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Ten Clinical Uses of the Adult Attachment Interview

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The Adult Attachment Interview (AAI) is both a mainstay of attachment research and a uniquely valuable clinical tool. This chapter begins with an account of the emergence of AAI methodology, pointing to how it transformed attachment research and built new bridges between attachment theory and the domain of clinical work, which is where attachment theory began (see Bowlby, 1949, 1988). Each adult pattern of response to the AAI is briefly described, following an account of intergenerational patterns of attachment (Main, Kaplan, & Cassidy, 1985; van IJzendoorn, 1995), but we first review infant–parent patterns of attachment (Ainsworth, Blehar, Waters, & Wall, 1978), the initial empirical base of attachment theory. The chapter then concentrates on 10 suggestions we identify as valuable to clinical work, drawn from our reading and interpretation of the AAI protocol, coding system, and associated literature. We draw attention to the ways the AAI can help establish a therapeutic alliance, facilitate shared goals for therapeutic work, and serve as a source of understanding and motivation that facilitate the therapeutic process, measurement of progress and outcome.

Origins of the AAI Methodology

The AAI emerged in the developmental literature just as Bowlby (1988) was compiling his penultimate book, *A Secure Base: Clinical Applications of Attachment Theory.* A chapter in that book concerned the role of attachment

in personality development. In it, Bowlby showed his familiarity with the work of Mary Main and colleagues, who were documenting individuals' reported influences of childhood experiences on adult personality via administration and coding of an interview that probes *how* adolescents and adults think and feel about their childhood attachment experiences. That interview, the AAI (George, Kaplan, & Main, 1985), accompanied by a technical manual for rating and classifying adults' interview responses (Main, Goldwyn, & Hesse, 2003), has attracted widespread interest from clinical psychologists, psychiatrists, social workers, case workers, nurses, and other mental health professionals. This may be so because the AAI captures something at the core and central to emotional and social well-being, namely, the ability, or lack thereof, to show an organized, credible, and consistent valuing of attachment relationships. In study after study, when this capacity is inhibited or lacking, adverse mental health outcomes are likely to be found (see van IJzendoorn & Bakermans-Kranenburg, Chapter 3, this volume). In our view, this confirms the basic assumption of attachment theory; that is, if mental health is to be achieved and maintained, then one must have had either the benefit throughout childhood of being genuinely and consistently supported or have reached a level of understanding concerning self, others, and the importance of close relationships by participating in supportive partnerships or therapeutic contexts in the adolescent or adulthood years.

Indeed the AAI literature suggests that if an individual was not fortunate enough to have experienced sensitive parenting during childhood, then various compensatory pathways can be charted so that mental health comes to be achieved by way of the human capacity to seek out care, accept it, and in turn provide care in ways that were not previously familiar to the individual. These "ways" seem to involve interactions with a new relationship partner (e.g., a spouse) or a caregiving figure (e.g., a therapist) who helps one arrive at new understandings of old troubles, so that they are much less troubling (see Jacobvitz, Afterword, this volume). The language the respondent "chooses" to use in response to the AAI questions, and the ensuing rating and classification system assigned to the transcript, provides new understanding of these transformations (Main et al., 2003).

The first comprehensive report of the AAI was "Security in Infancy, Childhood, and Adulthood: A Move to the Level of Representation" (Main et al., 1985)—a publication whose influence is difficult to overstate. It has been cited well over 1,000[1] times in the published literature, which makes it, by any measure of the term, a citation classic. This publication not only caused a seismic shift in developmental attachment research but also served suddenly to make attachment theory and research of great interest to clinicians working with adults. In a short period of time following 1985, developmental attachment research was lifted beyond the level of individual differences in nonverbal behavior observed among infants in the Strange Situation (Ainsworth et al., 1978), into the representational world. Thus, moving attachment studies for the first time into the study of narrative discourse analysis, the AAI gave

attachment theory a radical fresh claim to being a lifespan phenomenon and—of the highest importance—opened the field to clinical work with adults. Thus, the fact that subjects of interest were no longer only infants or young children but adult parents is critical to understanding the burgeoning interest in the AAI among clinicians treating children, adults, and families.

This great shift occasioned by the AAI was foreshadowed and followed by a growing interest across diverse fields in the nature and influence of narratives, autobiographical memory, and meaning making. In psychoanalysis, a radical and fresh interpersonal perspective on the emergence of the self was being introduced (Stern, 1985). In developmental and cultural studies, reality itself, or rather what we take to be real, had come to be widely appreciated as a set of shared assumptions encoded, stored, and communicated via narrative processes (Berger & Luckmann, 1966; Bruner, 1991). And, in cognitive psychology, the self was discovered, or rediscovered, in conjunction with observations of memory in terms of narrative processes linked to the self memory system and autobiographical memory (e.g., Conway & Pleydell-Pearce, 2000). This interpersonal and social constructionist approach to the self was being celebrated in the psychotherapy literature in ways that reflected emergent findings from AAI research insofar as there was increased attention to the task of "meaning making" with regard to one's personal history. One inspired contributor to this cross-fertilization between developmental research and psychotherapy suggested that the AAI is a measure of "autobiographical competence" (Holmes, 1992, 1993).

Infant Patterns of Attachment

Mary Ainsworth, John Bowlby's partner in science for more than 40 years, established the initial empirical evidence base for attachment theory to which she also made conceptual contributions, most famously by highlighting the role of the parent as a "secure base" in the young child's life. Ainsworth's work included field studies, detailed observations of mothers and babies, first in Uganda (Ainsworth, 1967) and later in thousands of hours of home observations over the first year of life in a Baltimore (Maryland, United States) community sample (Ainsworth et al., 1978). In the process, Ainsworth trained a generation of attachment researchers who have gone on to make landmark contributions in their own right, perhaps the most notable of which being the "move to the level of representation" achieved with the development of the AAI (Main et al., 1985).

To appreciate the clinical significance of the AAI, it is necessary first to note the intergenerational patterns of attachment observed with this instrument (Main et al., 1985; van IJzendoorn, 1995), the individual differences in parental sensitivity that underpin infant–parent patterns of attachment (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003), and the infant behaviors that give rise to these patterns (Ainsworth et al., 1978; Main & Sol-

omon, 1990). Ainsworth conceived of the lab-based observation sequence known as the Strange Situation, aiming to extend her home-based observational study of attachment in the first year of life with a set of tasks that would activate the attachment system in an unfamiliar, out-of-home, "strange" setting (Ainsworth & Marvin, 1995). This attempt to see whether observing mother and baby in a stressful situation involving two brief separations and reunions across 20 minutes, *outside the home*, would relate to maternal behavior in the home proved to be a resounding success, leading to many hundreds of developmental research studies (from the 1970s through the present day) across the globe (van IJzendoorn & Sagi, 1999). These studies have documented the probable consequences of individual differences in infant attachment patterns on adult psychosocial development and personality functioning that typically followed with lawful (comprehensible) variations (Sroufe, Egeland, Carlson, & Collins, 2005).

Ainsworth and colleagues (1978) built on Bowlby's (1969/1982, 1973) premises about the biological basis of attachment and the importance of actual experiences with caregivers, highlighting the need to "stress" or activate the attachment system to study and measure it. By introducing the 1-year-old and his or her mother into a brightly decorated, toy-laden playroom, she aimed to activate the child's exploratory (or play/work) system. By engineering two separations of mother from child minutes later, she aimed to activate the attachment (love) system. With one system called into action, she anticipated, the other would (normally) recede. And so it was that the normal or securely attached child who played joyfully in the presence of the mother showed a diminishment of play and joy upon separation and then bounced back upon reunion. For such children (approximately 55–60% of children in community samples), home observations confirmed a history of sensitive responsiveness from the mother. But for other less than joyful children, avoidant behavior on reunion and often ineffective exploratory play behaviors predominated, and appeared to be used defensively to mask inner distress upon reunion (approximately 20–25% of community samples fit into this insecure–avoidant pattern). For these children, home observations confirmed a history of interfering or rejecting maternal behavior. For still other children who showed resistant/ambivalent behavior upon reunion, exploration was ineffective, and distress prevailed across the 20-minute sequence, peaking on reunion, when the child would not settle with the parent. The home observations confirmed an ineffective style of maternal behavior despite (as is always the case) good intentions (approximately 10–15% of community samples fit into this insecure–resistant pattern).

As Ainsworth and her colleagues (1978) observed, mothers of infants who would later be judged secure in the Strange Situation were able to manage feedings in a manner that responded to infant signals (e.g., adjusting the provision of bottled and solid foods in step with the infant's capacity to ingest). Feeding was in response to the infant's initiative by the mothers of secure infants (Ainsworth & Bell, 1969). In face-to-face interactions, some

mothers were able to regulate pacing skillfully to establish smooth turn taking and coordination with the children's initiatives (Blehar, Lieberman, & Ainsworth, 1977). Physical contact between secure infants and their mothers was marked by a gentle and tender style that made the contact pleasurable for both mothers and infants. By the end of infancy, infants who had experienced open communication marked by sensitive care were more effective in communicating with their mothers.

Against this background of Ainsworth's initial evidence, replicated many times (De Wolff & van IJzendoorn, 1997), it is easy to see how security of attachment in infancy represents a protective factor as children approach subsequent developmental challenges; similarly, a history of insensitive care over the first year is a risk factor, in terms of not only insecure attachment at 1 year, but also with respect to later development. In some, though obviously not all cases, continuity of attachment persists into adulthood, such that we speak of some adults who appear "continuously secure" in their AAIs, and others whose security seems "earned," such that their early attachment to both parents appears insecure but their current adult profile in the AAI is secure.

In a pioneering research development, roughly coincident with the invention of the AAI, Mary Main and colleagues discovered an important fourth category of response to the Strange Situation, that of *disorganization* (Main & Solomon, 1990). This term was applied to infants who did not fit easily into any of the three organized patterns identified by Mary Ainsworth. These babies showed a mix of strikingly divergent behaviors (avoidance and resistance) or an odd collapse into helpless or angry distress, and an overall disorganized/disoriented response in which "fright without a solution" seemed best to capture the child's circumstance (Main & Hesse, 1990). In clinical samples of infants whose mothers had chronic mental health troubles, drug addiction, or histories of abuse that remain unresolved, the disorganized/disoriented response was observed in 50–80% of cases (for a comprehensive review, see Lyons-Ruth & Jacobvitz, 1999). It seems most likely that infants who show this pronounced fear in the presence of the parent, as Bowlby would have predicted, have had the routine experience of being cared for by a parent who is *frightening* or *frightened* (Hesse & Main, 2000, 2006).

Intergenerational Patterns of Attachment Discovered via Development and Use of the AAI

The AAI correlates of infant patterns of attachment are well established (Main et al., 1985; van IJzendoorn, 1995) and increasingly well known: AAI coherence and security links with infant security; AAI incoherence involving dismissal links with infant insecurity of the avoidant kind; AAI incoherence involving preoccupation links with infant insecurity of the resistant kind; and, finally, unresolved mental states regarding experiences of loss or abuse link

with infant disorganization. The cumulative size of parent–child pairs studied as of some 13 years ago was 18 samples and 854[2] pairs (van IJzendoorn, 1995). The reported magnitude of statistically significant effects predicting insecure versus secure infant status was Cohen's $d = 1.06$. This large effect by conventional standards (Cohen, 1992) merits much attention, because very many psychopharmacological interventions to prevent adverse health outcomes are advanced on much weaker evidence. Importantly, with respect to primary prevention work, the statistical significance of this cross-generational association is as powerful when the AAI is administered to the pregnant mother prior to the birth of the child whose infant–parent attachment status is being compared to the AAI (Benoit & Parker, 1994; Fonagy, Steele, & Steele, 1991; Steele, Steele, & Fonagy, 1996; Ward & Carlson, 1995).

Understanding these impressive correlations across generations requires a leap across domains from preverbal behavior in the infant to the organization of language and discourse in the adult when responding to systematic questioning concerning one's attachment history and generally what happened during one's childhood and how one thinks and feels about it in the present. The AAI questions include asking the individual to provide five adjectives to describe one's childhood relationship with both the mother and the father, and to elaborate upon these adjectives with specific memories; and to describe separations, illnesses, what happened when one was upset as a child, any loss or trauma, why one thinks the parents behaved as they did; and so on. (See Main, Hesse, & Goldwyn, Chapter 2, this volume, for a detailed rationale of the content and sequence of questions.) It is helpful to appreciate that the AAI questions serve as an activation of the attachment system in the adolescent or adult respondent (see Dozier & Kobak, 1992) by taking the adult back, in his or her mind, to childhood and earlier life circumstances, when the attachment system was *previously* activated. Thus, the AAI can be seen in this light as a test of the extent to which one can remain balanced and coherent when thinking about previously occurring attachment-related events or circumstances that were emotionally upsetting, while showing understanding and/or valuing of the persons and relationships concerned.

One of the aims of the AAI is to "surprise the unconscious" (George et al., 1985) by posing in a calm but persistent way a series of questions that serve invariably to take the interviewee back to highly emotional events in early childhood that he or she will not ordinarily have discussed or reflected upon, and to which, in some cases, he or she may not even have conscious access. In our view, Main and colleagues (1985) had taken what we would call a cognitive-developmental approach to the unconscious, thinking of it as the part of the mind that stores early memories and associated emotions not typically available to awareness, yet exerting an influence on mind and behavior. They drew on what was then a widely accepted model of memory, and one utilized by Bowlby, that posited the now well-known and extensively researched distinction between semantic and episodic memory (Tulving, 1972, 1983).

The Secure–Autonomous AAI Pattern of Response

The assumption of Main and colleagues (1985) was that security of attachment in adulthood would be evident in the adult speaker whose semantic (evaluative) memories of childhood with mother or father (e.g., it was "good," "caring," "difficult," "challenging," "unpredictable") would fit credibly with episodic (sensory) memories of events in childhood. In other words, from a psychodynamic perspective, security of attachment in adulthood should be reflected in a coherent integration of preconscious and conscious layers of mind.

Perhaps Freud (1923) was overstating the value of our integrative functions, but he appears to have alluded to this goal of integration and coherence when he wrote about the goal of therapeutic work in terms of "where id was, there ego shall be" (Freud, 1923). From this Freudian perspective, AAI questions can be seen as designed to test the ego's flexibility and strength. From the attachment perspective of the Berkeley group who formulated the AAI questions, and their well-validated approach to scoring AAIs, the goal of the interview is *to estimate as well as possible* (noting Hesse's [1999] emphasis on how these estimates may well be in error) *the probable attachment-related experiences* (e.g., loving vs. several kinds of unloving experiences with the mother, with the father) that appear to have characterized the adult's childhood *and*, most importantly, *to identify* the adult's current state of mind regarding attachment, viewed as a strategy for organizing thoughts, feelings, and behavior.

Adults who have an organized and secure–autonomous state of mind concerning attachment, have childhood memories (whether favorable or unfavorable) that are readily accessible and contained, and they are capable of discussing them in a coherent, cooperative manner. Such a speaker is an individual who appears autonomous with respect to (i.e., relatively able to deal effectively with) invasive feelings concerning the past or unreasonable worries about the future. Interestingly, "living in the present" in this way is also consistently linked to a clear valuing of attachment (see Main et al., Chapter 2, this volume; Main et al., 2003) Speech and related appraisal processes in the present reflect an integration of, or a conceivably *undefended* border between, more and less conscious aspects of memory and mind. There are two broad types of adults with a less organized or insecure state of mind concerning attachment: (1) one that *defends against* conscious awareness of childhood attachment difficulties (the minimizing or dismissing stance) and (2) another that gives sustained and compulsive attention to, or *does not defend well against*, childhood attachment difficulties (the maximizing or preoccupied stance).

The considerable number of AAI security subgroups[3] designated F for secure–autonomous represent the range of positions a speaker can take *between* the insecure poles of dismissal and preoccupation. For example, on the border with insecure–dismissing, some secure speakers have set aside some attachment concerns regarding a harsh background (F1a) or one that provided limited opportunity (e.g., hard work, poverty) for attention to attach-

ment (F1b), or they humorously indicate some dismissal or restriction, all the while showing that they value attachment (F2). The mainstream, obviously "continuously secure" subtype (F3a) is distinguished from the "earned secure" subtype (F3b). Approaching the border with insecure–preoccupied attachment, some secure speakers show a mild preoccupation with attachment against a largely supportive background (F4a) or an unfortunate (loss) or traumatic background (F4b). Finally, there is the secure speaker who is nonetheless resentful and conflicted in some ways but accepting of continuing involvement with attachment (F5). All these secure subgroups share a relative lack of defensiveness, moderate to high coherence, and a clear valuing of attachment.

The Insecure–Dismissing AAI Pattern of Response

Insecure–dismissing interviews (designated Ds) suggest a speaker with firm or even rigid defenses aimed at keeping actual childhood attachment experiences of rejection or neglect out of conscious awareness or, at least, out of the AAI conversation with the interviewer, in both cases—we presume—to prevent the speaker from becoming upset and potentially disorganized. This latter group of interviewees refrain from disclosing information about their attachment history, so that it is hard to tell whether they can remember but choose not to, or they simply have no conscious access to their past. Commonly, dismissing interviews are evident from verbal insistence on difficulty with recall (e.g., "I just don't remember") or a normalizing of experience (e.g., "It was ok" or "They were loving. Don't all parents love their children?"), with little or no specific personal memories to support the suggestion of a normally loving experience. In addition, there is evident in some speakers' dismissing AAIs a marked claim of personal strength that presents the self as invulnerable to any adverse consequences of past attachment experiences.

Dismissing interviews typically take one of three forms being primarily idealizing (Ds1), usually accompanied by claims to lack of memory; derogating (Ds2), often accompanied by claims to personal strength; or restricted (Ds3), often involving a reasonably clear cognitive retelling of childhood difficulties in a way that is disconnected from the probable feelings linked to these difficulties. Note that in each form, attachment concerns are pushed aside, often accompanied by the speaker's insistence on lack of memory (e.g., "All is well" and "I don't remember," as well as "It was normal, just normal"), most typical of the idealizing (Ds1) subclassification. Other dismissing interviews (e.g., the Ds2 subclassification) include descriptions that deride or mock significant attachment relationships, such as an interview in which a sibling is described as having "looked silly" when she cried at their father's funeral. Some dismissing interviews, the emotionally restricted (Ds3) ones, are not notable for high indices of idealization or derogation, but are striking for the way limited difficulties are described, sometimes with limited anger but without indices of sadness, hurt, or vulnerability.

The Insecure–Preoccupied Pattern of AAI Response

In contrast to the dismissing pattern, in preoccupied interviews, designated E for enmeshed, the speaker at times appears to be flooded by emotion and unfavorable memories of childhood attachment experiences that seem to have led to, and may still leave the speaker with apparent feelings of being unloved, misunderstood, and hurt. Often, the interviewer feels a pronounced pull in preoccupied interviews to agree with or, in some cases, to help or assist the speaker's negative appraisal of attachment figures. Preoccupied interviews take one of three forms: passive (E1), angry (E2), or fearful (E3). In angrily preoccupied interviews, the speaker overwhelms the interviewer with incidents and details of parental offenses and cannot seem to get off of the topic and address the questions. In passively preoccupied interviews, the speaker may say little that is negative about the parents but seems to get lost in vague discourse usages (e.g., "dadadada" or "and this and that") and cannot stay on topic, perhaps moving into lengthy discussions of the past. In fearfully preoccupied interviews, frightening events are suddenly brought into the interview when they are not the topic, for example, when probed on how the mother was (as described) loving, the speaker may suddenly describe how a stepfather sprang out at her in the dark one night. Preoccupation is shown here—and indeed in the passive and angry subgroups—in that the speaker is too overwhelmed or focused on past events or past relationships to address the interview questions.

Unresolved with Respect to Past Loss or Trauma: Additional Responses to the AAI

Independent of the organized patterns of response to the AAI (dismissing, secure, preoccupied) and Strange Situation (avoidant, secure, resistant) that map on to one another so reliably, there is a remarkable link across generations in terms of attachment disorganization/disorientation (Hesse & Main, 2000; Lyons-Ruth & Jacobvitz, 1999; Main & Hesse, 1990; Main & Solomon, 1990). Parents whose speech about a past loss or trauma is markedly unresolved[4] in their AAI are likely to have infants who show pronounced albeit often subtle or inferred indices of fear with these unresolved parents in the Strange Situation. The various anomalous forms of infant behavior conveying this fear are well-specified in the reliable and well-known criteria for judging disorganization/disorientation (Main & Solomon, 1990), including simultaneous displays of contradictory behavior, anomalous posture or movements, trance-like stilling, and direct indices of fear, such as putting a hand to the mouth upon the parent's entrance. Among the possibly persistent long-term consequences of disorganized/disoriented attachments in infancy are severe disturbances in affect regulation, proneness to dissociation, and a propensity toward abuse and violence in intimate adult relationships (Carlson, 1998; Hesse & Main, 2000; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999; West & George, 1999).

Ten Clinical Uses of the AAI

Here we turn to the presentation of 10 distinct but related lessons for clinical work that follow from becoming familiar with the AAI questions and the scoring system we have provided, but for a fuller picture, see Hesse (1999; Main et al., Chapter 2, this volume).

1. Helping to Set the Agenda

The AAI carries many lessons for clinicians who approach their work in the belief that current symptoms, as Bowlby long ago suggested, derive from prior patterns of thought, feeling, and behavior acquired and reinforced in one's family of origin, and through later important relationships. The AAI questions (see Main et al., Chapter 2, this volume) serve as an alert to the patient that current troubles may possibly be based on childhood experiences, and ways of thinking, feeling, and behaving as a consequence of childhood experiences. This is most evident when an interviewee warms up slowly but steadily in the course of a 1-hour AAI experience, as is common in secure interviews that appear to serve as a welcome excuse to begin to examine the childhood roots of current adaptations and difficulties. These speakers show their competence in providing a coherent account of their childhood attachment history. In interviews that are more likely to be classified insecure, the AAI questions appear to be challenges with which speakers are often visibly ill at ease. Nonetheless, they will have been alerted to the relevance of these questions and topics to the interviewer or therapist. And for the clinician, the responses provide a thorough account of how the individual constructs his or her attachment story.

The set of 20 AAI questions resonates with some of the basic premises of John Bowlby's attachment theory, particularly his concern with separation and loss experiences. Just the experience of being asked the set of 20 questions communicates a message about the importance in the mind of the therapist or interviewer of what happened during childhood at times of upset, physical hurt, illness, separation, or rejection that *usually happen to everyone in childhood at one time or another.* Furthermore, the plain questions and follow-up queries around any possible experience of loss or abuse signal to the speaker that this interview cuts to the core of personal family experiences.

Asking the protocol questions can help to usher in the patient's belief that becoming involved in the therapeutic experience is about being with someone who is able to hear, believe, and understand a great range of difficult stories about family experience. For clients whose previous experience with the mental health profession has comprised being told that they qualify for one or more diagnostic labels with a presumed biological or genetic origin (that have been or are still being treated with medication), the AAI will be a surprising relief. "Here is someone," the client is likely to surmise, "willing to consider the possibility that some of the origins of my difficulties derive from my relationship history."

We have so far assumed that the interviewer will be a helping professional, in line with the suggestion from George and colleagues (1985) about ethical considerations involving the AAI with vulnerable populations. In our experience, this is both desirable and efficacious insofar as it helps to establish a shared agenda, and it often saves time that might otherwise have been spent unearthing slowly, if at all, vital secrets to understanding the adult's inner world and behavioral adaptations. In the context of parent–infant work, saving this time is all the more valuable (Steele & Baradon, 2004). With the AAI being conducted by the therapist, then, an agenda for therapeutic work can be established early and accurately, there is no "division of labor" (e.g., when a second person conducts the AAI), and the tasks of therapy may be tackled more quickly.

However, there are at least two reasons that a therapist may not desire to be the interviewer. First, when the AAI is to be used as a measure of outcome in a test–retest design, it is desirable for the therapist *not* to be influenced by the initial AAI, or knowledge of it, because he or she may be seen to "coach" the client toward a more secure response. Second, some clinicians may prefer to wait for personal details or "secrets" of the client's life to present themselves in the natural course of the therapeutic process, *not* in response to the demand characteristics of the AAI experience.

Thus, there are interesting considerations for the therapist contemplating inclusion of the AAI in clinical work, including if he or she, or a second clinically skilled person, will conduct the interview with a patient. In either case, going into the process with both eyes open and a familiarity with the AAI literature is vital. Relevant here is the requirement specified in the AAI protocol that before administering an interview, one should first of all *be* interviewed and obtain the practical experience of interviewing someone else. This affords the opportunity to experience firsthand the sense in which the AAI may "surprise the unconscious" or possibly activate the attachment system (see Dozier & Kobak, 1992). In addition, devoting some time to transcribing an interview[5] is highly instructive.

To sum up, if the AAI is to be used as a measure of outcome, the therapist should not administer the follow-up interview, and possibly should not be the one administering the initial interview. However, if the AAI is being used strictly as an adjunct to therapy, there is much to recommend that a therapist begin work as the AAI interviewer. Whether asked by the therapist or someone else in the clinical/research team, the AAI questions signal to the client that relationships are important—those in one's family of origin, those that comprise one's current life experience, and those that one imagines in the future. Thus, an AAI conducted at the beginning of a therapeutic relationship may help establish an agenda for meaningful clinical work.

2. Facilitating the Therapeutic Alliance and Responsiveness to Therapy

When the AAI is administered at the outset of therapy, it may be, for the patient, the first time anyone has taken the time to ask for and listen to a sus-

tained account of his or her family experience, and *current thoughts and feelings* about self and relationships. The experience of being interviewed is always powerful, and it can be a positive experience that mobilizes the interest and commitment of the patient to the therapeutic process. Although in some instances (e.g., a fragile mother displaying psychotic features) due caution should be heeded, the administration of an AAI is in almost all cases unlikely to compromise the therapeutic process. In our view, the AAI is to be administered early in treatment, perhaps most usefully at the second meeting, as it will do much to help establish the therapeutic alliance and launch a productive therapeutic exchange based on a background of trust and a shared agenda.

The aim when administering the interview is to adopt a neutral listening stance, which for some interviewers may mean toning down one's wish to be entirely empathic and helpful. This apparently neutral listening position is often helpful in establishing a therapeutic alliance. Within the psychoanalytic tradition is a long history of musing about the role of the other in the therapeutic context; however, suffice it to say, that an interested but reserved role on the part of the interviewer allows interviewees to have their attachment story unfold exactly as they choose (consciously and unconsciously) to construct it, without undue influence from the interviewer. The interview is a demanding venture for every participant, leading to a palpable level of anxiety in some respondents, yet the skilled interviewer's role is to ask questions and pose follow-up probes in a respectful manner.

This is an absolute necessity, even in the face of the clinician's understandable temptations to (1) "rescue" the interviewee (e.g., when long and sometimes uncomfortable silences ensue) or (2) make "connections" for the client in the middle of the interview, linking up disjointed elements of the narrative. The lesson of the need for assuming a neutral, quiet, listening stance, introduced in training interviewers in the AAI, can have positive, concomitant benefits for those training to become therapists in most clinical modalities. The vital point is to resist the temptation, natural to many clinicians, to weave together the pieces of a patient's narrative, to pose questions (all variants of "I wonder what comes to mind when you say that"), and to propose possible modes of integration ("This links up with what you said before"). All of these interventions are to be cast aside by the interviewer, who must stick faithfully to the AAI protocol, asking for further elaboration only at the specified infrequent turns (e.g., late in the interview, asking "Why did your parents behave the way they did during your childhood?").[6]

Adhering to this professional interviewing stance reaps rewards in terms of the investment or commitment of many clients in the ensuing therapeutic process. A number of studies have documented this effect of enhanced responsiveness to therapy, primarily for more coherent interviewees whose narratives are likely to be judged secure (see Heinicke & Levine, Chapter 4, this volume; Jacobvitz, Afterword, this volume; Korfmacher, Adam, Ogawa, & Egeland, 1997; Teti et al., Chapter 5, this volume).

It is important to emphasize that we see the AAI as an adjunct to clinical work, and not a therapeutic modality in its own right. As this book attests, the AAI may be deployed in the context of cognitive-behavioral exposure therapy (e.g., Stovall-McClough, Cloitre, & McClough, Chapter 13, this volume), just as it can be applied in psychoanalytic parent–infant therapy (Jones, Chapter 7, this volume; Baradon & Steele, Chapter 8, this volume), toddler–parent therapy (Toth, Rogosch, & Cicchetti, Chapter 6, this volume), or a home visit program (Heinicke & Levine and Teti et al., Chapters 4 and 5, respectively, this volume).

3. Uncovering Traumatic Experiences and Important Losses

Attention to how traumatic experiences, including losses, are discussed in an AAI, or in a therapy context, can be highly revealing as to the progress the client can achieve. Often, when loss or trauma experiences remain hidden, a patient's progress may be compromised. For example, there are instances when the AAI questions lead the speaker to reveal thoughts and feelings about a particular loss experience that sometimes surprise both the interviewer and the interviewee. In one interview conducted early in the context of parent–infant work, a client who was asked how she felt about her father's death was surprised by her own response. She confessed that no one had ever really asked her how she felt. In the moment of describing the traumatic loss, she realized that having been 13 years old at the time her father was murdered meant that she deeply had felt that everyone else's reaction within her family mattered much more than her own. Having to "bury" her feelings about this important loss had a tremendous hidden impact, much more than she or the rest of her family would ever have believed. The subject's response to the question ultimately played a crucial role in addressing the trauma and the way she came to acknowledge that her feelings about her father's death had contributed to her ongoing troubled relationship with her young son. Had the AAI not taken place, many therapeutic hours might have passed without this critical feature ever arising spontaneously. Looking back at people who have benefited most from therapy, and those who have failed to improve, suggests that lack of resolution of loss experiences likely impedes or prevents progress in therapy, whereas others without this confounding emotional burden may much more readily show marked improvement (e.g., Routh, Hill, Steele, Elliott, & Dewey, 1995).

Of paramount interest for the coder of the narrative responses to the AAI questions, especially with clinical participants, is to judge whether the subject discusses the loss or trauma in a way that leads a trained judge to classify the interview as unresolved. The complex criteria for making this decision are only possible to rate (on a 9-point scale, in which a score of 5 or higher leads to a U, or unresolved, classification) after very careful study of the written transcript. However, knowledge of the unique features of interviews that are ultimately classified as U are of clinical interest, especially because the unre-

solved classification has been shown to have a significant association (if not a causal link) to a range of types of psychopathology (see van IJzendoorn & Bakermans-Kranenburg, Chapter 3, this volume). And in the expansive epidemiological literature, early parental loss and prolonged separation experiences have been linked repeatedly to depression in the work initiated by Brown and Harris (1978) and, more recently, early parental loss has been implicated in the background of people with schizophrenia (Agid et al., 1999). Thus, even without an intimate familiarity with the criteria that identify lack of resolution of mourning, the AAI responses provide for the therapist valuable basic background information about the *occurrence* of loss and separation experiences that may figure prominently in a client's mind, and possibly trigger heritable dispositions toward mental illness.

The criteria for identifying and scoring unresolved mourning in an AAI (Hesse, 1999; Main et al., 2003; Main et al., Chapter 2, this volume), include subtle and discrete markers of how language conveys reliable clues to the ways that loss and trauma experiences may lead to clients' persistent irrational beliefs, deep fears, and pronounced disturbances of behavior. Becoming familiar with these criteria may prompt astute clinicians to listen to their clients' descriptions of loss and/or trauma in a different way. For example, the coder is required to monitor the extent to which the speaker shows clear signs of absorption—a phenomenon linked to normative forms of dissociation that is characteristic of unresolved mourning and linked to independent measures of this construct (see Hesse & van IJzendoorn, 1999). Another important indicator of unresolved trauma is seen when the subject shows lapses in speech (confusing statements about when a loss occurred that the client does not monitor or correct) or reasoning (referring to a dead person as having animate, live qualities). (Further description and examples are provided by Main et al., Chapter 2, this volume.)

With regard to rating lack of resolution of experiences of physical or sexual abuse, the trained coder looks for speech evidence indicating a client's unreasonable sense of having been culpable, such that the victim (self) is blamed for the actions of the victimizer; or that the abusive actions are denied or normalized in an interview that also includes clear acknowledgment of the abuse. Accordingly, the coder looks for signs that the speaker several times alternately affirms and denies being abused, or that he or she clearly does not consider the experience abusive (e.g., the unresolved speaker questions whether beatings that left welts were actually abuse, or having called an incident abusive then immediately denies that it was abusive, then a few minutes later calls it abusive again).

When unresolved mental states with respect to mourning or other trauma are evident in a AAI, there is good reason for the therapist to keep such problems in the zone of concern and find ways to help patients reorganize their thoughts and feelings around this experience, so that its pernicious grip is lessened. The therapist will be helped by the patient's probable awareness regarding any significant loss or trauma discussed at length (not just mentioned

occasionally, as in a slip) in the AAI. The nature of attachment is such that, once activated by AAI questions, memories and affects to do with loss and traumatic abuse experiences command attention and call upon emotional resources; here the therapeutic situation can easily be seen to provide an opportunity to advance the process of reorganization and resolution. In the most extreme cases of chronic abuse by attachment figures throughout a subject's entire childhood, a lack of resolution around abuse is all but inevitable in the context of a dissociative identity order (see Steele, 2003). Treatment in these cases can be supported by repeated administrations of the AAI at timely intervals to appraise the extent to which a subject moves toward integration. Such AAIs typically do not fit into any single classification but instead qualify for multiple classifications and also the "cannot classify" group (Hesse, 1996, 1999)—a topic that is discussed by Main and colleagues in Chapter 2, this volume.

Here, under the heading of "loss considerations," it is worthwhile to compare the fairly restrictive definition of loss in the AAI system to that applied widely in the clinical literature. In the AAI context, we are concerned exclusively with loss of a loved one, typically an attachment figure, close family member, or friend in contrast to the way attention to loss experiences pervades clinical work, including attention to loss of job, loss of house, loss of opportunity, loss of the idealized parents one imagined oneself to have as a young child, loss of meaning, and so on. There are theoretical reasons, and sound research advantages, to focusing on the loss of attachment figures or dependents (children). According to Bowlby (1973, 1979), these losses that represent the greatest threats to our survival and reproductive success are the hardest to come to terms with, and research has documented this to be so; even DSM-IV Axis IV, concerning the extent of stress in people's lives, notes that there is nothing more stressful for a child than the loss of parent, and for a parent, nothing is more stressful than the loss of a child. Correspondingly, when unresolved loss is noted in an AAI, it typically concerns a parent or other attachment figure. And, for clinicians, AAI criteria for judging whether a speaker's loss or trauma is unresolved may be usefully extended to how a patient speaks about other loss events in his or her life. In other words, listening to what the patient says about a wide range of threats and losses, using AAI criteria to determine unresolved mourning, may reveal much about what most troubles the patient.

4. Identifying the Range and Extent of a Patient's Reliance on Defensive Processes

Though the notion of defense mechanisms belongs to a psychoanalytic ego psychology perspective (after A. Freud, 1936) linked to Freud's theory of instinctual drives, and Bowlby unquestionably postulated an alternative and contrasting theory of human motivation, he did not throw out the baby with the bathwater. The "baby" for Bowlby was the notion of *defensive exclusion*,

understood in terms of the fervent work we do to keep from awareness any perceptions, feelings, and thoughts that would otherwise cause unbearable anxiety and psychological suffering.[7] For Bowlby, the vital cause of defensive exclusion in the child's mind includes all things a child "has been told, . . . has overheard, . . . and what he has observed but is not supposed to know" (Bowlby, 1979, p. 23) such as when a parent (whether maliciously or unwittingly) seeks to limit what a child remembers about a painful experience so that his or her construction will be (falsely) positive. At an unconscious level (Bowlby, 1988), outside of awareness, the "true" negative experiences and associated thoughts and feelings are nonetheless stored. Evidence of this process can be detected in AAI narratives, when a speaker claims that a relationship to the mother or father was "normal" or "loving," yet, when asked to think of memories that support this image, recalls events that strongly contradict the positive image. The trained AAI coder makes notes on the "state-of-mind" scale indexing "idealization of mother or father" (Main et al., 2003; Main et al., Chapter 2, this volume). This phenomenon is linked to "insistence on difficulties with recall," and both scales *lead one to think* of the overall insecure (and defensive) AAI pattern termed *dismissing of attachment*.

The rating of idealization is another example of the way the AAI rating and classification system can alert the clinician to aspects of individuals' descriptions of their attachment history that can otherwise, quite simply, be deceiving. In most cases (except those in which the speaker may be deliberately hiding his or her past and/or feelings from the interviewer), the patient him- or herself is deceived, driven by the defensive need to exclude awareness of painful events and feelings, as are others (occasionally clinicians) as well, into accepting the positive "cover" story as true enough. Here we draw on the data from our attachment representations and adoption outcome study, in which social workers, working without knowledge of applicants' AAIs, excluded from their list of potential adoptive parents those adults in the insecure–preoccupied group. We assume this to have been the case as our sample of adoptive parents included none with AAIs judged *preoccupied*. This compared to nearly 20% of adopters who were independently classified as insecure–dismissing (see Steele et al., Chapter 17, this volume). This, we argue, is likely because the obvious demonstration of insecurity in terms of high levels of anger or passive speech spilled over into the "normal," non-AAI screening process involving detailed meetings and observations. It would seem that adults who present their history through rose-colored lenses or idealizing terms, and put forward an upbeat and/or glowing description, albeit devoid of specific intimate relationship incidents, are harder to discern as belonging to the insecure group.

Another common state of mind in dismissing interviews concerns the devaluation of others via derogation (e.g., "Who needs him/father or her/mother—they don't matter!"). Interestingly, this pattern of AAI response is linked in clinical studies to problems with aggression and externalizing disorders (see van IJzendoorn & Bakermans-Kranenburg, Chapter 3, this volume).

We suggest that this is because the border in the mind—between an idealized and ultimately false view of self as positive, and the rival (unconscious but more accurate rendering of experience)—is zealously defended. Threats to it, even minor criticisms of the dismissing stance assumed by the self, are likely to be fought off vigorously. In Anna Freud's ego psychological terms, this dismissing AAI pattern would most likely be described in terms of *isolation of affect* and *identification with the aggressor.*

For the clinician who detects this defensive AAI profile at the beginning of therapy, it may be very useful to know about the potentially explosive rage that may be shown by patients in response to any attempts to breach the internal wall and reveal patients' hidden vulnerabilities. In social-cognitive terms, a dismissing/derogating AAI is likely to be a forewarning of overreliance on hostile attributional biases in social judgments. Whatever the therapeutic plan of action, great firmness and care are needed to promote a more balanced understanding of self and others. This message is most successfully delivered in the context of demonstrating an understanding that patients have good reasons (rooted in childhood experiences) to have held to their firm (idealizing or derogating) but ultimately restrictive and unhelpful beliefs.

In addition to these "cool" distancing strategies aimed at exclusion of implicit "hot" emotions are the opposing goals evident in some AAIs, in which strategies that seem to involve, as opposed to avoid, the interviewer are evident, as in AAIs judged insecure–preoccupied. Transcripts judged to be insecure–preoccupied typically take an *angry* or *passive* form, and there is in both groups a strong pull on the interviewer to agree with the angry speaker or help finish the sentences for the passive speaker. The passive form of preoccupation readily invites *comparison with* (but is by no means identical to) what clinicians may mean by a passive–aggressive defensive pattern. The angry form of preoccupation may be seen as pointing toward defensive operations of displacement, projection, and projective identification. We make these suggestions in an attempt to make clear how readily AAI material can be rendered (albeit by no means in a one-to-one fashion) into a psychodynamic framework that relies on the identification of defense mechanisms.

In some interviews rated as preoccupied, the actual childhood experiences of these speakers seem to coders to include pronounced levels of *role reversal*, in which the child was called upon by the parent to provide care (typically because the parent was physically unwell or psychologically distressed *and* lacked the resources to cope as a parent). According to Bowlby, such a child was forced to defensively exclude the natural belief "I am a child and I need help, care, and love," so that a burdensome contrary belief could be consciously endorsed (i.e., "I am a big boy/girl who must help, care for, and love my parent who needs me"). For adults with this kind of history, especially if it has been established early in childhood and persisted through the adult years, there is likely to be either an absence of a strong sense of self and a marked passivity in speech (reflecting an ongoing dependence on parents) or—as we just discussed—a sense of self linked to a high degree of anger toward the

offending parent. Here we are, of course, discussing the two main forms of insecure–preoccupied interviews presented earlier: passively preoccupied (E1) and angrily preoccupied (E2).

A third subtype of preoccupied interview, most notable among adult survivors of serious abuse during childhood, as mentioned earlier, is termed *fearfully preoccupied* (E3). In these interviews, the operative theme appears to be failure of defensive exclusion insofar as memories of past trauma frequently intrude into the narrative. To be coded as fearfully preoccupied, these intrusions must, of course, be inappropriate, such as when the subject is not being queried about abusive or otherwise frightening events, but about some more benign topic not obviously linked to trauma. These intrusions are frequent in these interviews. Such interviews often also qualify for high ratings on the scale indexing unresolved mourning to do with past trauma. Freezing, absorption, and dissociation—among the most primitive of defensive processes—appear to be at work in the minds of individuals who present with this type of AAI, and are linked to similar phenomena in their infants (Hesse & Main, 2000, 2006).

A therapist who provides an atmosphere of respect, belief in the seriousness of trauma suffered, safety, and containment is called for in such cases. A focus on the management of current, here-and-now demands (transportation, housing, child care issues, job/work demands) is likely to be necessary before ending a session in which a subject's AAI has taken this direction. Follow-up to establish that there have been no deeply unsettling thoughts, feelings, or behavior—always a relevant consideration—is particularly appropriate with speakers whose interviews qualify as fearfully preoccupied and, very likely, additionally "unresolved."

5. Identifying the Gravitational Pull from Early Relationship Patterns on an Adult's Mind and Behavior

The *move to the level of representation* in attachment research ushered in by Main and colleagues (1985) has become so central in part because it has concentrated the focus of attention back on one of the main tenets of Bowlby's theory, namely, the construct of the internal working model, which includes the apparatus of perception, memory, and affect guiding how we interpret the behaviors of others, the shaping of our sense of self, and as we presented earlier, the decisions we make defensively to exclude (from awareness) appraisals of the self or others. The *internal working model of attachment*, of course, was Bowlby's rendering of psychoanalytic ideas about the critical importance of mental representations of self and others that form the landscape of the internal world—considerations that have remained central to psychoanalytic theory and technique for many decades (e.g., Sandler & Sandler, 1998).

In this sense, the AAI provides a window upon the inner world of the adult, as well as what clinicians often term his or her *internal objects* (representations of self in relation to the mother, father, and others), enhancing the diagnostic profile that can be built up. Specifically, a closer knowledge of the

internal representations of self, other, and the relationships between them (i.e., the "objects" in the mind of the patient) as is afforded by the AAI is vital, because "a source of severe resistance . . . (in therapy) . . . one that often leads to a negative therapeutic reaction, is our need to cling to the internal objects we have constructed" (Sandler & Sandler, 1998, p. 140). For the therapist, then, it is tremendously informative to know what early and perhaps ongoing attachment relationship patterns are exerting such a strong pull on the patient's loyalty. From the perspective of a patient's AAI, unreasonable, odd, and sometimes highly damaging behaviors in the present (e.g., compulsive caregiving or aggressive outbursts) can often be understood as the repetition of a past attachment pattern that may be deeply familiar and all too easily activated. Listening, then, to a speaker's response to the AAI (most commonly via reading the transcription) provides powerful clues as to the gravitational pulls on his or her attention, emotion, and behavior.

6. Use of the AAI as an Aid (among Other Information) in Placement, Parole, or Custody Decisions

So often in our applied or clinical work we are called upon to make a potentially life-changing recommendation. Should a parent be permitted to keep a child around whom there are documented child welfare concerns? As persons assigned to watch over a child's welfare, should we believe that trust in a given parent has been earned?

First, it should be clear that we do not advocate basing a parole or a placement decision regarding a child on an assessment of a person's response to the AAI alone. However, in the context of other kinds of interviews with parents (or prisoners), direct observations, and clinician and other assessment measures, the AAI offers an additional, vital contribution on its own (see Jones, Chapter 7, this volume). As we elucidate directly below, for example, one indication that an abused person *may not* go on to abuse his or her own child (here the AAI is, again, only one assessment among others) is when the speaker seems both to accept having been abused, and attempts to understand (and, in a few cases, even forgive) the abuser. But it is unlikely that understanding and accepting that one was abused, and that the abuser was another fallible, understandable person, can have taken place in a vacuum. As an illustration, a particular AAI question is relevant here (i.e., "Were there any other adults around in your childhood who played a caregiving role, like parents, but they were not parents?"). This question, late in the AAI sequence, sometimes brings to light some compensatory attachment figure (e.g., a grandmother). Often this is someone the speaker has not yet recalled in the AAI. And it is someone, perhaps the only one, who played a vital positive role by demonstrating that there was someone on whom the child could rely on for a humorous, considerate, and attentive response. This 'unsung' hero in the life history of the adult often needs to be unearthed, and the positive influence of this adult may come as a pleasant surprise to the speaker. We say more about this in the seventh clinical use of the AAI, under the heading 'Identifying the

Angel in the Nursery." Here we address the issue of what it may mean to resolve abuse experiences, a supreme challenge.

It is obviously a positive sign in the AAI when a speaker demonstrates that he or she has not left unresolved a past trauma. Indeed, in the nonclinical population whose childhood experiences have involved trauma, it is not uncommonly the case that the speaker conveys a sense of moving beyond the fear he or she felt so often as a child. Additionally, such speakers are capable of going some way toward understanding, though not necessarily forgiving, *caregiving* figure(s) who perpetrated abuse against them as children. In these circumstances, the interview often reveals a robust sense of self, interpersonal awareness, and valuing of attachment, so that the therapist entertains the hope that this adult, who was abused, is not likely to become an abuser. Such resilience typically emerges because the individual discovered one or more secure bases or refuges beyond the abusive relationship, such as an immediate or extended family member, but also perhaps a friend, a teacher, a spouse, or a therapist. Against this background, the AAI may be seen to provide important additional information in making life-changing recommendations (to parole boards or family courts), not least of which may be recommending therapy that helps a patient grasp vital attachment difficulties that arise in the interview.

7. Identifying the Angel in the Nursery

The way loss or trauma in the mind inevitably impinge upon a parent's relationship with his or her baby was captured by Fraiberg, Adelson, and Shapiro (1975), who wrote about how, in every nursery, there are "ghosts" from the past lives of the parents. And the AAI can be seen as a reliable and valid way to "measure the ghost in the nursery" (Fonagy, Steele, Moran, Steele, & Higgitt, 1993). Yet, as we suggested earlier, there is also much evidence that the AAI can be used to identify "angels in the nursery" (Lieberman, Padrón, Van Horn, & Harris, 2005). Evidence of such angels may appear at any point in the interview, though the specific question relevant to this comes late in the set of AAI questions, at a time when the speaker is about as relaxed as he or she is likely to be in thinking about childhood, and often this calls to mind the most positive adult figure in a speaker's childhood. It is frequently a grandmother (see Hrdy [1999] regarding how the grandmother's role in assisting in the care of her offspring's offspring may help in accounting, in evolutionary terms, for her own extended life). And whereas mention of the benevolent influence of this person may be brief in an AAI, the story often represents a shining light in an otherwise dense and dark net of memories. One of the particular clinical applications we envision is relying on the AAI as a source of information and support in parent–infant therapy (see Baradon & Steele, Chapter 8, this volume; Jones, Chapter 7, this volume; Steele & Baradon, 2004).

We know from much developmental research that having just one safe haven and secure base in one's childhood, perhaps not even for an extended period, is enough to make a momentous difference. For the therapist, knowing

about this "angel" may provide a powerful ally in clinical work in which one might otherwise despair (with the patient).

8. The AAI Permits Reliable Observation of Reflective Functioning

The concept of reflective functioning arose out of an infrequently observed phenomenon in some AAIs, that, is the state-of-mind scale known as metacognition, which is defined as monitoring and correcting one's own speech and thoughts (Main et al., 2003; Main et al., Chapter 2, this volume). In the 200 AAIs that began our longitudinal study of attachment (Steele & Steele, 2005), we found it necessary to enlarge our rating of metacognition to include monitoring not only one's own speech but also the observation and monitoring of others' speech, thought, and emotions. Over time, this came to be called *reflective functioning* (RF), broadly defined as (1) awareness of the nature of mental states in the self *and* others, (2) the mutual influences at work between mental states and behavior, (3) the necessity of a developmental perspective, and (4) the need to be sensitive to the current conversational context (Fonagy, Target, Steele, & Steele, 1998[8]; Steele & Steele, 2008). This elaboration on metacognition led us to examine whether individual differences in RF were linked to individual differences in infant–parent attachment (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). We found that this was particularly true for parents who had experienced significant adversity during childhood *and showed* high RF in their AAIs. RF was a marker of resilience in these parents (Fonagy, Steele, Steele, Higgitt, & Target, 1994). RF expresses itself most clearly in response to AAI questions that demand reflection (e.g., "Why do you think your parents behaved the way they did during your childhood?"). The speaker who is interested in this question is likely to find psychotherapy attractive but may need help to reign in his or her seemingly analytic stance, and structure thoughts and feelings, lest he or she become stuck in a low mode of RF termed *hyperactive*. The patient who finds nothing of interest or value in this question and is limited to absenting him- or herself from responsibility for knowing (e.g., "My parents behavior? How should I know? Ask them!") presents a different set of challenges to the therapist, who must aim to cultivate the inhibited reflective process, lest the patient be stuck in an RF mode termed *disavowal* or—lower yet—*hostile*. Mentalization-based treatment takes this as the core aim of clinical work (Fonagy, Target, Gergely, & Jurist, 2002). Here, it is important to note that the validity of the RF concept is based on rating it in AAIs, and although therapy may lead to increases in RF, this may not mediate improvements in child–parent outcome (see Toth et al., Chapter 6, this volume).

9. Selection and Training of clinicians

Another useful application of the AAI for clinicians involves the role of the therapist in the clinical domain. Here we propose that the AAI may have a potentially important role, namely, in helping clinicians in a training or super-

visory position to work with candidate clinicians, as well as clinicians in training.

In case this seems too radical a proposal, it should be noted that the psychoanalytic tradition especially has taken this idea very seriously: Most training involves undergoing personal analysis. This is done in part not only to offer a unique form of assessment and aid to the budding clinician but also to assist the candidate in getting "his or her own house in order" before offering help to others. Although we do not advocate use of the AAI as a sole method for selection of candidates, it may be helpful in identifying the challenges that a given applicant needs to address and resolve.

A most pertinent study by Zegers, Schuengel, van IJzendoorn, and Janssens (2006) compared AAIs of clinicians working with emotionally and behaviorally disturbed adolescents in an inpatient setting. Zegers and colleagues found that secure attachment, as identified in AAIs given to the clinicians, was predictive of an increase over time in the adolescents' perception of their mentors as psychologically available. This intriguing area of research is in its early stages, but given the pressure to deliver evidence-based treatments and to measure fidelity to models, it would seem a natural next step to use the AAI to assist in identifying the presence of the relevant qualities of clinicians delivering treatment.

The use of the AAI in an earlier study that compared the AAIs of clinicians and patients alongside therapeutic outcome was also highly revealing (Tyrrell, Dozier, Teague, & Fallot, 1999). This study examined dismissing/preoccupied strategies on a continuum, not unlike the AAI security subgroup scores described earlier, with some classifications on the border with dismissal (F1–F2), and others on the border with preoccupation (F4–F5). They found that a mismatch between therapist and patient predicted better outcomes than did a match (i.e., those secure therapists whose scores bordered on dismissing worked better with patients who scored high on preoccupation and vice versa). The cases of mismatches seemed best suited to promoting a positive therapeutic outcome, because the therapist was best able to challenge the patient's habitual mode of relating. This work, and our rendering of it, echoes suggestions by Slade (1999) concerning adult psychotherapy and the AAI. She argues that precoccupied patients need someone to provide structure and boundaries, whereas dismissing patients need to be encouraged to cross boundaries to which they adhere too rigidly, and to adopt a more liberal, accepting attitude toward themselves and others. Patients can, and do of course, move from preoccupied to dismissing stances or the other way around (see Ammaniti, Dazzi, & Muscetta, Chapter 10, this volume).

10. Assessing Relevant Therapeutic Outcome

There has been a recent increase in both case studies and systematic research, including randomized, controlled treatment trials. Representative examples of this important work are briefly considered below. The findings are promising

and point to the immense relevance of the AAI as a tool for tracking treatment progress and outcomes.

The randomized, controlled treatment trial of note is that reported by Levy and colleagues (2006) involving 90 outpatients with borderline personality disorder, randomly assigned either to transference-focused psychotherapy (TFP), a modified psychodynamic supportive psychotherapy, or dialectical behavior therapy. Treatment was delivered by therapists trained to high levels of competence in these manualized approaches, and each received weekly supervision from acknowledged experts in each approach (see Diamond, Yeomans, Clarkin, Levy, & Kernberg, Chapter 11, this volume, for a case illustration of this program of work). AAIs were administered prior to beginning treatment and 1 year into treatment by independent assessors (not the therapist). This approach, yielded rewards insofar as AAI coherence increased significantly over the year of treatment, as did RF, and the frequency of secure AAI classifications increased threefold, from 5 to 15%, but only for patients treated with TFP. Reading how these authors phrase the goal of TFP, one can easily imagine AAI security, coherence, or high RF being described: "The patient develops the capacity to think more coherently and reflectively, with more realistic, complex, and differentiated appraisals of the thoughts, feelings, intentions, and desires of self and others" (Levy et al., 2006, p. 1037). By contrast, the focus—and mechanisms of change operating in—dialectical behavior therapy and supportive psychotherapy appear somewhat tangential to the AAI; hence, they are less effective in terms of assisting a patient to acquire secure autonomy—at least in this study.

The case studies literature includes repeat administrations of the AAI that provide a detailed window on changes in the internal world that occur in psychoanalytic psychotherapy across years of treatment (see, e.g., Ammanitti et al., Chapter 10, this volume). Coherence is clearly shown to improve in one patient, whereas other patients are shown to shift from deeply insecure modes of feeling, thinking, and relating to less insecure, more organized modes of functioning. Given the extent to which mental health in adulthood is correlated with AAI security and resolution of loss or trauma (see van IJzendoorn & Bakermans-Kranenburg, Chapter 3, this volume), we can expect continued growth in research and case study reports that rely on the AAI as an indicator of change and therapy outcomes.

Conclusion

It is vital to remember that the use of the AAI in clinical contexts encompasses an interdisciplinary approach. Although the underlying theoretical constructs are clearly rooted in psychoanalytic theorizing, as constructed by John Bowlby, analysis of the AAI includes elements of linguistic discourse analyses alongside contemporary developmental psychological research that may otherwise be outside the domain of most clinicians. From the protocol itself one

understands what may usefully begin a therapeutic relationship in terms of listening carefully for global descriptions in contrast to recounting specific incidents, or paying special attention to discussions of hurt, rejection, separations, and, most obviously, loss and/or trauma.

The centrality of the concept of coherence is a widely appreciated goal of clinical work, which familiarity with the AAI uniquely highlights and expands (see Main et al., Chapter 2, this volume). Understanding the sophistication involved in measuring coherence and the obvious connection to Bowlby's writings on defensive exclusion of painful material that characterize many (incoherent) psychotherapeutic encounters can illuminate the clinical process. And this process itself can be facilitated by understanding the role of the therapist as providing a secure base for the client. From this base, clients are encouraged to explore their various states of mind, many of which are connected to their attachment figures, and some of which they would rather avoid and not think about, let alone put into words. Attending to the deviations that ensue from a coherent and unencumbered narrative can potentially provide the therapist with important clues on how best to proceed. In particular, via familiarity with the AAI coding system, and the particular AAI response(s) provided by the patient, the therapist is likely to arrive at an improved understanding both of transference and countertransference reactions.

Thus, there are many lessons for clinicians to be derived from the AAI protocol, the coding system, and the expansive literature that has arisen out of the move to the level of representation in developmental research ushered in by Main and her colleagues (George, Kaplan, & Main, 1985; Main et al., 1985; Main, Goldwyn, & Hesse, 2003). It is our hope that this chapter has provided the reader with an appreciation for how this move initiated with the AAI delivered attachment theory and research back to the clinical domain from which it initially evolved (Bowlby, 1949, 1988), and promises—particularly as new applications of the AAI are uncovered and elucidated—further growth in the future.

Notes

1. Google Scholar, January 24, 2008, cited 1,291 times.
2. See Chapter 3, this volume, in which van IJzendoorn and Bakermans-Kranenburg report on the explosive growth in the number of clinical studies (n = 61) and on results garnered from over 4,200 AAIs from published work, and remark on some 9,000 AAIs having been collected and analyzed as of August 2006.
3. We borrow freely here from Main et al. (2003) in providing this overview of the principal AAI classifications and subclassifications. More details are provided by Main et al. in Chapter 2, this volume.
4. Markers of speech that signal a lack of resolution of mourning concerning past loss or trauma are described in the next section of this chapter, and also in (Main et al., Chapter 2, this volume) on the rating and classification system. Additionally, further chapters in this book rely on this clinically relevant set of criteria.

5. Guidelines for transcription are available from Mary Main or Erik Hesse, Psychology Department, University of California, Berkeley.
6. Full guidelines for how to administer the AAI are available from Mary Main or Erik Hesse, Psychology Department, University of California, Berkeley.
7. See Bretherton and Mulholland (1999) for a full discussion of Bowlby's term *defensive exclusion* and its origins in Piagetian thinking, information-processing theory, and Bowlby's rendering of psychoanalytic theory in terms of how real-world experiences with parents shape the internal working model of the developing child.
8. The unpublished RF manual elaborates at length on how to score RF or mentalization as it may appear across the whole AAI, not simply one or other question. An overall score on a scale ranging from –1 to 9 is assigned.

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