

## **Attachment Theory and Attachment-Based Therapy**

**Chris Purnell**

Published In  
Attachment and Human Survival  
Edited by M.Green and S.Scholes  
Karnac Books 2004

*June was becoming increasingly desperate to get through the checkout and get home. Her two year old son, Adam, sitting in the front of her supermarket trolley, was tired and irritable. He screamed in frustration as he struggled to free himself from the trolley seat, and held out his arms towards his mother demanding to be picked up.*

*There was little that she felt able to do to pacify him as struggled to pack her shopping into bags. She turned and smiled apologetically to the woman behind her in the queue in response to the disapproving gaze that was focused upon Adam. A man standing behind the woman visibly winced, his nerves jangling, as Adam let out another piercing shriek. June thrust payment for her shopping in the direction of the cashier with one hand as reached towards her son with the other in a further attempt to calm him. The cashier smiled sympathetically as she gave June the change for her shopping.*

*Thankfully, June put the money into her purse and wheeled the trolley out of the shop. Immediately she stopped and picked Adam, still screaming, out of his seat and held him. For a few moments he continued to scream as she spoke gently into his ear and held him to her, then he began to calm as the physical closeness and her words reached him through his protest. His crying reduced to a whimper as he snuggled against her, feeling reassured and comforted by the physical contact.*

*Within a further few moments Adam had stopped crying altogether, and only the occasional shudder of his body gave any evidence of his previous distress. June felt herself begin to calm as Adam settled. She sat down on a seat outside the shop and continued to simply hold him as he drifted off into sleep, and then gently carried him in one arm, whilst using the other to push the trolley toward her car in preparation for their journey home.*

Every reader of the above story about June and Adam will be able to relate to and locate oneself in it in some way. It is a story about Attachment, and this is something that is important to us all. The need for human beings to be attached to someone who can provide them with safety and reassurance when they are frightened, anxious or tired was first talked about by John Bowlby, the originator of Attachment Theory.

*Bowlby and others have contributed much to our understanding of the ways in which we form Attachments, and the consequences of Attachment experiences for our emotional development. Importantly, we seek safety and security throughout our lives, and the way in which we are able to obtain these conditions shapes our self-understanding and our relationships with others. In this chapter, we will review the variety of Attachment patterns that*

*early Attachment experiences generate, and consider how an understanding of these patterns helps both client and practitioner in a psychotherapeutic environment.*

## **Early Attachment Experiences and Attachment Patterns**

June and Adam had what Bowlby would have described as a Secure Attachment relationship, because as soon as she was able to do so she responded to the distress that was caused by Adam's fatigue by taking the time to comfort him. This enabled him to settle and go to sleep. It is the ability of a caregiver to respond in this way that forms the basis of a Secure Attachment. It would not have been sufficient for Adam if somebody else in that supermarket had tried to comfort him. He needed his mother because of the specific attachment bond that he had with her – she was the one that he depended upon as a caregiver.

June's response to Adam provided him with what Bowlby called a *Secure Base*. That is a sense of safety and security which would give him the confidence to explore and interact with the world in the knowledge that June was there to give him physical comfort and reassurance when he needed it.

This basic attachment need for a Secure Base is so strong that a child will always attempt to develop a bond with its caregivers (usually in the first instance its parents) regardless of how its caregivers respond to it. Where a caregiver fails to provide a secure base by responding sensitively to a child's attachment needs, then the child will adapt its behaviour and develop what Bowlby called an *Anxious Attachment*.

Let us imagine for a moment what might have happened had Adam's mother been one of the other women in the supermarket queue – the one who gazed with disapproval at Adam. It is probable that Adam would have learned from the earliest age that to cry when he was distressed would not gain him the comfort that he was seeking, but would more likely result in an experience of rejection. In order to maintain any contact with this woman as a caregiver, he would have had to learn to keep his distress under control. He would have learned that he could maintain contact with his mother, and avoid rejection, if he covered up his need to be comforted, reassured and to feel secure.

The Attachment relationship that he developed would be known as *Avoidant*; in the supermarket scenario he would appear as a well mannered child who in spite of being tired, sat quietly in the trolley. Instead of looking towards his mother for comfort, he might distract himself by playing with a package out of the shopping trolley or by simply focusing upon the surrounding activity in the supermarket. His mother might proudly tell people what a well behaved and undemanding child he was. And, this approval of him would encourage him to further develop his insular and self contained behaviour because this would help him maintain an Attachment relationship with his mother.

Another kind of Attachment relationship might have developed if Adam's caregiver had been the man in the supermarket queue who visibly winced when Adam screamed. If that had been the case, Adam might have developed another form of anxious attachment that is known as *Resistant*. Picture Adam in the queue with this caregiver: the child gets tired and irritable

and his father takes a biscuit out of the shopping trolley and gives it to him to pacify him. Adam, however, doesn't want a biscuit. He wants his father. And so, after a couple of nibbles he throws the biscuit on the floor and continues to protest. His father pats him on the head and tells him to hush. Adam, finding that he now has his father's attention cries even louder, demanding to be picked up.

In this scenario, the woman in the queue who gave the disapproving look makes a quiet comment to the person behind her about spoilt, ill-disciplined children. In the meantime Adam's father gets increasingly frantic, being intensely aware of the attention that the protest is creating, but feeling completely unable to appease his son. Finally, Adam's father reaches a point where the screams make him feel so desperate that he smacks his son's leg and tells him to stop screaming.

Having paid for the shopping, Adam's father leaves the supermarket and wheels the trolley holding his still screaming son, to the car. As he lifts him out of the trolley, Adam throws himself backwards away from his father who desperately bundles him, struggling and wailing, into his car seat. By the time they reach home Adam has screamed himself into an exhausted sleep.

The Resistant Attachment pattern portrayed in this scenario illustrates a caregiver that is inconsistent in his response to his child. He has no clear strategy for comforting his child. Because of this inconsistency or unpredictability the child becomes difficult to pacify when upset, because it never knows just how much attention it is likely to get, or how long it will last.

There is a third type of anxious attachment which might not be so readily identifiable in our supermarket scenario, but which along with the Attachment patterns described, has been clearly identified by developmental psychologists through a process known as the Infant Strange Situation (Ainsworth 1978).

This third type of anxious attachment develops out of a child's experiences of a caregiver who in one way or another frightens it. The source of the fear might be abusive behaviour or it might be simply that the caregiver acts in a frightening way because of, say, psychotic behaviour or substance abuse or alcoholism. In some instances the caregiver's frightening behaviour is born out of their own fearfulness in their relationship to the child. Whatever the cause, the child now experiences a dilemma - *how to maintain closeness and contact when the caregiver that it needs to be close to at times of fear or anxiety is also the source of its fear*. The observed behaviour of infants suggests that such a dilemma results in a collapse of any strategy to maintain proximity to a caregiver (Main & Hesse 1990), and a *Disorganised* Attachment relationship develops.

These various types of Attachment that grow out of our early experiences are not features of just childhood. They matter for the kinds of people we become. This is because Attachment experiences with caregivers lead a child to develop mental representations of how to deal with Attachment relationships. Bowlby called these Internal Working Models of Attachment (Bowlby 1989). Essentially an Internal Working Model is the child's mental blue print of how to handle present and future attachment relationships. For

example, Adam's internal working model of Attachment with June, his mother, was based upon the knowledge that when he cried she would respond by comforting and soothing him. His internal working model developed out of the many and repeated interactions with his mother over time. As Adam develops – and this is true for all children - his experiences of other Attachments either reinforce or modify the original working model. As we move through infancy and childhood, and into adulthood, our Internal Working Models become increasingly more complex and sophisticated.

## **Adult Attachments and the Process of Remembering**

Much has been learned about adult Attachment through the work of Mary Main, who developed the Adult Attachment Interview (AAI). What Main's research tells us is that for adults, Attachment experiences remain with us, and persist at the level of mental representations. (By this we mean the way in which attachment experiences have become registered in the mind). Furthermore, behaviours that relate to internal working models of attachment in children as described by Bowlby and Ainsworth, become increasingly complex and representational in the progression towards adulthood. (Main 1991)

The AAI is a method of evaluating attachment patterns through scoring the unconscious responses of adults to interview questions about their childhood. What the method demonstrates very clearly is that it is not traumatic or difficult relationships or events in themselves during childhood that dictate anxious Attachment patterns in adults, but rather the manner in which those experiences have been internalised as memories and states of mind.

Adults who are judged to be Secure are those who are able to give a structured and coherent account of their childhood, and who are able to speak about traumatic events in such a way as to demonstrate an ability to reflect upon them and put them into perspective. It is as though the ways in which these adults were responded to when they themselves were children, provided emotional protection from the worst of their childhood traumas and this contributed to their capacity to develop secure attachment relationships.

Adults with *anxious* Attachment patterns, on the other hand, are less able to narrate their childhood story in a coherent fashion. Using the AAI classifications, distinctive patterns emerge.

1. *Dismissing*. In this instance, in giving accounts of their childhood, adults minimise the relevance or importance of childhood experience; sometimes they claim to remember very little about the events of their childhood, or recount those events as normal. In some instances, the accounts that are given by *Dismissing* adults will be excessively brief, or they might contain idealisations, contradictions or unsupported statements. In the case of our supermarket scenario, it is very likely that the woman with the disapproving attitude toward Adam would prove to be Dismissing if she participated in the AAI.

2 *Pre-occupied*. Here, their accounts become very entangled and incoherent grammatically. Such adults are unable to bring their accounts of

childhood events to a coherent and concise conclusion. Sometimes Preoccupied adults appear to become angry or fearful when relating their experiences. Again, thinking about the supermarket scene, the man who winced when Adam screamed could quite likely be classed as Preoccupied if he were to take part in an AAI.

3 *Unresolved / disorganised.* In these cases, accounts particularly of traumatic events become subtly incoherent, through changes in discourse or lapses in reasoning. It is likely that what the AAI identifies is the *dissociative* mechanisms relating to trauma.

The AAI highlights relevance, consistency and coherence of an adult's account of childhood events, and also the capacity to reflect (Fonagy et al., 1997) upon the affective internal state that is generated by memories of these experiences. This reflective function is of immense importance in helping to explain why for example, a adult caregiver might be unable to adequately respond to the attachment needs of a child. It represents a capacity to know what it is that the child is communicating through an ability to reflect upon the internal affective state that the child's signals generate within the caregiver; the capacity to think about what one is thinking. The child's experience of being understood by its caregiver is key to the development of a secure base. Thus the child that develops an anxious attachment style is likely to have experienced a caregiver who is unable to tolerate the affect that its expressed attachment need generates inside them. The affect is therefore blocked or reacted to, rather than reflected upon and used to understand and respond to the child's own internal state. Picture the response of the Preoccupied father of the Resistantly attached Alex in the supermarket example, and how this man found it difficult to respond appropriately to his child's distress.

Similarly the Dismissing mother's inability to reflect upon Avoidant Adam's Attachment needs meant that he had to adapt by suppressing any outward sign of distress, and it easy to imagine how he in turn might learn not reflect upon his internal need for Attachment. .

The capacity of a person to think about what they are thinking will have bearing upon how they are able to engage in the process of psychotherapy. However, even where this reflective capacity is limited, psychotherapy can still be effective provided that the therapist has the ability to attune to the feelings that the person is expressing and in doing so provide them with the experience of a secure base.

Most readers are likely to be able to identify elements of themselves somewhere within the attachment patterns that have been described, and the research provides a rich framework of evidence-based theory that is of immense value in informing us of what can be effective in the clinical practice of psychotherapy.

### **Attachment-based Therapy**

The impact of Attachment experiences persist from childhood into adult life. However, whilst the Internal Working Models that are formed as a result of these experiences become more ingrained over time, they are open to revision and change in the light of later experiences. This was something that

Bowlby himself claimed, and it is a key principle of an Attachment-based approach to psychotherapy

The attachment classifications provide a helpful frame of reference for helping a psychotherapist to know how best to respond to people in a psychotherapeutic setting, and it is not necessary to go through a formal interview process and classify people in order to make use of the theory. Usually it is possible for an experienced therapist to get a 'feel' for an attachment pattern, partly from the person's use of narrative and also through the way in which they relate to their therapist and how they deal with their relationships generally.

John Bowlby (1988) identified five therapeutic tasks that need to be addressed when he talked about the clinical applications of Attachment theory:

If you were starting attachment-based psychotherapy, then the first of thing you would need is a secure base from which you could begin the self exploration that is an integral part of psychotherapy. This involves your therapist not only paying attention to making their consulting room a safe environment, but also being attuned and responsive to your *internal* need for a sense of safety and security. In order to respond to the latter need, it would be necessary for your therapist to have some insight into or understanding of your internal working model of attachment.

For example, in a similar way to an AAI account, a person with a Dismissing attachment pattern is likely to avoid going into too much detail about their childhood, claiming that it is irrelevant or unimportant, or saying that they do not remember much about it. They may also normalise their accounts of childhood events – ie. *'I can't say that my childhood was particularly happy, but then at the end of the day, what is happiness and how many people can truly say that they were happy?'* In a similar way they are likely minimise the importance of the therapy relationship and their need for it to provide them with a secure base. They would be inviting their therapist to collude with the notion that Attachments are unimportant, by accepting this view and not responding to their underlying Attachment need, and this simply reinforces their Internal Working Model which has been built upon the experience of their attachment needs being dismissed or ignored.

The therapist's skill in offering a secure base involves being able to recognise and respect their client's self-contained strategy for dealing with Attachment related situations, whilst also providing the possibility of a different and more secure attachment experience through therapy.

A clinical illustration of this was a Dismissing person who was dealing with trauma relating to a serious illness. He was handling this trauma in a very self contained and insular manner. Working with him in therapy involved sessions where there were prolonged periods of silence, where the therapist began to experience uncomfortable counter-transference feelings of ineffectiveness and helplessness in her apparent inability to form any meaningful contact with him. - Counter-transference refers to the process by which a therapist *exports* thoughts or feelings onto the client or into the relationship that exists between

them. Sometimes the therapist also *imports*, or picks up feelings or sensations that the client might be unconsciously communicating. (Southgate 1990)

The therapist's temptation was to give in to the apparent lack of progress and abandon further attempts to engage the client in therapy. However, what she actually did was to bring some of these feelings into the therapy by talking about how difficult the sessions sometimes felt, and wondering what these difficulties might be about.

This enabled the client to consider that the therapist might be capable of understanding and subsequently responding to his internal state of anxiety. This allowed him to open up and talk a little about his own feelings of helplessness in relation to his illness, and his fears around death and dying. What the therapist had managed to do was respond to rather than dismiss the client's need for a secure base and provide him with a sufficient sense of safety and reassurance for him to begin to talk about his fears.

In similar way a Preoccupied person will use their internal working model of attachment as a means of perceiving that attachments are inconsistent or unreliable. In therapy such a client might be anxious about their therapist's reliability or availability and continually test it through expressions of clinging anxiety, sometimes mixed with angry rejection. The therapist's attempts to provide the client with a sense of safety and reassurance is likely to be continually tested with further expressions of anxiety, and when the anxiety becomes too great it turns into criticism and rejection of the therapist.

For the therapist such behaviour can produce counter-transference feelings of exasperation and an impulse to reject the client, and of course to do so would simply serve to confirm the client's internal working model of attachments as inconsistent or unreliable. Again, the Preoccupied person's need is for a consistently containing response which will help him to experience something that more closely resembles a secure base.

People with Disorganised attachment patterns can often appear to have many of the features of the other anxious patterns, or they may on the surface appear to be Secure in attachment terms. The thing that they are likely to have in common is an experience of childhood trauma that was potentially overwhelming, and usually where significant attachment figures were the source of the trauma. As already described, this presents a child with the dilemma of how to maintain proximity to caregivers who are either frightening or frightened.

Longitudinal studies (Cassidy & Main 1988) have suggested that infants who display Disorganised behaviour in the Strange Situation procedure at one year old tend to develop controlling or compliant strategies for dealing with those that they are attached to by the time that they reach the age of six. This I would suggest, provides the basic template that many people with Unresolved / disorganised Attachments will use in a psychotherapy relationship.

Main (1994) refers to research which suggests that the lapses of reasoning and discourse, which are evident in Unresolved / disorganised adults through the AAI, are related to dissociation. This is a process of 'passive' coping (van der Kolk, van der Hart & Marmar 1996) where an individual will

psychologically disengage from an extreme threat or trauma from which there is no physical means of escape, and can take the form of simply 'spacing out', or in cases of severe trauma, Dissociative Identity Disorder (DID) which is sometimes also referred to as multiple personality.

The same attachment needs apply for people who have a history of severe trauma. Judith Herman (1992) proposes that people who have experienced prolonged and extreme trauma often suffer from what she describes as complex traumatic stress. She identifies the creation of safety as the first requirement for people who are to be treated for such traumatic disorders. In other words they need a secure base, and of course in some instances where there has been severe trauma this might on occasions involve making available the sanctuary of a specialist psychiatric unit. Unfortunately the experience of many survivors of such trauma is of periods of hospitalisation where misdiagnosis and inappropriate treatment of their condition has left them with a deep mistrust of the mental health system.

In Attachment-based psychotherapy, experiencing a secure base also involves having a therapist who is what psychoanalyst and author Alice Miller (1989) described as an enlightened witness. This is someone who will listen to and validate the person's story of their childhood. This is particularly important where there has been abuse and trauma, and where as Bowlby said, a child's thoughts and feelings have been 'disconfirmed' by caregivers who are unable to acknowledge the pain and hurt that their actions may have caused or their unresponsiveness may have exacerbated.

As one person put it:

*'I found that my therapy was so important because it was the one place where I could talk about how I felt about my past and know that my feelings would be completely understood. If spoke to close friends, for example, and told them how angry I felt with my father and the way in which I had been treated all my life they wouldn't understand why I was still so angry. They would say that I should put it all behind me and make efforts to mend the rift with my father, but I wasn't ready to do that. In fact I didn't, and still don't see that the onus is upon me to do this. My therapist was the one person that I could speak to who didn't make me feel that I was making a fuss about nothing and who allowed me to express how hurt I felt without being judgmental about it. Therapy was the only space that I had and without it I don't think that I could have managed to break free of my past.'*

Another important element of Attachment based psychotherapy is the facilitation of the process of mourning as the person works through the memories of experiences of loss during their life. Loss is represented not only by actual physical loss of Attachment figures but also the loss of the sort of childhood that might have been experienced had a secure attachment relationship been available.

Mourning is what Bowlby saw as nature's cure for loss. This involves a process of grieving whereby a whole range of feelings and emotions such as disbelief, anger, guilt, sadness are worked through as the loss is talked about and remembered. The whole purpose of mourning is to allow us to let go and move on. It is a natural process, and this it is why it is such an important part

of psychotherapy. This is an important point to emphasise because very often people who start therapy have never had the opportunity, or have never been given permission to grieve, and so they have minimised its importance.

Apart from providing the client with a secure base, Bowlby (1988) identified additional tasks to be addressed in therapy, which involve assisting a person to explore the way in which they engage in relationships with significant figures in their current life. Clients should also be encouraged to consider how their current feelings and expectations, perceptions and actions are influenced by events or situations that took place during childhood. These tasks very much involve helping a person to recognise and understand their own internal working models of Attachment, and to gain sufficient insight in order to be able to modify them.

A further crucial task is to explore the particular relationship between the therapist and the client. This is a key element within various modalities of psychotherapy, but from an Attachment perspective it involves making use of the therapy relationship as means of providing a person with a modified and more secure Attachment experience. It is about enabling them to use the therapy relationship to gain a glimpse of what is possible in terms of altered Attachment experiences, which open up the possibility of change in their wider relationships.

A clinical example of this was provided by a person with a Preoccupied Attachment pattern who was particularly anxious about an approaching 3 week break in therapy due to the therapist's holiday plans. The client expressed a great deal of concern and anxiety about how he was going to cope without his weekly psychotherapy sessions and in the weeks leading up to the break the client used the sessions to talk about his fear of being abandoned by the therapist.

No amount of reassurance by the therapist about his intention to return and not abandon the client could alleviate the fear. All that he could do was simply allow the client to express his anxiety and help him to understand it in terms of his internal working model and past attachment experiences.

As the break in therapy came closer, the client expressed reluctance to leave at the end of sessions and the therapist, understanding the protest that this represented, consistently interpreted the client's expression of anger and reassured him that he would see him as usual the following week. The therapist's holiday came and went, and therapy resumed.

The client told the therapist that even though the break had been difficult at times, it had been possible for him to alleviate some of his anxiety by reminding himself of the therapist's reassurances that he *would* return. He told the therapist that this was a new experience for him, and that through it he had gained a clearer understanding of what a secure Attachment might be like.

For the client to be able to hold the therapist in mind is important, but it is equally important to be able to let go in order to explore new situations and to develop and grow. Another person's description of his therapy provided a very clear illustration of how he experienced it as a secure base when he made the following observation:

*'I notice how I am able to leave you here in this room between our therapy sessions. In my previous therapy I found myself to be constantly thinking about my therapist at times when I was faced with situations that were difficult or worrying; it felt almost like an obsession in that I felt completely unable to let go of her. Now, even though I still have worries, I don't feel the same need to hang on to you when I am not here'.*

Given that Attachment behaviour is triggered by external and environmental factors and that the response to this is to seek safety and re-assurance, there are times when people who could be considered to be securely attached can still find the secure base that attachment-based psychotherapy offers helpful. Such times might be when a person is dealing with a serious illness either in herself or in a close relationship, or when a close relationship is under threat through some other form of conflict or separation.

Attachment theory not only provides a means of understanding and working with individuals in therapy, it also offers a framework for helping with difficulties within family and couple relationships.

John Byng-Hall (1991), a leading figure in the world of family therapy described how in stable adult attachment relationships there is what he referred to as a "complementary system" where, when there is a conflict of interests in a relationship, it is handled by one person (usually the stronger) giving way to the more vulnerable other's need for proximity or distance in a de-escalating cycle, even though the demands which the more vulnerable partner is making are unwelcome at the time.

Byng-Hall described a process of distance regulation in an unstable relationship between two people (a dyad) where there is what he calls an "approach / avoidance conflict". He referred to such relationships as 'too close / too far' systems. These systems represent anxious attachments and the nature of the care giving – care seeking relationships of the individuals involved:

**(In the relationship) "each sees the other as being as powerful, as or more powerful than, the self. Each then feels compelled to take very active measures to prevent the other from either approaching too close, or deserting altogether. If this does not seem to work then even greater efforts, on each participant's part, are felt to be needed to prevent the other from forcing an intolerable situation on an unwilling victim. There is then the possibility of a symmetrically escalating conflict, in which each move away or toward is resisted with increasing force."**

**(Byng-Hall 1991:209)**

What Byng-Hall gives us is a snap shot of the process that takes place in the various dyad relationships that are part of a close family system where anxious attachments exist, particularly relationships between couples, and parents and their children.

It is possible for couples who have anxious internal working models of Attachment to experience a relatively stable relationship because their attachment needs are complementary. For example a preoccupied partner may feel that their dependency needs are being adequately met by a dismissing partner, whose ability to accommodate such needs comes through

their own strategy of distancing from any potential personal anxiety. In other words, the dismissing partner finds it easier to focus upon the other person's preoccupied anxieties, because it enables them to avoid their own. Such a relationship can seem to work fine until something happens to disturb this equilibrium, often in the form of illness or loss. This intensifies a cycle of approach and avoidance, and leads to an escalation of conflict as the partners struggle to maintain a too close / too far relationship.

The diagram in Figure 1 demonstrates this process. It also illustrates what is sometimes seen happening to a client's closest Attachment relationship as they work through issues in therapy and experience increased dependency needs through activation of the mourning process. I think that it is sometimes important to point out to people who are planning to engage in therapy that the process which they are proposing to embark upon can seriously alter their anxious attachment relationships.

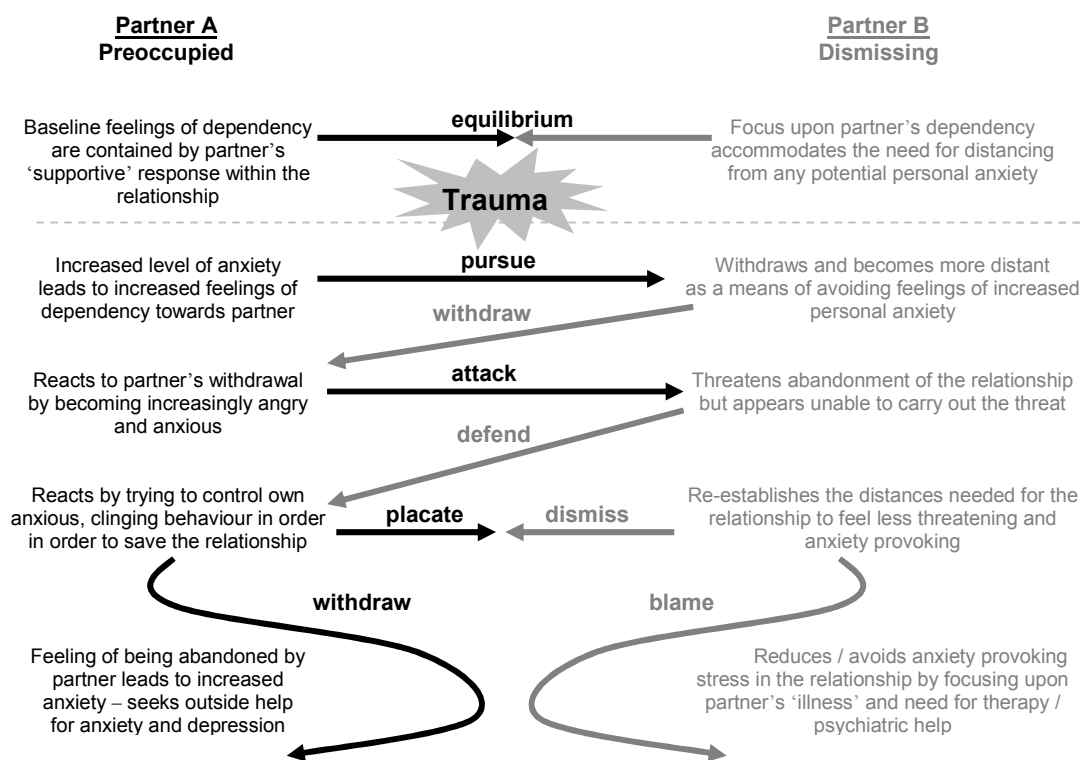


Figure 1

If it is possible to engage both partners in therapy, then an attachment focus can make it possible to work through the difficulties and alter the relationship to make it more secure.

Johnson's (1996) Emotionally Focused Therapy (EFT) emphasises the importance of focusing upon attachment needs in couple therapy, and describes how attending to the emotional content of a couple's relationship can be effective creating a secure connection between them. She points to the difference between primary and secondary emotion in couple's relationships, where the primary emotion represents the reactive response that partners perceive when they seek comfort, reassurance or a sense of safety in each other.

Such emotional responses might involve anger or rejection or distancing, which can produce similar counter responses in the other partner. The secondary emotion would be the unexpressed, underlying one and often represents the fear, vulnerability or feeling of helplessness that is experienced when faced with another's attachment needs, or when one's own needs remain unmet. Secondary emotions are usually the very ones that generate a need for secure attachment.

Sometimes couple's relationships deteriorate through critical moments when there has been a failure of one partner to respond adequately to the attachment needs of the other, and although these moments are important, the emphasis in EFT is to move from the content of those moments to an understanding of the *process* that takes place when attachment needs are expressed within the couple's relationship.

Once the process and the secondary emotions are understood it is possible for a couple use this new understanding to reshape the way in which they relate to one another. Thus for example, once a partner's dismissing, anxious or angry behaviour can be understood by both parties to represent an expression of an underlying sense of helplessness or fearfulness, it becomes more possible to find new ways of expressing and responding to the couple's attachment needs.

Johnson suggests that trauma survivors who have a close relationship with a partner can greatly benefit from couple work to improve their secure base. She points out that very often, where a close relationship exists, it is the arena within which repetitions of the trauma are played out, and it is also a primary focus for any potential change in terms of attachment experience:

**“a partner who understands the nature of the terror that takes over his or her spouse is often capable of more empathy than we or the survivor ever imagined possible. Not only that but a spouse or lover is there in the middle of the night when the dragon (the lasting effects of past trauma) comes, whereas the therapist, no matter how expert or empathic, is miles away. The fact that if partners are not part of the solution, they are, almost inevitably, part of the problem, is a cogent argument for couple interventions”.**

**(Johnson 2002:9)**

EFT has proven to be effective therapy where there is a desire by both partners to repair the relationship. Research (Johnson & Lebow: 2000) has indicated that in most cases, a successful outcome to therapy can be achieved in a relatively small number of EFT sessions, and there is little doubt that the success of this therapy owes at least as much to the evidence-base of Attachment research that informs it, as it does to the skills of the therapist.

### **Therapy across the life cycle**

There is little doubt that John Bowlby would have been gratified to see the extent to which his original contribution to our knowledge and understanding of the fundamental human need to be attached is continuing to have such an

increasingly important influence upon the way in which people can be helped by psychotherapy.

Attachment theory is something that most people can readily identify with and understand because it has relevance to everybody's life story - from the way which in we form relationships in our early years, through to how we choose and handle our close relationships in adulthood.

When we ourselves become parents, our previous attachment experiences have a great influence upon how we are able to relate to and nurture our children. Even in later years, attachment needs are important as we adjust to the changes and losses that are an integral part of the process of aging.

The stories that people bring to therapy are often about attachments that have failed or gone wrong. This is why, in the world of psychotherapy, attachment theory and research is continuing to gain increasing importance. It is a theory that helps our understanding of a fundamental human need that persists right across the life cycle – literally from cradle to grave.

## **References**

**Ainsworth, M.D.S., Blehar, M., Waters, E. & Wall, S. (1978) *Patterns of Attachment: A psychological Study of the Strange Situation*. Hillsdale, NJ: Erlbaum**

**Bowlby, J. (1989) *Attachment & Loss Vol. 1 - Attachment* Penguin Books: London**

**Bowlby, J. (1985) *Attachment & Loss Vol. 2 - Separation* Penguin Books: London**

**Bowlby, J. (1991) *Attachment & Loss Vol. 3 - Loss* Penguin Books: London**

**Bowlby, J. (1988) *A Secure Base* Tavistock/Routledge: London**

**Byng-Hall, J (1991) *The Application of Attachment Theory to Understanding and Treatment in Family Therapy* in *Attachment Across the Life Cycle*. Editors: Murray Parkes, Stevenson-Hinde and Marris. Routledge: London**

**Fonagy, P, Steele, M., Steele, H., & Target, M. (1997) *Reflective Functioning Manual, Version 4*. Psychoanalysis Unit, University College London**

- Herman, J.L.** (1992) *Trauma and Recovery*  
Basic Books: USA
- Johnson, S.M.** (1996) *Creating Connection: The Practice of Emotionally Focused Marital Therapy*  
Brunner / Mazel: New York
- Johnson, S.M.** (2002) *Emotionally Focused Couple Therapy with Trauma Survivors: Strengthening Attachment Bonds*  
The Guilford Press: New York London
- Johnson, S.M., Lebow, J.** (2000) *The "Coming of Age" of Couple Therapy: A Decade Review*  
Journal of Marital and Family Therapy, Vol.26 No1
- Main, M.** (1991) *Metacognitive Knowledge, Metacognitive monitoring, and Singular (Coherent) vs. Multiple (Incoherent) Model of Attachment in Attachment Across the Life Cycle.*  
Editors: Murray Parkes, Stevenson-Hinde and Marris.  
Routledge: London
- Main, M.** (1994) *A Move to the Level of Representation in the Study of Attachment Organisation: Implications for Psychoanalysis*  
Annual Research Lecture to the British Psycho-Analytic Society:  
London. July 1994
- Main, M., & Hesse, E.** (1990) *Parents' Unresolved Traumatic Experiences Are Related To Infant Disorganised Attachment Status: Is Frightening Behaviour the Linking Mechanism?* in *Attachment in the Pre school Years.*  
Editors: Greenberg, M.T., Cicchetti, D., Cummings, E.M.
- Main, M. & Cassidy J.** (1988) *Categories of Response to Reunion with Parent at Age 6: Predictable from Infant Attachment Classifications and Stable over a 1 Month Period*  
Developmental Psychology, 24, 1-12
- Miller, A.** (1989) *Thou Shalt Not Be Aware: Society's Betrayal of the Child*  
Pluto Press: London
- Southgate, J.** (1990) *Towards a Dictionary of Advocate Based Self Analysis*  
Journal of the Institute for Self Analysis, Volume 4 No 1
- van der Kolk, B.A., van der Hart, O., & Marmar, C.R** (1996) *Dissociation and Information Processing in Posttraumatic Stress Disorder* in *Traumatic Stress.*  
Editors: van der Kolk, McFarlane & Weisaeth  
Guilford Press: New York London