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PSYCHOTHERAPEUTIC APPLICATIONS

OF THE ADULT ATTACHMENT INTERVIEW

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The immense therapeutic usefulness of an interview which thoroughly probes the family history of an adult was commented upon as early as 1949 by John Bowlby in what is widely regarded as the first paper on family therapy (Bowlby, 1949). Some 40 years later in the preface to his penultimate work, Bowlby would comment on his sense of surprise that attachment theory attracted so little attention from clinicians and, instead, remained for many years of almost exclusive interest to developmental psychology (Bowlby, 1988). This seeming paradox may be attributed in part to the deep reluctance of classical psychoanalysis to dispense with Freudian drive theory, as Bowlby proposed, in favour of an ethological account of the attachment behavioural system underpinning human development (See Steele & Steele, 1998). Bowlby's scientific perspective tended to be far wider than those which occupied his psychoanalytic colleagues in the early 1960s, and this launched him on the path of observing parent-child behaviour in the natural context, and anchoring his theorising on reliably observed behaviours. This left him free to champion the cause of child welfare based on reliable arguments about what children *actually* experience, rather than speculations concerning children's fantasies. Many colleagues including, James Robertson, helped advance this view. Notably, Robertson's filmed observations of toddlers going to hospital in the early 1950s remain a moving visual testimony to the importance of young children's attachments to parents. Most remarkably, Bowlby had a professional partner in *the attachment project* who was a developmental and clinical psychologist, Mary Ainsworth (Ainsworth, 1967; Ainsworth, Blehar, Waters & Wall, 1978; Ainsworth, 1990). Ainsworth collected crucial observational support for, and provided inspiring conceptual extensions to, Bowlby's theory concerning the importance of the early infant-mother relationship for the child's current and subsequent mental health. By 1988, as Bowlby himself knew and commented upon in a chapter on personality development in his book on the clinical applications of attachment theory, the tide was turning. A growing body of developmental research was documenting the influences of childhood experiences upon adult personality via administration and coding of an interview which has remarkable clinical relevance. That interview is known as the Adult Attachment Interview or AAI (George, Kaplan & Main, 1985) which -- together with an accompanying specialised manual for rating and classifying adults' interview responses (Main & Goldwyn, 1998) – is attracting widespread interest from clinical psychologists, psychiatrists, social workers and related mental health professionals. This chapter provides (1) an overview of the normative findings utilising the AAI, (2) a summary of clinical and forensic findings, and (3) a discussion of three related psychotherapeutic uses of the Adult Attachment

Interview, concerning diagnosis, therapeutic action, and assessment of outcome effectiveness.

Origins and normative research findings based on the Adult Attachment Interview

1.1 Origins of the interview and evidence of intergenerational patterns

The Adult Attachment Interview was developed and first tested in the context of the Berkeley longitudinal study of attachment patterns (George, Kaplan & Main, 1985; Main, Kaplan & Cassidy, 1985). One of the stated aims of the interview was to surprise the unconscious (George et al., 1985). The Berkeley-based group of developmental psychologists reported three classes of response to systematic questioning concerning childhood experiences and current thoughts and feelings regarding these experiences: secure (free-autonomous) and insecure (dismissing or preoccupied) classifications. Furthermore, in the pioneering Berkeley study, these adult interview classifications were reported to map on to the well-known infant patterns of attachment available for their children from prior assessments made of these children's attachment relationships with mother (at 12 months) and with father (at 18 months). Great excitement surrounded and followed the report of these intergenerational results. This was so because of what were already robust findings concerning the long-term social, emotional and cognitive consequences of infant patterns of attachment. Some two decades of previous work had documented both short- and long-term developmental outcomes of these infant-parent patterns of attachment. For example, secure attachments during infancy predict optimal patterns of peer relations and adjustment in the preschool years, high levels of academic achievement in the school years, and adaptive coping in the adolescent years (See Cassidy & Shaver, 1999). Correspondingly, the insecure (avoidant, resistant and the more recently discovered disorganised) infant patterns have been shown to predict much less favourable, sometimes psychopathological, developmental outcomes.

In the original Berkeley work, mothers' interviews were uniquely related to the previously observed infant-mother relationship and fathers' interviews were similarly predictive of the infant-father relationship. This suggested a remarkable level of cross-generational consistency, and relationship specificity, in the social and emotional meaning young children derive from their interactions with parents. These findings were confirmed in a prospective design, involving attachment interviews with expectant mothers and fathers and subsequent assessments of the infant-mother and infant-father attachment quality (Steele, Steele & Fonagy, 1996) and replicated widely across linguistic and cultural barriers (Van IJzendoorn, 1995). Still many questions remain for further research and, notably; these questions have enormous clinical implications. One important line of inquiry regards the developmental trajectory from infant relationship-specific patterns of attachment (i.e. to mother or to father) to person-specific adult patterns of attachment (where the secure pattern is typified by coherence and integration stemming from the composite of earlier and current attachments). For example, does one parent, e.g. mother (Freud, 1940), have precedence in influencing the path of self development and extent of integration achieved within the mind of the developing individual? When is such integration ordinarily achieved? These questions are the

subject of much ongoing developmental research. With respect to the present chapter, it is important to note that adults from the clinical population are frequently suffering from the ongoing effects of adverse childhood experiences that not uncommonly include past trauma and/or loss. As a consequence, it seems, these interviews tend to lack an integrated state of mind concerning, and a valuing stance toward, attachment so typical of the healthy autonomous-secure adult pattern.

1.2 The capacity for arriving at, and expressing, an integrated state of mind concerning attachment

AAI research involving non-clinical samples suggests that by 17 or 18 years of age, if not sooner, individuals have developed a well-functioning capacity to report, monitor and evaluate their possibly very different types of early attachment experiences, i.e. with mother, father and others (e.g., Kobak & Sceery, 1988). Further, Main (1991) has suggested that by 10 years of age, children who have benefited from a secure early attachment to mother are more likely to demonstrate metacognitive awareness in response to probing questions exploring the nature of mind and knowledge. Relatedly, in our own longitudinal research, we have found that children as young as six years are advanced in their understanding of emotions if they were securely attached to their mothers at one year, and if their mothers' AAIs were classified autonomous-secure and *integrated* (Steele, Steele, Croft & Fonagy, 1999). This finding is relevant for two reasons. First, it offers further empirical support for the intergenerational link between parent and child. Second, it highlights the connections that need to be made with regard to the usefulness of having a working lexicon of words to describe affect experiences, affect regulation and security of attachment. Thus the concept of secure attachment seems to overlap closely with what clinicians often cite as their foremost goal in therapeutic work, i.e. to help patients 'put feelings into words' or perhaps to 'put the adult individual at ease with the child within'. Not surprisingly, the gold standard of measuring adult attachment involves close and detailed study of the words adults choose to tell their attachment stories.

We next review the systematic method of eliciting this attachment story with attention to the clinical value of the line of questioning followed. Notably, the Adult Attachment Interview questions may be seen to comprise three distinct challenging modes of inquiry into memories for, and current evaluations of, past experiences of attachment-related distress:

(1) questions that ask about negative experiences and related emotions which are part of *everyone's* childhood experiences, including emotional upset, physical hurt, illness and separations from parents;
(2) questions about negative experiences and related emotions that are part of *some people's* childhood experiences, including loss and abuse; and
(3) questions which demand that the speaker think about the possible meaning and influence upon adult personality of childhood attachment experiences, including requests that the speaker provide an account of why parents behaved as they did during childhood.

Because the adult's childhood experiences with specific caregivers (e.g. mother, father, others) are probed in detail, the interview provides a fertile ground for assessing the extent to which attachment experiences are integrated in the mind of the speaker. Ideally, an autonomous point of view arises concerning the balance an adult needs to seek between depending on important and valued others -- and having such others feel that one is dependable. One expectant father, when asked about his hopes for his unborn child twenty years on, stated his awareness of this integrative balancing act as follows:

> "When I think about my child's future, well I hope he or she will be strong enough to follow his or her interests and passions . . . and that I will be able to make them feel that I am still there for them . . . not too busy or cut off . . . that they can count on me for guidance without undue interference. And, most importantly I'm sure, that they find with something like the range of feelings I share with their mother – I don't think it will be easy for them --or I-- but I am looking forward to it!"

Approximately 65% of the normal population convey in one way or another a valuing of attachment, and a respect for exploration, which leads raters to assign their attachment interviews to the category 'autonomous-secure'.

Importantly, the trained rater first scores the narrative on a number of nine-point dimensions pertaining to probable past experience and current state of mind concerning attachment. The dimensions of probable past experience which are rated include loving, rejecting, neglecting and role reversing experiences with each parent. The dimensions of current state of mind concerning attachment which are rated include attention to the emotional quality of parent-specific mental representations, e.g. the extent to which each parent is with idealisation, anger or derogation. Additionally, state of mind of the interviewee is rated in terms of more global considerations including the extent to which the narrative is coherent, passive, and showing signs of metacognition (Main & Goldwyn, 1998). Noteworthy, especially for its clinical relevance, we have been involved in a London-based effort to extend the scoring of metacognition (awareness of one's own thought processes) to include awareness of mental states as motivators of behaviour in oneself *and others* (Fonagy, Steele, Steele, Moran & Higgitt, 1991). This effort has led to the development of the concept of 'reflective-functioning' which we see as normatively growing out of early childhood experiences of having our inner worlds reflected upon more-or-less accurately by caregivers (e.g. Fonagy, Steele, Steele et al. 1995). Further, reflective functioning may be markedly inhibited or skewed as a result of deficient empathic responsiveness from caregivers in early childhood. In such circumstances, an elevated likelihood of psychopathological child and adult outcomes may be expected (see the discussion of criminality in section 2.1 below, and the suggestion that reflective-functioning is perhaps synonymous with psychological insight in sections 3.2 and 3.3).

For the present purposes, it is important to note that the autonomous-secure interview typically provides evidence of a balanced, non-idealising representation, of mother and father. Relatedly, the behaviours of each parent (whether favourable or adverse) during childhood are described in credible episodic detail, while the current emotional stance of

the speaker is neither angry nor derogatory. These are, of course, qualities rarely observed in clinical populations, at least prior to therapeutic interventions.

1.3 Failures at integration

Beyond the 65% of interviews from non-clinical samples which merit the description of organised, integrated, and autonomous-secure, two insecure patterns are noted. Both of these insecure patterns reveal difficulties with integrating past negative attachment experiences into a current and balanced state of mind concerning attachment. Some of these interviews err on the side of minimising or dismissing past difficulties with one or both parents (circa 25% of the non-clinical population) while other of these interviews err on the side of maximising and becoming preoccupied with past attachment difficulties. These two alternates to the free-autonomous group are termed insecure-dismissing and insecure-preoccupied respectively. In the former 'dismissing' case, the speaker seems inexorably focused *consciously* on positive or normal aspects of experience, to the exclusion of what is probably (*unconsciously recognised as)* a much more mixed and negative set of actual experiences. In the latter 'preoccupied' case, the speaker seems angrily or passively gripped by past relationship difficulties that intrude upon current thoughts about relationships and are accompanied by confusing and difficult-to-control negative feelings. While this pattern is observed only about 15% of the time in non-clinical samples (van IJzendoorn, 1995), the proportion of interview responses fitting this preoccupied pattern swells to over 50% when clinical psychiatric populations have been assessed (van IJzendoorn & Bakermans-Kranenburg, 1996).

1.4 The disruptive influence of loss and/or trauma: Resolution vs. lack of resolution

A further important consideration when rating and classifying attachment interviews concerns past loss and trauma. When there is clear evidence of a significant loss or trauma (physical and/or sexual abuse) the rater or judge follows a number of specified guidelines (Main & Goldwyn, 1998) for assessing the extent to which the past trauma is resolved. In sum, this comes down to determining the extent to which the overwhelmingly negative experiences are (a) identified as such and (b) spoken about in such a way as to indicate that they have acquired the characteristics of belonging to the past without lapses in the monitoring of reason or discourse when discussing the past loss and/or trauma (after Main & Goldwyn, 1998). For example, where loss has occurred, it is important for the speaker to demonstrate full awareness of the permanence of this loss. And, where abuse has occurred in speakers' childhood experiences, it is important for speakers to at once acknowledge the abuse, and also show that they understand they are not responsible for the maltreatment they suffered. Important clues as to the extent of resolution in the speaker's mind follow from careful study of the narrative for a logical and temporally sequenced account of the trauma which is neither too brief, suggesting an attempt to minimise the significance of the trauma, nor too detailed, suggesting ongoing absorption. Interestingly, in a study of 140 college students, Hesse & van IJzendoorn (1999) report that speakers whose attachment interviews were judged unresolved with respect to past loss were statistically more likely than speakers who were judged resolved (or those who had suffered no significant losses) to score highly on an independent

assessment of proneness to absorption. Thus, in a non-clinical sample, brief lapses in the monitoring of discourse or reason when discussing loss in the context of the AAI have been associated with the propensity toward absorption, measured by agreement to questionnaire items such as 'At times I feel the presence of someone who is not physically there'.

Unresolved loss and/or trauma is observed in approximately 10-15% of non-clinical interviews, which are also assigned to the best fitting of three main groups, autonomous, dismissing or preoccupied. A recent finding confirms clinical intuition insofar as it has been found that a parent who is autonomous-secure throughout an AAI, save for when speaking of a past loss in an unresolved manner, does not carry the same risk in terms of her child's development. This contrasts with those parents who were both insecure and unresolved regarding a past loss in the AAI context who were more likely to have children with disorganised infant-mother attachments (Schuengel, Bakermans-Kranenburg, & van IJzendoorn,1999).

It is a similarly positive sign when a speaker demonstrates that past trauma has been resolved. Indeed, in the non-clinical population, where childhood experiences have involved trauma it is not uncommonly the case that the speaker conveys a sense of moving beyond the fear they 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 one can say the adult who was abused is not likely to become an abuser. Such resilience invariably emerges out of the individual discovering one or more secure bases or refuges beyond the abusive relationship, such as may be provided by an extended family member, spouse or therapist. In this respect, the AAI offers a uniquely powerful clinical and legal tool insofar as it may be seen to provide a reliable indication as to whether or not abused adults are likely to repeat the pattern upon their children.

2. Clinical findings based on the Adult Attachment Interview

2.1 Applying the standard categorical scoring system to non-standard experiences and conditions

Research to date applying the Adult Attachment Interview in clinical contexts has revealed that loss and trauma experiences are highly common in psychiatric samples. With respect to specific (sometimes comorbid) diagnostic groups, borderline personality disorder has been associated with high prevalence of unresolved and insecure-preoccupied interviews (Patrick et al, 1994, Fonagy et al, 1996). Eating disorders have been linked to unresolved and insecure-dismissing interviews (Cole-Detke & Kobak, 1996; Fonagy et al, 1996); and suicidality has been associated with unresolved and 'disorganised' interviews (Adam, Sheldon-Keller & West, 1996).

There have been two forensic studies reporting on the administration of AAIs to prisoners incarcerated for crimes against people and/or property. One of these studies was conducted in Holland by van IJzendoorn, Feldbrugge, Derks, de Ruiter et al (1997) and one conducted in England by Levinson & Fonagy (1998), the latter work also being the subject of discussion in Fonagy, Target, Steele & Steele (1997). While both these studies illustrate the high incidence of abuse in childhood, and the dramatically elevated prevalence of insecurity (dismissal and/or preoccupation), the English study is especially noteworthy for the contrast observed between criminals who have perpetrated violence against people as compared to violence against property. The former most violent group was observed to be almost totally lacking in any capacity for reflection upon mental states in themselves and others; in other words, when the humanity of the other is denied, severe violence becomes possible, perhaps inevitable.

For a review of DSMIV Axis 1 and Axis 2 disorders, including descriptions of the disorders, relative contributions of environment and genetics to each disorder and the extent to which attachment phenomena may be implicated in each disorder, the reader may consult the recent chapter by Dozier, Chase Stovall & Albus (1999). For present purposes, it may be sufficient to relate a common thread through the Dozier et al. presentation, i.e., if a disorder is highly heritable, 'less in the way of unfavourable caregiving may be necessary for the disorder to emerge" (Dozier et al., p. 503). Thus it is not surprising that the strongest associations between insecure AAI patterns and clinical phenomena have emerged in respect of those conditions which have a low heritability rate and are correspondingly understood as relationship disturbances, i.e. borderline personality disorder, eating disorders and criminality. With respect to these adult difficulties, it may be argued that the AAI provides a detailed picture of some of the etiological or causal factors. With respect to other more heritable disorders, the AAI may be seen to provide a window upon mediating or moderating factors.

2.2 Emerging recognition of profound threats to self-integration and organisation of feelings and thoughts concerning attachment

As Adam et al's (1996) use of the word 'disorganised' suggests, what the standard scoring system takes for granted, i.e. a primary, integrated and more-or-less organised mental and emotional stance toward attachment, may be fundamentally lacking in some speakers. This was a phenomenon noted by Hesse (1996), one of the individuals closely involved with the development of the interview coding system who has also studied a great number of interviews from clinical populations. Hesse's (1996) brief report suggested that a likely conclusion from considering some interviews, particularly those from clinical samples, is that they should be assigned to a 'cannot classify' category because they contain deeply divided states of mind concerning attachment. For example, a speaker may be insecure-dismissing with respect to a physically abusive father, e.g. speaking of him in a cold, hostile and uncaring manner, while being insecure-preoccupied with respect to an occasionally very caring mother who failed miserably at protecting the child, e.g. speaking of her in a heated, angry and involving manner. This is but one of many pathways that may lead to an attachment interview that is impossible to classify in a singular way --- the common element to all these pathways appears to be severe and

repeated experiences of trauma. Correspondingly, most 'cannot classify' interviews are also rated high for unresolved mourning concerning past loss and/or trauma.

In our London-based consulting work involving the AAI, we have been using the interview to help arrive at a comprehensive assessment of individuals suffering from profound dissociative difficulties. This work is confirming the clinical relevance of the 'cannot classify' category just as it is providing corollary evidence in support of the diagnostic category Dissociative Identity Disorder (DID) or Multiple Personality Disorder. Remarkably, the AAI when used with this population elicits multiple voices from the same individual plausibly reflecting distinct personality organisations, with unique attachment patterns. While evidence of unresolved mourning arising within the context of the AAI has been associated to evidence of dissociative symptoms outside the AAI (Hesse & van IJzendoorn, 1999), as discussed above, this is the first evidence of marked and repeated dissociation occurring within the AAI itself. In some instances, the dissociation or splitting that occurs within the interview includes the retreat of one personality and the advance of another personality, occasionally of a different gender, with a unique name and story to tell about the inevitably horrific physical, sexual and emotional abuse sustained repeatedly during childhood. The switches that occur appear to happen without the knowledge of the primary personality. The term 'cannot classify' goes only some way to capturing the attachment strategies these adults have deployed to cope with their history of life-threatening traumatic experiences.

For example, one woman presented with a surface personality that was pleasant, polite, valuing of attachment (engaged to be married), and troubled by the distant relationship she has with her mother. This speaker was also partially able to discuss how she was rejected, abused and abandoned by this mother who also loved her (suggestive of a mildly preoccupied and resentful type of hard-earned security/autonomy). Yet as the interview progressed, a series of different attachment patterns emerged via a series of distinct voices/personalities. Notably, at no point in the interview did the interviewer ask if there was another voice/person with a different view from the one being expressed by the 'current' speaker. Staying with the present example, a marked shift was introduced by a question about who cared for her after her mother abandoned her at age 5? A different more hostile voice emerged to say that "care means chronically abused and ruined emotionally". This was now a male voice, not a female one, who had a tough observer 'big brother' status in the interviewee's life. He spoke with severe disapproval of any attempt by the surface personality to repair relations with her mother, saying 'I think she should tell her mother to fuck off after all she's done to her . . . make her face up to reality, make her listen to what we went through'. The content of what 'we endured' included ongoing ritualised abuse over many years perpetrated and maintained within the context of being in the care of governmental social services. Interestingly, beyond the horrendously abusive experiences suffered within the context of services set up to protect children, what was perhaps the strongest source of ongoing suffering for this interviewee (in all her persona) was the abandonment by her own mother. This relates to a theme common to many of the attachment narratives provided by individuals suffering from DID. That is, while psychic pain certainly accompanies the recall of the abuse per se, this pales in comparison to the much greater pain that accompanies the recall of being betrayed by trusted caregivers and siblings.

3. Psychotherapeutic applications of the Adult Attachment Interview

Given the depth and range of information elicited by the Adult Attachment Interview, anyone trained in the administration and (more complicated task of) coding the interview has had the repeated experience of being approached by clinicians interested in learning more about the interview. Potential clinical applications of the interview include diagnosis, treatment, and outcome evaluations in therapy, legal and social work. For example, the interview may be used to help identify relationship difficulties that may be an important focus to treatment of individuals with Axis 1 disorders. Or the interview may be used to help with court assessments of adults whose parenting capacities need to be comprehensively evaluated. Relatedly, the interview may be used to assist in assessing the suitability of adults hoping to adopt a child. And more ominously, the interview may be used to help in assessing the extent to which sex offenders have reformed themselves such that they might return to the community? In all of these and other related areas the Adult Attachment Interview is being, or will come to, be applied.

For the clinician contemplating use of the interview, what is crucial to remember is that the instrument was initially developed and tested by psychologists who have evolved an effective system for training those who use the interview. This is particularly important with respect to the system for rating and classifying interviews (Main & Goldwyn, 1998) which requires participation in an initial two-week intensive training 'institute' after which participants must complete a reliability test of some 30 interviews over a period of many months. This insures that findings reported from different research or clinical groups may be compared, and -- equally important --, that ethical considerations may be thoroughly discussed and adhered to by those using the instrument. The standards of science and good clinical practice require nothing less. We have found that a useful way of incorporating the AAI into clinical work, when the clinician is not trained in the standard system of rating and classifying the interview is for an attachment researcher with such training to offer consultation. This may include the administration of the interview, and always includes the provision of rating and classifying the transcription of the audio-recorded interview.

What follows is a discussion of some of the many possible clinical applications of the interview. This is the most speculative section of the current chapter as only very few studies have reached the stage of reporting results, while the vast majority are ongoing efforts of which we are aware. No doubt, many other clinical efforts involving the Adult Attachment Interview are underway, of which we have no knowledge. This discrepancy is, in part, based on the fact that there are a great many researchers and clinicians administering the interview protocol (George, Kaplan & Main, 1985), but only a few of these are also trained to reliability in the rating and classification manual (Main & Goldwyn, 1998).

3.1 The use of the AAI in clinical diagnosis

The Adult Attachment Interview should, of course, not be thought of as a substitute for diagnosis. However, it may be useful in identifying the particular profile of inter-

personal and intra-personal difficulties that may distinguish one depressed and/or anxious individual from another individual with similar symptoms. In other words, the interview yields a systematic and relatively deep social history. "Deep" in this context refers to material that reflects both early memories and modes of responding to (or coping with) experience stored at diverse levels of awareness.

The finding that bipolar depressives are more likely (than unipolar depressives) to be dismissing (Fonagy et al, 1996) and unresolved (Tyrrell & Dozier, 1997) may serve as an illustration of the potential diagnostic value of the AAI and its use in therapeutic intervention. Dismissing interviews are noteworthy for the frequently unrealistically positive or highly idealised image of parent(s) that is conveyed by the speaker. Correspondingly, just as negative aspects of one's parenting experience are underplayed or denied, the self is presumed to have been unaffected by negative experiences. With respect to the speaker's representation of loss or other traumatic experiences, the interview may indicate that mourning work is ongoing. Both these observations, readily picked up by an Adult Attachment Interview (and perhaps typical of an individual with bipolar disorder) may provide some directions along which the therapeutic intervention may proceed.

Above all else, in our experience, what the AAI is likely to provide to the diagnostician is the opportunity to discover some unsettling loss or other traumatic experience which has *not yet* been presented. "Not yet" is put in italics so as to alert the reader to the very real possibility that unconscious defensive processes, and not only a conscious sense of embarrassment or shame, may be preventing the individual from reporting one or more toxic traumatic events from their history. In this sense, the AAI delivers on its promise to 'surprise the unconscious' (of the speaker) and even sometimes the therapist. A poignant example of just such a situation occurring came within the context of parent-infant psychotherapy work that was carried out by colleagues at the Anna Freud Centre, London. The AAI has been incorporated into selected cases as part of an exciting initiative which will explore the its use in parent-infant psychotherapy. One compelling case noted how a young mother was able to shift dramatically in her capacity to relate to her infant after the AAI uncovered feelings about a traumatic event that had never been explored. The young woman, in an affect-laden moment stated "you know, no one has ever asked me about the event before. They all took for granted that I was just too young to matter."

3.2 The use of the AAI as a guide to therapeutic intervention

To our knowledge, there has not yet been any systematic attempt to administer the AAI to a group of individuals where material from the AAI has been used as the basis for the intervention. One might envision a study where a comparison group who are also interviewed with the AAI but do not receive the AAI-based intervention are included. In such a circumstance, the relative added value of the AAI-based intervention may be assessed. Despite such a report being unavailable, there are a number of relevant studies which have intervened using AAI-like goals with mothers whose babies are at-risk of developing insecure attachments (See Lieberman & Zeanah, 1999, for a review and

appraisal of this work). Positive outcomes have been reported in response to these interventions which facilitate the establishment of a secure base with the therapist, and the exploration of current *and past* relationship difficulties. These intervention programs often involve mothers in both individual therapy and group therapeutic settings (e.g. Erickson, Korfmacher & Egeland, 1992), thus maximising the potential for participants to become aware of the toxic (transferential) influence of the past upon the present. This opens up new ways of thinking, feeling and relating which bring immediate rewards in terms of the enhancements observed in maternal understanding and responsiveness to infant needs, and the joyful interactions that result. Bowlby's (1988) summary of his clinical approach was stated very much in these terms. No doubt, further work will demonstrate the utility of the AAI to this process.

One possible impediment to the clinician thinking the AAI useful to the therapeutic process may be the ultimately categorical nature of the taxonomy relied on in the research literature (as opposed to the multi-dimensional mode of thinking which often feels more familiar *and real* to the clinician). And, indeed, the most common element to the AAI literature is the discussion of secure vs. insecure (dismissing or preoccupied) classifications on the one hand, and resolved vs. unresolved classifications on the other hand. Yet, as mentioned above, there are numerous dimensions considered with respect to interviewees' probable past experiences with caregivers, and their current states of mind concerning attachment. Also, as Slade (1999) has recently reminded us, Mary Main herself has held to the view (which we heard her elaborate in 1987) that every speaker who is dismissing in the context of the AAI is unconsciously preoccupied, while the preoccupied speaker is unconsciously dismissing or restricted in feeling. In other words, there is a range of primitive to more sophisticated psychological defenses or strategies available to every individual (Freud, A., 1946), with one's habitual conscious reliance on some sub-set of these defenses being a scaffold behind which operates other, more primitive defenses. Nonetheless, as Slade (1999) illustrates, the AAI classification system may help the therapist to navigate a therapeutic path that might assist the patient toward noticing the connections between conscious, verbally articulated patterns of behaviour and earlier experiences of rejection, separation, loss, and – more generally -- fundamental unmet attachment needs. For patients with a dismissing attachment presentation, the therapist is alerted to the challenges of gently breaking down affectless psychological structures, borne out of the need for self-protection against attachment distress. By contrast, for patients with a preoccupied attachment presentation, the therapist's time must be devoted to the "slow creation of structures for the modulation of affect" (Slade, 1999, p.586). The additional consideration of treating unresolved mourning concerning past loss or trauma requires different skills, on account of the fact that the emotions surrounding the trauma have, by virtue of them unresolved, been radically dissociated and/or distorted. From an attachment perspective, this therapeutic challenge requires a gentle and monumental effort at reconstruction of the traumatic history -- what, when, where, how, and why are questions that demand answers. For the individual with unresolved grief, the task is alluring but carries multiple risks of renewed terror and further dissociation. Ultimately, it is hoped that the individual may achieve a narrative that finally contains, *and relegates to the past*, the persisting loss and/or trauma.

We have explored one area of overlap between AAI research and the clinical process in London, at the Anna Freud Centre, stemming from our work on the dimensional concept of reflective-functioning. Notably, ratings of this capacity in the AAIs from pregnant women we have studied in London (Steele et al., 1996) have revealed that reflective-functioning is a more powerful predictor of infant-mother attachment security than any other single AAI rating scale (See Fonagy et al, 1996). The capacity to reflect on one's own internal world and to appreciate the perspective of another individual is a crucial question in the mind of the clinician when they are assessing a patient for 'treatability'. Often there are limited resources with which to offer psychotherapy services to those that seek it and could benefit from it. The question of how to assess whether an individual might make use of treatment is a critical one for the clinician, whether in public or private practice. A familiarity with the concept of reflective functioning might have a very important role to play in this challenging area of clinical practice. An example of an adolescent boy who sought help at the Anna Freud Centre, exemplifies a situation in which a capacity to reflect upon his painful situation was predictive of a good therapeutic outcome. Steven, at age 16 years suffered from intense bullying by his schoolmates. This included being locked in a locker at school for a full hour, and having a cigarette lighter held to his cheek. He was engaging in some self-harming behaviour and was involved in a sado-masochistic relationship with his father with whom he battled on a daily basis. However, he was also able to comment at the diagnostic stage of potential treatment, "My father will never be satisfied … even if I was the type of boy my father thinks he'd be happy with, he still wouldn't be happy with me." Indeed, over the course of intensive psychotherapy that followed, Steven was able to explore both his own role in the difficult relationship with his father but also to see his father's contribution to the pathological situation.

3.3 The AAI and therapeutic outcome

The AAI may well be a useful guide to how well treatment has gone, particularly if it has been administered prior to treatment beginning for later comparison with an outcome AAI. Further, the trained raters judging the interviews should be kept blind to psychiatric diagnosis and the initial classification and rating scores. All this said, if the treatment is in any way based upon material obtained from the pre-treatment interview (as we advocate in section 3.2 above) then the AAI should not be considered as the outcome measure so as to maintain the possibility of achieving an independent assessment of the treatment process.

The only report of the AAI being used in a pre-treatment and post-treatment design comes from the Cassel Hospital in-patient family unit in London (Fonagy, Leigh, Steele, Steele, Kennedy et al., 1996). This 1996 report commented on a sub-set (circa 35) of adults from a larger sample (circa 85) being followed over one year of treatment. No significant movement from the insecure to secure classification was observed. However, two significant outcome effects were observed. First, patients' levels of reflective-functioning improved, suggesting that rating scales, rather than overall classification may be the most useful AAI index to chart therapeutic progress. It is after all easier to move in a particular area, for example toward a less idealising stance with regard to a particular parent than to shift in several different areas which would be necessary for a

classification shift. The Fonagy et al. (1996) study also showed that those patients whose initial AAIs were insecure-dismissing were most likely to show this improvement, while those whose AAIs were insecure-preoccupied were least likely to show improvement. Slade (1999) has written at length about the particular challenges to treatment presented by patients who are primarily preoccupied. She comments on how "progress is . . . hard won. It seems to follow not from words or interpretation, but from the therapist's long-term emotional availability, and tolerance for fragmentation and chaos" (Slade, 1999, p. 588). Thus, perhaps it was the relatively short-term nature of the follow-up in the Fonagy et al (1996) study that permitted only those patients with primarily dismissing strategies to show improvement.

A window upon the particular challenge to treatment that dismissal represents is provided by Dozier, Lomax, Tyrell & Lee (2001) based on their study of 34 patients with serious psychopathological difficulties. Patients' dismissing vs. preoccupying attachment strategies were considered in relation to their behaviour in video-filmed interpersonal problem-solving sessions with significant others or case managers. Dozier et al (2001) suggest that those patients with dismissing strategies were more likely to lack concentration in, and report more confusion following, interactions with case managers, while also showing greater rejection of significant others in interactions with them. No doubt, there are distinctive challenges presented by patients with predominantly preoccupied as opposed to dismissing profiles of attachment insecurity, and we still have much to learn about how these profiles react to treatment, and moreover, which treatments are best-suited to each.

So far we have considered the AAI as reflecting characteristics of the patient which may influence diagnostic considerations of the therapist, therapeutic progress and outcome *without* commenting on characteristics of the therapist, and responses of the therapist to attachment-related characteristics of the patient. Obviously, however, every therapist has an attachment narrative of his or her own which will influence the therapeutic alliance formed, and the way in which the inevitable ruptures in this alliance are managed (Safran & Muran, 2000). There is one study that has systematically investigated this countertransference issue from the attachment perspective (Dozier, Cue & Barnett, 1994). These authors confirm the expectation that secure as opposed to insecure therapists are better able to negotiate successfully the challenges of treating either dismissing or preoccupied patients. This study deserves to be replicated so that its implications for the work of training and supervision of therapists may be fully explored.

Conclusion

That clinicians across the mental health field are finding in attachment theory and research much that is relevant to their work is arguably owed, in large part, to the discovery and now well-established reliability and validity of the Adult Attachment Interview (AAI). This chapter has attempted to provide an overview of this research instrument, pointing at its many possible clinical applications. A skeptic might say that it is only the research-minded clinician that will wish to become truly familiar with the interview's properties and promises. However, with the research tide turning so that even

the most research shy clinician is now being asked for audit and efficacy statistics to be produced, it may offer unique and fruitful opportunities that would not have otherwise informed their work.

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