psychobabble.

In the *teleological* mode, action replaces thought and emotion; that is, goal-directed behavior takes the place of experiencing and expressing mental states. Accordingly, impulses and emotions quickly lead to action, in effect bypassing deliberation, reflection, or even emotional awareness. In this mode, intense emotional distress is not mentalized but rather is directly expressed in such behavior as substance abuse, nonsuicidal self-injury, bingeing or purging, sexual promiscuity, suicide attempts, and so forth. Such problematic behavior led Maria Holden, a postdoctoral fellow working with me, to propose the need for a *pause button* (Allen 2001), shorthand for the need to mentalize.

Developmental Impact of Disorganized Attachment

Like the organized patterns of attachment, disorganized attachment shows a mixture of stability and change in longitudinal studies. On the whole, with assessments in infancy and reassessments ranging from 1 month to 5 years later, researchers find substantial stability (van IJzendoorn et al. 1999). Moreover, long-term longitudinal studies reveal some continuity from disorganization in infancy to unresolved trauma in the Adult Attachment Interview administered in late adolescence (Main et al. 2005) and early adulthood (Sroufe et al. 2005).

Yet disorganization frequently changes in form by early childhood. Main and colleagues (2005) discovered that many children who showed disorganization in infancy develop an organized *controlling* pattern of interacting with their parents by early childhood. Moreover, their controlling behavior takes one of two forms. Some children become *punitive* in their interactions, perhaps ordering the parent around (e.g., "Sit down and shut up, and keep your eyes closed!"), whereas others adopt a *caregiving* stance, becoming solicitous (e.g., "Are you tired, Mommy? Would you like to sit down and I'll bring you some [pretend] tea?") (p. 283). These controlling strategies in child-parent interactions belie the fact that these formerly disorganized children remain extremely anxious and insecure. For example, children who show this pattern give fearful responses to projective storytelling tests about separation experiences, which include catastrophic fantasies about injuries to the parents or the child.

Ellen Moss and colleagues (2011) found that controlling-punitive children are more disruptive and aggressive than their controlling-caregiving counterparts. They are more difficult to raise, and they perform more poorly in school. The controlling-caregiving children were more likely to have mothers who had suffered loss of an attachment figure during the child's early years, consistent with the child's developing a caregiving stance. Notably, although many disorganized infants develop a controlling strategy by early childhood, a substantial minority remains disorganized. Moss and colleagues' description of one such 4-year-old boy is noteworthy in suggesting dissociation. When reunited with his mother after a brief separation, the child made "bizarre, frightened, and self-

depreciative comments" and then "seemed to completely forget about this part of the conversation when his mother answered him back." Also, the child "seemed to experience abrupt changes of state evidenced by a sudden shift of affect and disruption in his discourse" (p. 64). These children showing ongoing disorganization tended to come from families with a high level of marital tension and, like the punitive group, showed especially high levels of behavioral and academic problems.

As these findings suggest, infant disorganization portends diverse developmental problems from childhood to adulthood (Lyons-Ruth and Jacobvitz 2008), especially when it occurs in combination with maltreatment (Melnick et al. 2008) and other developmental risk factors such as broader family adversity (Deklyen and Greenberg 2008). Worryingly, disorganization in infancy increases the likelihood of developing PTSD symptoms in response to trauma later in childhood (MacDonald et al. 2008). More generally, infant disorganization was the strongest predictor of global psychopathology at age 17½ in the Minnesota longitudinal study of attachment and adaptation across development (Sroufe et al. 2005). That study exemplifies a broad principle of crucial importance: maltreatment and infant disorganized attachment are *nonspecific risk factors* for a wide range of subsequent disturbances.

Further attesting to the presence of nonspecific risk associated with attachment trauma, continuing unresolved-disorganized attachment in adulthood, as measured by the Adult Attachment Interview, is associated with a wide range of concurrent disorders in adulthood. Combining findings from studies that included more than 4,200 participants, researchers found a strong relationship between adult disorganization and the likelihood of psychiatric disorder (van IJzendoorn and Bakermans-Kranenburg 2008). Disorganization was relatively uncommon in the nonclinical adolescent and adult participants (16.5% and 15%, respectively) and relatively high in the adult clinical sample (41%). These combined studies showed disorganization to be most strongly related to borderline personality disorder, suicidality, and PTSD in relation to a history of abuse.

One intriguing exception to the principle of nonspecific risk is that some instances of disorganized behavior in the Strange Situation have a dissociative quality, such as dazed, trancelike states or sudden eruptions of contradictory behavior. Notably, such infant behavior may mirror parents' dissociative states in the Adult Attachment Interview (e.g., bouts of confusion and disorientation, such as talking about deceased parents as if they were still living). With data from the Minnesota longitudinal study, Elizabeth Carlson (1998) found infant disorganization to be associated with dissociative and self-injurious behaviors in grade school and high school; moreover, disorganization in infancy related significantly to dissociative disturbance assessed by interviews and self-report questionnaires in late adolescence. This is truly remarkable developmental continuity.

Consistent with Carlson's findings, extensive evidence now shows that infant disorganization is associated with dissociative disturbance (Dozier et al. 2008). Most crucial to my view of attachment trauma, Lyons-Ruth and colleagues (Melnick et al. 2008) proposed specifically that chronically disrupted communication and lack of caregiver responsiveness might be *more* predictive of later dissociative disturbance than is outright abuse. If one thinks of dissociation as disconnection—disconnection from the self and disconnection from others—and thinks of mentalizing as psychological glue for attachment with others and with oneself, then the research findings make sense: disconnection begets disconnection. To reiterate, the feeling of disconnection—at the extreme, invisibility—lies at the heart of attachment trauma. Dissociative disturbance is a dramatic instance of this pervasive experience.

Synthesis

In his wonderfully integrative book *Polarities of Experience*, Sidney Blatt articulated a developmental framework that puts the attachment research I've reviewed in this chapter into broader perspective. As Blatt (2008) explained,

> Every person throughout life confronts two fundamental psychological developmental challenges: (a) to establish and maintain reciprocal, meaningful, and personally satisfying interpersonal relationships and (b) to establish and maintain a coherent, realistic, differentiated, integrated, essentially positive sense of self. . . . The articulation of these two most fundamental of psychological dimensions—the development of interpersonal *relatedness* and of *self-definition*—provides a comprehensive theoretical matrix that facilitates the integration of concepts of personality development, personality organization, psychopathology, and mechanisms of therapeutic change into a unified model. (p. 3, emphasis added)

I find downright elegant the correspondence between Blatt's (2008) contrast of relatedness and self-definition, on the one hand, and Bowlby and Ainsworth's concepts of the safe haven and secure base, on the other hand. Thus, as the safe haven provides a secure base for exploration, Bowlby and Ainsworth ingeniously showed how relatedness fosters self-definition. Similarly, in their work on the complex mirroring process through which children learn what they feel, Fonagy and colleagues (2002) showed how relatedness promotes self-definition. Conversely, as Blatt argues, self-definition promotes relatedness; relationships are pred-

icated on two individualities coming together. Beginning in infancy, relationships and self-definition are forged from oscillating patterns of engagement and disengagement—being together and being on one's own.

In my mind, secure attachment relationships have an accordion-like quality; we oscillate between closeness and distance while remaining connected. Our capacity to mentalize—encompassing self-awareness and awareness of others—maintains our sense of separateness while keeping us related (i.e., as we hold mind in mind). Mindful that we must view attachment through the dual lenses of science and ethics, I was captivated by the book *Virtue Ethics* by New Zealand philosopher Christine Swanton (2003). Swanton referred to nineteenth-century German philosopher Immanuel Kant's differentiation of two grand moral forces: love and respect. Kant viewed love as coming close—no surprise there. Less intuitively, Kant viewed respect as maintaining distance. Thus, respect entails keeping one's distance in the sense of giving the other person space and supporting autonomy. Failures of respect are evident in being controlling, possessive, intrusive, and demeaning. Kant contended that in any good relationship, these two moral forces must be kept in balance. Love and respect maintain each other: the secure base of relatedness supports autonomy, and granting autonomy is crucial to maintaining healthy relatedness. As attachment theory shows, possessiveness (as in ambivalent attachment) undermines relationships, as does excessive distance (as in avoidant attachment). Plainly, from this perspective, attachment trauma in the most extreme form of neglect and abuse exemplifies our most glaring—and all too common—moral failure: neglect is a failure of love, and abuse is a failure of respect.

Just as secure attachment maps onto an optimal balance between relatedness and self-definition (love and respect), insecure attachment patterns map onto imbalance. As diagrammed in Figure 1–3, ambivalent attachment reflects preoccupation with relatedness to the exclusion of self-definition and autonomy; conversely, avoidant attachment entails dismissing of relatedness with an overemphasis on self-definition and autonomy. Lastly, disorganized or fearful attachment entails a failure to establish relatedness coupled with a failure to sustain self-definition and autonomy, leaving the person alone in distress and unable to manage.

With Patrick Luyten and others, Blatt made a strong case that we therapists should view psychiatric disturbance from a developmental perspective and that we should approach treatment from a person-centered rather than a disorder-centered perspective (Luyten et al. 2008). But reformulating our understanding of psychiatric disturbance remains a work in progress, and meanwhile we cannot discard the lens of psychiatric diagnoses, nor can we afford to ignore everything we have learned from dis-

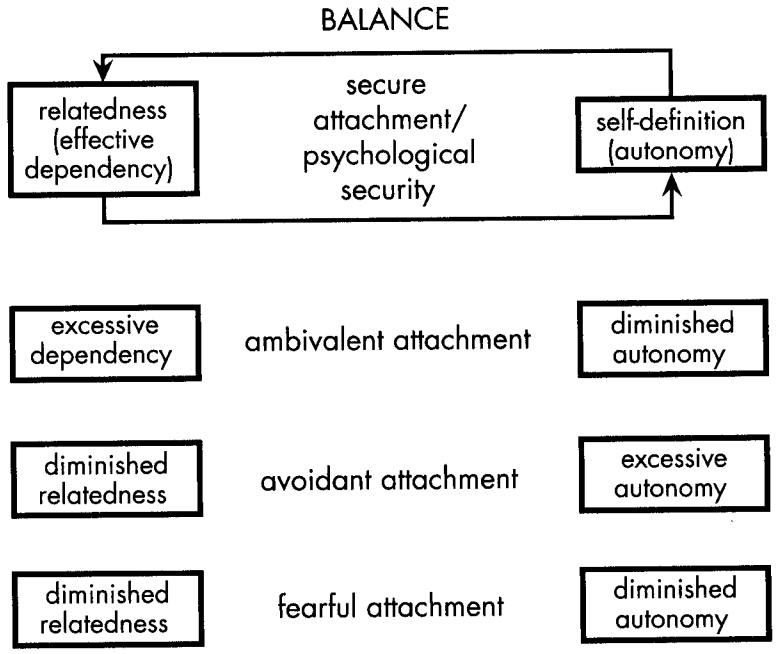

FIGURE 1–3. Relatedness, self-definition, and attachment categories.

order-centered treatments. Accordingly, I review these trauma-related disorders and treatments in the next few chapters, while keeping in mind what we've learned about relatedness and self-definition, secure and insecure attachment, and mentalizing and mindfulness. To reassert the ethical perspective, we must strive to overcome attachment trauma by creating relationships that embody a balance of love and respect. These two great moral forces, exemplified in relatedness and autonomy, form the ethical foundation for plain old therapy.

Key Points

- Attachment evolved not only to ensure physical protection but also to provide a feeling of security. Secure attachment is the foundation of emotion regulation. In providing a safe haven (for comfort) and a secure base (for exploration), secure attachment optimally balances the fundamental developmental dialectic of relatedness and autonomy; the securely attached child or adult is effectively dependent *and* independent.

- Attachment security and insecurity are maintained by internal working models of the self, the attachment figure, and the relationship. These internal models are based on patterns of infant-caregiver interactions and show a balance of stability and change over the lifetime. Secure attachment stems from the caregiver's consistent emotional responsiveness, and the typical patterns of insecure attachment are adaptive strategies to maintain attachment in the face of suboptimal care. For example, the avoidant pattern might entail deactivating attachment needs in the face of consistent rejection; the ambivalent pattern might entail hyperactivating attachment needs to elicit care in the face of inconsistent or unresponsive care.
- Parents' attachment proclivities are passed on to their children: extensive research demonstrates that a parent's state of mind in relation to his or her childhood attachments influences the parent's pattern of caregiving, which in turn influences the child's attachment pattern. This intergenerational pattern is influenced by the parent's mentalizing capacity; ideally, mentalizing begets mentalizing and attachment security.
- Attachment trauma stems from mentalizing failures: the child is left psychologically alone in unbearably painful emotional states. Abuse and neglect represent the extreme of attachment trauma, but less conspicuous disruptions of parenting, evident in hostility, helplessness, or disrupted emotional communication, also can lead to profoundly insecure (disorganized) attachment that carries a high risk of subsequent psychopathology. Such disabled caregiving stems from a failure of parental mentalizing, which also compromises the child's development of mentalizing. Hence, as mentalizing begets mentalizing (and attachment security), nonmentalizing begets nonmentalizing (and, potentially, profound insecurity).

CHAPTER 2

Posttraumatic Stress and Dissociative Disorders

This and the next two chapters cover psychiatric diagnoses related to trauma and specialized treatment approaches. In these three chapters, I'm juggling two perspectives. On the one hand, I intend to maintain the developmental, person-centered approach to understanding trauma-related disturbance established in the first chapter ("Attachment, Mentalizing, and Trauma"). This approach is consistent with my argument for the enduring value of plain old therapy. On the other hand, I want to make full use of the knowledge gained from research on trauma-related psychiatric disorders and the associated evidence-based treatments. As an advocate of plain old therapy, I am a generalist, but I'm keen to make use of whatever we generalists can learn from our specialist colleagues. As I hope to have exemplified in the first chapter, I believe that we generalists, like specialists, must ground our work in ongoing research evidence.

Yet I take a critical stance toward diagnoses, owing to the limitations associated with our efforts to categorize trauma-related disturbance. I want to dissuade people from taking diagnoses too seriously. And I want to dissuade them from the idea that we need to match a neatly tied box of symptoms to a tidy package of treatment interventions. As all clinicians who make diagnoses and patients who receive them know, symptoms are