The Man Without Words: Attachment Style as an Evolving Dynamic Process

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ABSTRACT. The following paper will use findings from attachment theory and its elaboration by Fonagy and Target to show how attachment findings are linked with intersubjective and relational treatment. These concepts will be applied to the clinical situation through a case vignette that examines the treatment with a patient who has an avoidant-fearful attachment style. The clinical vignette will detail the treatment process and show how, through the treatment relationship and process, an attachment style can change over time.

KEYWORDS. Attachment theory, intersubjectivity, relational treatment, avoidant-fearful attachment style

Relational and intersubjective theories provide a contemporary conceptual perspective from which to view intrapsychic structures, interpersonal patterns and therapeutic interactions. Current attachment research has added an empirical basis to our understanding of these developmen-
Attachment processes, and their implications for later character development and adult psychotherapy (Stern et al., 1998; Lichtenberg, Lachmann & Fosshage, 2003). Linking the findings from attachment research with relational and intersubjective treatment approaches can deepen our understanding of early developmental processes and their application to clinical practice with children and adults (Sable, 1992, 1995). While a great deal of empirical research was done on attachment patterns in children (Ainsworth, 1985; Fonagy, 2000; Main, 2000; Main & Goldwyn, 1991), clinical accounts that specifically concern the impact of client-therapist interactions on the client’s attachment style are still scarce (Travis, Binder, Bliwise & Horne-Moyer, 2001). This paper, therefore, will attempt to address this issue through a detailed description of the clinical process with a client who has a fearful-avoidant attachment style. In addition, the relevant findings in attachment research and their implications for personality development will be summarized. These will include Fonagy’s concept of mentalization, affective regulation, and the application of these concepts to practice with withdrawn and isolated clients.

**ATTACHMENT STYLES AND THEIR ROLE IN PERSONALITY DEVELOPMENT**

Attachment research has provided an empirical basis from which to understand the etiology of infant personality styles and behavior patterns based on early relational disruptions with caregivers, as well as the effect of these early attachment experiences on later adult personality and behavior (Main & Goldwyn, 1991). Attachment styles, however, can change and evolve over time depending on what new relational experiences are provided by caregivers and clinicians (Fonagy & Target, 2000). Thus the therapeutic relationship, through an intersubjective interchange that is both verbal and non-verbal, can supply affective and cognitive provisions that will optimally modify earlier insecure attachment styles. These interchanges may include particular facial expressions, tone of voice, smile, as well as the therapist’s ability to contain and/or help articulate the patient’s affects. Following is a short summary of attachment theory and its relationship to both historical and current psychoanalysis.

Bowlby (1969) was the first to observe children’s behavior in response to their mother’s temporary abandonment during WWII. Rather than looking at intrapsychic factors in development as did Freud (1940) and Klein (1948), he instead observed children’s behavioral patterns in response to attachment disruptions with their mothers,
such as separation and loss. Because of his emphasis on behavioral, rather than dynamic factors, Bowlby was marginalized by the psychoanalytic community. His collaborator, Ainsworth, elaborated on his theory through her empirical findings, thus moving attachment theory further away from clinical applications to behaviorism and empiricism (Mitchell, 2000). Ainsworth (1989, 1985) developed the experiment of the Strange Situation, and found three distinct attachment styles, which she attributed to the mother’s personality and parenting patterns. These attachment styles are what Ainsworth termed “secure”; “insecure-avoidant”; and “insecure-ambivalent.” Later on, Main (Main & Goldwyn, 1991) identified a disorganized attachment style and found that adult attachment patterns, assessed through the application of the adult attachment interview, closely corresponded to Ainsworth’s earlier identified attachment styles in children. Interestingly, however, Main found that what mattered in adult attachment styles was not particular childhood events, but the subject’s ability to maintain a coherent and organized narrative memory of childhood. This finding corresponded to emerging theories in psychoanalysis that emphasized “hermeneutics, constructivism and narrativity” (Mitchell, p. 85). In other words, corresponding to these findings in attachment research, psychoanalytic theories emphasize the patient’s ability to frame affective experiences cognitively through the capacity for insight and self-reflection. The capacity to reflect on internal experiences was further elaborated upon by Fonagy and Target, who coined the concept of “mentalization” (1998). These developments have opened new linkages between current intersubjective and relational theories and attachment research, as psychoanalytic concepts can now be validated through the growing field of infant studies and attachment research with adults (Fonagy et al., 2001).

MENTALIZATION AND THE THERAPEUTIC PROCESS

While Bowlby was mainly interested in behavioral observations, he started to develop a theory of the psychology of the mind, or what he called “internal working models.” These were akin to object relations theory and therefore linked to psychoanalytic thinking, in order to explain how attachment experiences become an internalized blueprint for future relationships. Fonagy and Target (1998) have continued to elaborate on this theory through their concept of mentalization, which describes how internal working models evolve into cognitive structures through which the child perceives the world, itself and self-other interactions. Mentalization also refers to affect regulation, a capacity that
can be learned through interactions with caregivers (or therapists) who mirror back the child’s affective states with a sense of “irony or pretend” (Fonagy, 2003). This process helps the child differentiate between internal and external, self and other affective states, reality and fantasy. The capacity to mentalize, however, is disrupted when the child does not experience mirroring, empathy, and validation from significant others. Fonagy’s theory, based on careful empirical research, closely ties psychodynamic treatment approaches to attachment research findings. Self psychology emphasizes the process of repairing emotional deficits through empathy and mirroring. Intersubjective theory elaborates on the reciprocal interchange between patient and therapist which contributes to the development of cognitive and affective structures and the ability to recognize the feelings and needs of others.

Using empirical research, Fonagy (1998) found that 46% of infants who were characterized as insecure failed a test that required them to identify a character’s feelings, based on their knowledge of the character’s beliefs (p. 273). Children with insecure attachment fail to perceive the mother’s own desires, needs and feelings as separate from their own, or to assess her interest in them as individuals. This empirical study seems to validate Benjamin’s concept of mutual recognition between child and caregiver as a maturational achievement that contributes greatly to the child’s developmental process (Benjamin, 1994). In fact, Benjamin states that the child’s (or patient’s) ability to recognize its mother (or their therapist) as a separate being with her own needs and limitations indicates the child’s development of a sense of self. Thus the self develops within an intersubjective context. In the context of relational treatment, the child’s cognitive and affective functions can be enhanced through the intersubjective matrix between client and therapist in a process of self and mutual regulation, and through the working through of old relational paradigms that may be enacted within the treatment, as will be illustrated in the case vignette. From a self psychological point of view, the therapist can meet the client’s emotional needs and help him/her to consolidate a cohesive sense of self through mirroring and empathic attunement (Kohut, 1977).

**AVOIDANT ATTACHMENT STYLE**

Avoidant children, whose caretakers tend to be dismissive and to ignore their needs, seem to respond by hiding their distress while still experiencing it internally. This was found through the measurement of avoidant children’s physiological arousal in response to the mother’s
apparent abandonment (Spangler & Grossman, 1993). Interestingly, Lyons-Ruth (2003) found that the mothers of insecurely attached children had a higher than average incidence of depression and other mental disorders. Avoidant children seem to internalize their caregiver’s defense, rather than their own emotional experience, a process that leads to the development of a “false self” so that they can still maintain a semblance of a bond with their caregivers (Winnicott, 1969). Thus, they learn early on to shield themselves from their emotional states and their insecure attachment impinges on autonomy, self-esteem, and other dimensions of self-development. Finally, a dismissive parent does not mirror back the child’s affective state for a variety of reasons, making it difficult for the child to move on to the more complex task of learning to maintain appropriate boundaries, as well as to learn to identify and express complex emotional states and communicate them to others (Fonagy & Target, p. 278, 2000).

Lichtenberg, Lachmann and Fosshage (2002) note that while the avoidant parent may care for the child’s concrete needs such as food and clothing, they may show little sensitivity to the child’s affective signals and distress reactions. These authors suggest that, although these children can appear indifferent to their parents, they still have heightened levels of cortisol, suggesting high levels of anxiety and hypervigilance, which they use to track the closeness/distance they need to maintain from others. Their sense of self, therefore, becomes constricted and devoid of authentic inner life. More recently, researchers found two distinct avoidant styles: fearful and dismissing. Fearful attachment is characterized by a “negative view of self and others,” while “dismissing attachment is typified by a positive view of self and a negative view of others” (Travis et al., 2001, p. 150). In the clinical situation, dismissive attachments may be seen as narcissistic behavioral characteristics, while the fearful avoidant style coincides with a schizoid-like behavior. The therapist, therefore, needs to carefully construct a “secure base” and then to track subtle non-verbal cues from these highly withdrawn, frequently inarticulate patients by helping them identify, articulate and assign meaningful narratives to their core feelings and experiences.

**APPLYING RELATIONAL AND INTERSUBJECTIVE CONCEPTS TO THE TREATMENT OF INSECURELY ATTACHED PATIENTS**

Intersubjective theories emerged from self-psychology, and emphasize mirroring and empathy as important therapeutic tools, along with
the use of moments of misattunement in the treatment process as opportunities for growth and maturation (Lichtenberg, Lachmann & Fossingham, 2002; Beebe & Lachmann, 2002). From an intersubjective point of view, there is a reciprocal interaction between client and therapist and a consequent pattern of relating that can serve as a new relational paradigm to help build healthier internal structures, thus helping to modify insecure attachment styles. Based on observations of caregiver-infant interactions, Stern et al. (1998) and Beebe and Lachmann (2002) examined the pre-verbal, pre-symbolic interactions in the therapeutic process. This is important especially with clients who have difficulty verbalizing and elaborating on their affective states, thoughts and life experiences. Thus gestures, space, eye contact, and tone of voice may become important signifiers in the treatment, and close observation of countertransference responses can provide a key to unverbalized enactments between client and clinician. From a relational point of view, it is important for the therapist to be aware not only of their subjective responses to the patient (countertransference), but also of the patient’s perception of their subjectivity towards them (Aron, 1991). Aron goes on to say that even in highly disturbed patients who are withdrawn, narcissistic or psychotic, there is a basis of truth in their observations of the therapist, not a fantasy of their own distorted reality. Frequently, however, these observations will be communicated nonverbally and indirectly, and consequently, he affirms, the therapist needs to be attuned to a complex array of signals from the client. The therapist, Aron suggests, needs to be open to and curious about the client’s perceptions and observations about them, rather than expecting transference distortions, the more classical notion in psychoanalysis. It is important for the therapist to make these relational dynamics conscious and to verbalize them within the treatment.

McLaughlin (1996) describes an unconscious enactment between therapist and client in which the client repeats past interactions with family, projecting fear, expectations and disappointment onto the therapist. These enactments are an attempt to repeat, in order to understand and resolve, problematic relationships in the client’s history. Attachment theory provides a useful framework in which to examine and observe these therapeutic interactions because it uses precise behavioral indicators.

In summary, both intersubjective and relational theorists suggest that the therapeutic situation can be seen as an arena, in which earlier attachment templates are played out via verbal or non-verbal means in a safe environment, where there is an opportunity for more successful attach-
ment styles to evolve. The following vignette illustrates the treatment process with a client who has a fearful-avoidant attachment style. It also demonstrates the gradual process of change in his view of self, in his relational style, and in his professional aspirations through reciprocal therapeutic interactions.

**CASE VIGNETTE**

Howie was a 47-year-old bicycle messenger. His job changed, however, when phone, fax and email cut down his assignments. He lived alone in a seedy hotel downtown, and attended a local community college. A talented draftsman, he had also been taking regular life-drawing classes at a well-known art school. His previous therapist, whom he saw for about two years, referred Howie to me. Howie reported that he simply needed someone to talk to.

The first time I saw Howie he was messy and bedraggled, his clothes old and wrinkled, and his gray hair wild and unruly. His behavior as well as his name made me think of him as an overgrown child. Howie glanced at me shyly and furtively, and spoke in monosyllables. He laconically described his previous therapist as “nice”, but cool and distant, but reported that he was disproportionately sad when she left and surprised to find himself crying during their last session. She was the only person that he regularly spoke with until he met me.

I learned that Howie had lived an almost completely isolated life. His parents died a number of years ago and since their deaths, he had infrequent contacts with his younger brother, who lived in a nearby state. He had never had a romantic relationship or even a friendship. After his parents died, their house was sold and he moved to a tiny room in the rundown hotel, where he had lived ever since. Despite his age, Howie seemed to be psychologically and socially immature. He did not know how to interact with others, and felt fearful, tongue tied and anxious in social situations, preferring to spend most of his time alone.

I eventually found out from Howie that his father had been extremely critical and disappointed in him, preferring his brother, whom he took on camping trips and invited to his carpentry workshop. Howie’s mother had provided for his physical needs, but had been either critical or disinterested in him. I later speculated that she might have been depressed, and thus emotionally unavailable to Howie, a common phenomenon among children with an insecure attachment style (Lyons-Ruth, 2003). As long as he could remember, Howie felt different from every-
body else. He didn’t fit in in school, and had been bullied by the local boys for his strange behavior and immaturity. He was diagnosed in school as having a learning disability. I felt, however, that this diagnosis was based on Howard’s poor social and communication skills and his immature presentation, rather than reflecting his talents and considerable intelligence. Following his mother’s death, the last genuinely personal bond in Howie’s life was severed.

Without his saying so, I could sense Howie’s deep loneliness and longing for human contact, which were buried under his fear and overwhelming anxiety. I felt as if Howie had forgotten, or perhaps had never learned how to use words to communicate his emotional needs and feelings because he had experienced such limited meaningful human contact throughout his life. One of my therapeutic tasks, therefore, was to model words and phrases to help describe his internal and relational experiences. Howie’s thwarted attempts at closeness had resulted in his withdrawal into a shell of deep isolation, but the fact that he invariably showed up on time and didn’t miss a session was a strong indication to me that despite his fears, he longed for friendship and connection. Our work together included building a safe, consistent intersubjective space. I provided Howie with the language to describe his experience and often advised him about his day-to-day concerns. Gradually, I started to encourage him to examine his deeply buried feelings of anger, grief and loss.

While Howie did not often refer to his mother, it was clear that his memory of her had a deep effect on his internal life. Initially, Howie was unable to speak of her beyond the most mundane details, such as her preparing and cooking his meals. Whenever he was asked to talk about their relationship in greater depth, he would start to cry and, like a small child, threaten to leave if we continued to pursue the subject. It seemed that he still found her loss both too traumatic to integrate as well as deeply disorganizing. It seemed clear to me that he had never mourned his mother fully, and I felt that we needed to work at building a “safe base” so that he could do so openly. About a year later, as we were again discussing the loss of his therapist and his unexpected, intense grief, I wondered aloud if the loss of his therapist had reminded Howie of his mother’s death. Howie started to weep uncontrollably, but this time he was able to experience and express his grief. He shared with me that he still missed his mother deeply, and that he felt especially sad because he had never told her he loved her.

After this session, Howie seemed to change. He became more expressive, and with my encouragement, more able to articulate his need.
for more intimacy and connection. As we continued to examine his relationship with his mother, he started to express feelings of ambivalence; affection mixed with resentment for her lack of understanding and disinterest, her frequent impatience, and her general gruffness with him. In addition, he felt both angry and sad that his father preferred his brother’s company to his. Howard’s growing ability to feel secure enough to experience and articulate an increasingly complex and ambivalent array of feelings towards his family spilled over into our relationship as well.

I would like to present myself here as a consistently patient, empathic and caring therapist, but to be truthful, I occasionally felt impatient, irritated and resentful during our sessions, especially at the beginning. Howie would frequently sit silently throughout the session, passively, it seemed to me, waiting to be asked questions, and dutifully telling me the most minute details of his daily life. He would report, for example, what he ate and how well he slept the previous night. I found myself in the role of a mother to a young child who recognizes mother as the source of nourishment and protection, but not as a person in her own right. Mutual recognition, in Benjamin’s terms, had not yet occurred. I resigned myself to the idea that Howie was one of those clients who would be coming to see me for a long, long time without evidencing much progress or change. To my additional irritation, he was never late, never missed a session, and seemed to exude a wordless, childish neediness and dependency on me. This negative countertransference was mixed with my deep feelings of empathy for his pain, loss, and intense loneliness. I knew that I was the only person Howie spoke to on a consistent basis. I reflected later that my impatience and irritation, and Howie’s subsequent withdrawals were an obvious reenactment of his early interactions with his mother.

As he gained inner security and confidence, Howie was eventually able to trust our relationship enough to express his perceptions of my own behavior. Finally, he started to perceive me as a person with my own needs and limitations, and to risk my rejection and potential retaliation. He accurately commented once that at times I seemed impatient and inattentive to him, and added that sometimes he wondered whether I wanted to “get rid of him” and to end our sessions early. Instead of rejection from me, his comment effected a more open and spontaneous dialogue between us, and I started to feel invigorated and more fully engaged in our therapeutic process. I admitted to Howie that although I liked him a great deal and often enjoyed our sessions, I frequently found myself wanting him to take the initiative and to become bolder and more expressive during our sessions. Howie seemed both surprised and
pleased that I expected so much more from him. He became more active in our sessions, introducing new material and demanding greater engagement, not only from me but also from others in his life. He recalled, for example, that he had experienced condescension and impatience from his younger brother, who had treated him like a child, cutting their conversations short, waiting for him to beg before doling out his inheritance money, and hardly spending any significant time with him. Howie subsequently decided to ask his brother for a meeting, and requested a more equitable financial arrangement and regular communication between them.

Along with his relational development, Howard’s aspirations grew as well. He took up photography and taught himself to develop his own negatives. With a new portfolio and excellent grades, he applied for and was accepted to a good university outside the city. At the age of 51, he had finally left his old life behind and started anew. For several years, I continued to receive occasional cards from him. One day I received a phone call. A male voice introduced himself as Howie’s new therapist. With Howard’s permission, his therapist proceeded to ask me a number of questions about him. For me, the transformation of Howie to Howard aptly conveyed his growth, his maturation, and his gradual shift towards a more secure attachment style.

**DISCUSSION**

Initially, attachment research has focused on the observation of infants’ and caregivers’ interactions. More recently, however, the implications for adult treatment have been elaborated upon by several authors (Beebe & Lachmann, 2002, Lichtenberg, Lachmann, & Fosshage, 2002, Stern et al., 1998). As a result of the collaboration between researchers and psychoanalytic clinicians, especially in the relational and intersubjective arenas, therapeutic process and outcomes can now be observed and studied more accurately. The application of findings from attachment research to psychodynamic treatment models has shown that early attachment styles can be modified based on clinical interventions and on the therapeutic relationship. Howard’s case shows how lifelong behavioral and personality structures can be changed. Change began by building a relatively secure, consistent therapeutic context. It continued with the working through of old transference countertransference paradigms, and by helping Howie to first identify
and then articulate and assign meanings to his pivotal experience of emotional abandonment and loss.

The use of concepts from attachment theory and research has also helped shift the emphasis in diagnosis and treatment from a medical model, which emphasizes individual diagnostic categories and pathology, to a more relational, ecological framework which considers the influence of family, society and the larger environment. This trend has become apparent in the DSM-IV-T-R, where a range of attachment disorders have been included and elaborated upon. Finally, current findings in attachment research and neuroscience suggest that the therapeutic relationship in itself, as a provider of safety and security (or a “secure base” in the words of John Bowlby) and as a change agent, plays a central role in the therapeutic process and outcome, and is the catalyst for other developmental achievements (Brandell & Ringel, 2004).

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