

**To what extent do Attachment and Emotional Attunement influence the Therapeutic
Relationship?**

by

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Abstract

The proposed research is intended to demonstrate that attachment and emotional attunement are key elements in forging and maintaining the therapeutic alliance.

Therapeutic alliance, the bond between therapist and client, is a powerful factor in the process of emotional and psychological healing. Therefore, initiating and maintaining a good Therapeutic alliance is the foundation of therapy.

The focus of this study is to understand the extent which attachment and emotional attunement influence the therapeutic relationship.

KEY TERMS

Attachment theory; attachment styles; emotional attunement; affect regulation; therapeutic relationship; therapeutic alliance; therapeutic process.

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I would also like to thank all my clients for making this journey of counselling an exploration worth making. Being a witness of their journey has been an amazing adventure.

Dedication

I would like to dedicate this Thesis to my dear husband who has been my most dedicated supporter and has encouraged me to always fight/look for what I want. He made all the necessary efforts so that I would arrive at the end. I would also like to dedicate it to my children.

Like E.E. Cummings, I say “I carry your heart(s) with me, I carry it in my heart. I am never without it”. This is the strength that makes me go.

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Chapter 1: Introduction

*Because I feel that, in the Heavens above
The angels, whispering to one another,
Can find, among their burning terms of love
None so devotional as that of 'Mother'*

– Edgar Allen Poe

I started this Master's of Counselling program with a past, tangled in the routines of the present but with little vision of a future.

Looking back after almost three years, living in the present and envisioning the future were all playing together a symphony that, at times, didn't seem harmonious.

Now, at the end of this journey another question invades me: What thesis topic will I chose? What is important to me? What is my utmost passion? How will life look different when this program finishes?

Difficult reflection. Even now, I am unsure of the answer, since there are many.

Concerning the thesis topic, I decided by one aspect that for long is deeply part of myself: motherhood. It started as a wish whispered in my unconscious being, became a dream, and then a reality. Motherhood has been the longest, and most fascinating, adventure in my life. It has turned my life upside down, it has made me cry and fear as I never feared before; and rejoice as no other event had made me rejoice. I changed as a person. I grew, matured and I still feel that I am just at the beginning.

When I became involved with helping professions, specifically mental health, I have been discovering the many similarities between being a mother and a therapist.

Some aspects of the deep bond established between mother-child and client-therapist, the feelings in the here-and-now that we cannot find words to fully express them.

As a mother I am fully involved in the relation with my children. I am fully present in the moment, I am intuitive to my family needs. I hope I was, and still am, a “good enough mother” to provide them what they need and trust in their capacity to do things by themselves, the self agency that all of us carry inside.

I have realised how the emotional attunement is an ongoing process in my relationship with each one of my children. The body first expresses what later words might say. For me, it's barometer to easily access how they are as persons in that moment. I have different children with different temperaments and different ages, and therefore different needs. As a mother I have been a “mom” in diverse ways, the ways they need me to be. I witness their growth and world exploration. Later, I enjoy listening to their dreams and aspirations. I share with them good moments, and I am there for the setbacks that life might present. There are times when I feel what they feel and we co-construct some meaning of what is happening in the here-and now. Many times, we are just together in silence. As I am aging, I have been more and more appreciative of this way of being a “mom” for them.

I have recently experienced the moment where they want to fly and leave the nest searching for their own adventure with other “others”. It is a different way of caring for them: being a witness of their achievements.

As a therapist, I believe in a the person-centered collaborative approach, started initially by Carl Rogers and expanded afterwards by authors such as Michael White, Tom Anderson or Harlene Anderson. The value of the process (therapeutic relationship) is the most important elements in therapy. The process of forming a therapeutic

alliance itself fascinates me. I am a true believer of the power of human connection. Connections expressed in many ways, caring, nurturing, understanding, witnessing such as just being together in silence, “putting silent thoughts into spoken or written words,” as Harlene Anderson so beautifully wrote (Anderson, 2000, p. 8).

Just as my children require that I respond differently to their needs, the same happens with clients who come to therapy with different needs.

The reader might say that the two situations are different and comparing both is a little too much!

I do feel the same. There is something substantially different. Certainly, the biological, emotional, social and spiritual connection is stronger with our children. Nevertheless, I considered some aspects of the process present in both situations: the establishment of a bond (attachment) and emotional attunement required in both situations.

Then the thesis question appears clear to me: To what extent do attachment and emotional attunement influence the therapeutic relationship?

This is the content of the present study.

Chapter 2: Attachment

Introduction

The present chapter intends to explore the core concepts of attachment theory. In fact, the research on this field is vast. I found it was impossible to speak briefly about attachment and at the same time grasp the full meaning and interconnections of attachment and its multiple aspects on human functioning.

Attachment conceptualizations are deep and at the same time subtle. Like a light breeze on a beautiful spring day, almost imperceptible and at the same time so determinant in the enjoyment of the moment. That's how I see attachment, so deep and subtle that one could easily dismiss its importance.

The selection of materials was made to give a clear understanding of attachment and highlight the attachment expressions that might be interconnected with affect regulation and therapeutic alliance.

The full integration will be made in the discussion chapter later in the current study.

Attachment Theory

Across human evolutionary history, protection from danger by a stranger, older and wiser figure has been essential for the survival of vulnerable infants and young children. To ensure sufficient protection, evolutionary selection pressures produced an innate system – the attachment system- that motivates vulnerable individuals to seek close physical and/or emotional proximity, particular when they are distressed (Bowlby, 1969, 1973, 1980). These behavioral strategies would have increased the chances of survival.

John Bowlby's work

John Bowlby's work on attachment theory started when, at the age of 21, he worked in a home with boys with behavioral problems. Bowlby's clinical experience with two boys, whose relationship with their mothers was massively disrupted, had a profound impact on him. A retrospective study carried out ten years later, examining the history of 44 juvenile thieves (Bowlby, 1944), formalized his view that the disruption of the early mother-child relationship should be seen as a key precursor of mental disorder. Later he studied the relations between mothers and institutionalized children (Bowlby, 1951). Children who had been seriously deprived of maternal care tended to develop the same symptoms that he had identified in the young thieves. He insisted the problems were mostly external, rooted in real relationships with real people, as opposed to Freud's vision that the problems lay in the internal, psychic, conflicts and unconscious fantasies (Jordan, 2008).

Bowlby in 1958 was one of the first to recognize that the human infant enters into the world predisposed to participate in social interaction. Bowlby's defended the infant's need to an unbroken (secure) early attachment with the mother. He thought that a child who does not have such support was likely to show signs of partial deprivation expressed with an excessive need for love or revenge, guilt, and depression: or a complete deprivation expressed with listlessness, quiet unresponsiveness, retardation of development, and later in development signs of superficiality, want of real feeling, lack of concentration, deceit, and compulsive thieving (Bowlby, 1951).

Later, 1969 and 1973, he placed these interactions into a framework of reactions to separation: protest – despair- detachment. Protest begins with the child perceiving a threat of separation. It is marked by crying, anger, physical attempts at escaping, and searching for the

parent. It last for as long as a week, and intensifies at night. Despair follows protest. Active physical movement diminishes, crying becomes intermittent, the child appears sad, withdrawn from contact, more likely to be hostile to another child or a favorite object brought from home, and appears to enter a phase of mourning the loss of the attachment figure (Bowlby, 1973). The final phase of detachment is marked by a more or less complete return of sociability. Attempts by other adults to offer care are no longer accepted, but the child who reaches this stage will behave in a markedly abnormal way upon reunion with caregiver.

Bowlby's attachment theory has a biological focus. The child behavior, such as smiling and vocalization, alerts the caregiver to the child's interest in socializing, and brings him or her into close proximity with the child. Bowlby's emphasized the survival value of attachment in enhancing safety through proximity to the caregiver in addition to feeding, learning about the environment, social interaction and safety. Attachment behaviors were seen as part of behavioral system, a term that Bowlby borrowed from ethology.

No specific behaviors can be identified with attachment. After three decades of research there appears to be a general agreement concerning the key components of attachment as a psychological mechanism. The behaviors that establish and maintain proximity include: 1) signals that draw the caregivers to their children (e.g., smiling), 2) aversive behaviors (such as crying) that perform the same function, and 3) skeletal muscle activity (primarily locomotion) that bring the child to the caregiver (Fonagy, 2001, p. 8).

According to the same author, the entire system of behaviors has the common function of optimizing proximity across a different range of contexts. The system exists to ensure a stable internal organization. The goal is not so much the object itself (mother), but initially a physical

state and maintenance of a desired degree of proximity. Later this goal could be expressed in a more psychological phenomenon as a state of “being or feeling closeness.”

In the first volume of the Attachment and Loss trilogy, Bowlby defines proximity as the set goal for attachment system, and its measurement was simple and purely behavioral. The absence of the figure of attachment generates the biological need; her return and presence turn it off.

When a child is by himself or goes off exploring and finds that it is too far from his mother or something happens that frightens him/her the fear system is activated, which activates the attachment system and the exploratory system is turned off. If the mother is available to come closer or simply show herself and reassure the child that he/she is safe, this will turn off the fear system and activate the exploratory system. The mother acts as a safe haven (a place to return if needed) for that child since she has been a secure base (she was there, available, and assuring closeness which meant safety).

Later, Bowlby (Bowlby, 1973, p. 202) will define this caregiver’s accessibility and responsiveness with a single term: *availability*.

These behaviors repeat themselves, and if the mother’s answer is consistent, it will form an internal *schemata* of predictable mother behaviors, that are available and provide closeness and safety. By a process similar to imprinting, this will form Internal Working Models of operating in close relationships.

Bowlby was influenced by Konrad Lorenz’s imprinting concept. In Lorenz’s studies with geese, just by passing through their line of sight during a critical period the geese would be attached to him by imprinting. Bowlby applied the same concept to the mother-infant interactions.

These representations are influenced by experience and are subject to change depending on new experiences. Nevertheless, Bowlby believed that some aspects of these internal working models, particularly those that are not accessible to consciousness, would be especially resistant to change.

Each individual's working model of a particular relationship includes concepts of the self and the other, as well as expectations of the relationship.

Mary Ainsworth's work

In the 1970s the contribution of Ainsworth helped refine the concept of attachment. She recognized that separation (physical absence of the mother) was not the key element to understanding the infant's response to the Strange Situation.

The strange situation is a 20 minute laboratory test used to evaluate the infant attachment style. The child is exposed to two separations from the attachment figure no more than 3 minutes each. Mary Ainsworth and her colleagues (Ainsworth et al., 1978) found that the majority of middle class one year old children respond to the mothers with proximity seeking and relief at reunion (securely attached B infants), about 25 percent respond with subtle signs of "indifference" (anxious avoidant attachment – A infants) and 15 percent respond with proximity seeking but little relief at reunion (anxious resistant attached – C infants). There is a fourth category in attachment style called disorganized/disoriented (D).

Ainsworth considered that it was the mother's behavior that accounted for the child reaction and not so much her physical presence or absence. Therefore, the disruptions occasioned by separation from the primary caregiver are modulated by an increasingly complex set of (unconscious) evaluative process. Ainsworth saw these different patterns of behaviors as

adaptive strategies, they serve to maintain the relationship with the mother and a sense of safety (Hill, 2015).

The secure pattern of distress at separation and reassurance by the reunion is thought to reflect an internal working model characterized by confidence that the caregiver will be comforting. The anxious avoidant pattern is thought to indicate the infant's lack of confidence in the caregiver's availability leading to a strategy to control or down regulate emotional arousal. These children show little distress during separation and disinterest in reunion as a coping mechanism. Anxious ambivalent/resistant infants, who show distress at separation but are not confronted by the caregiver's return, appear to have adopted the strategy of exaggerating or up-regulating affect in order to secure the caregivers attention.

The disorganized/disoriented infant, in general, seeks proximity to the mother in strange and disoriented ways, for example, approaching the mother backwards, hiding, suddenly freezing in the middle of a movement, or just staring into space (Main & Solomon, 1990).

There is some controversy of the value of strange situation as an accurate method to establish an attachment style. It seems that the stability of this pattern is a more secure measure. From research on this area, when the strange situation is repeated 3 months later the patterns A, B and C vary but the pattern D is stable in both evaluations (Belsky et al., 1996).

Other research following the same trend, stated that the set goal of the attachment system was "felt security", rather than physical distance regulation (Sroufe & Waters, 1977).

The concept of attachment includes social, emotional, cognitive and behavioral components. Attachment is a property of social relationships in which a less skilled individual relies on a more competent and powerful one for protection (Goldberg, 2003). Each individual

emotional experience ties to the other and each participant engages in behaviors that reflect and maintain the relationship.

During the late 70s and 80s, attachment research was more concerned with child maltreatment, physical and sexual abuse. The disorganized/ disoriented classification of strange situation behavior marked by fear, freezing, and disorientation (Main & Solomon, 1986) was linked to maltreatment of the child (Cicchetti & Barnett, 1991) and unresolved trauma in the parent's life story (Main & Hesse, 1990). The frightened/frightening behavior of the parent is expressed as being either a signal of safety or a signal of danger. Longitudinal studies have concluded that infant disorganized attachment style is linked to psychopathology later on in life (Lyons-Ruth, 1996; Schuengel et al., 1999).

From the many theorists that had posteriorly studied attachment, it is important to mention Cassidy.

Cassidy and Marvin (1992) developed a five-category attachment classification for children between 2 1/2 and 4 1/2 years old. The reunion of secure children is described as smooth, open, warm, and positive. Reunion of ambivalent children is described as strong on proximity seeking but babyish and shy. Disorganized children show in reunion setting controlling, sometimes punitive behavior, as well as behaviors of disorganization.

Attachment is a useful construct to understand behavior, but is important to consider the ways in which attachment manifests across cultures (Kietaibl, 2012). In attachment evaluation is important to contextualize the cultural meaning of that behavior (ex: proximity) in that particular cultural environment before drawing any assumptions. For example, the way each culture sees proximity is different and is expressed differently.

The Biological Basis of Attachment

The biological basis of attachment remains. Hofer's work revealed that the evolutionary survival value of staying close to and interacting with the mother goes beyond protection. He says: "relationship provides an opportunity for the mother to shape both the developing physiology and the behavior of her offspring through her patterned interactions with her infant" (Poland & Hofer, 1999, p. 177). Attachment is not an end in itself, it is a system adapted by evolution to fulfill key ontogenetic physiological and psychological tasks.

Attachment predictors

Concerning secure attachment predictors, the maternal caregiving is one of the most important factors. In particular, maternal sensitivity, responsiveness to distress, moderate appropriate stimulation, interactional synchrony and warmth, involvement, and responsiveness have all been demonstrated to be predictors of attachment security (Belsky, 1999). Avoidant attachment is generally predicted by intrusive, excessively stimulating and controlling interactional style. Ambivalent/resistant infant attachment appears to be related to a generally unresponsive and under-involved approach.

Attachment Theory Expansion and Application to Other Fields

Attachment theory research has increased, and attachment has been applied to many other fields of human behavior such as information-processing, social competence, affectional bonds and emotion regulation (Goldberg, 2003).

Attachment and emotion regulation

Emotional development and expressions change in the course of life. Emotional expressions become more differentiated, subtle and complex as we get older.

Thompson said that “emotion regulation consists of the intrinsic and extrinsic process for monitoring, evaluating and modifying emotional reactions, especially their intensive and temporal features, to accomplish one’s goals” (Thompson, 1994, p. 27). In infancy, caregiver response to infant affect provides a template for the child’s acquisition of self-regulatory abilities (Feldman et al., 1999).

Attachment theory relates with emotional regulation in two different ways:

1) The way attachment figures respond to affect (i.e., adult emotional regulation) is considered to be a key element that shapes the attachment patterns. Each different style of attachment is marked by distinct affective characteristics in the caregiver's emotional expression. In this sense, we can say that the caregiver’s attachment style and their emotional regulation and expression are main factors in building, in early relationships infant-caregiver, a particular attachment style in the infant.

2) The early attachment style could predict in which way the child, youth and adult will express and regulate their emotions. For example, adolescents whose attachment interviews identified themselves as dismissing received relatively high peer ratings for hostility, and reported more loneliness and less social support from their families than those in the other attachment group (Kobak & Sceery, 1988). The evidence indicates that the avoidant/dismissing group experiences more negative feelings than they express. Therefore, these negative emotions are either softened or suppressed (Goldberg, 2003).

Emotional development concerns acquisition of the ability to perceive, interpret and accurately label the expressed emotions of others. In children with secure attachment, emotions are openly expressed and discussed (Bertherton et al., 1986). Therefore, we would expect secure attachment to be associated with more realistic perception and interpretation of the emotional

experiences and expressions of others. If insecure attachment is associated with discrepancies between what is felt, expressed and discussed, we would predict that insecure attachment would be associated with more difficulty and confusion in interpreting and describing the emotional expressions of others.

The mechanisms used to regulate the affect differ within the groups. The securely attached child's affect regulation was resilient, moving from hyperarousal when afraid and returning efficiently to homeostasis when reassured. They use both mechanism to obtain emotional attunement: self and dyadic regulation.

The anxious-ambivalent children show prolonged states of hyperarousal and use mainly the dyadic regulation to soothe themselves.

The avoidant children manifest prolonged states of hypoarousal and self regulation as the main strategy to regulate their affects (Hill, 2015, p. 26).

In the past twenty years two theories have been developed to explain affect regulation, both considering attachment as a primary influence in its development. One is the Regulation Theory, proposed by Schore (1994, 2008, 2012), in which early forming, automatic, fast, nonconscious, psychoneurobiological processes take place. The second theory was developed by Fonagy and is called the Mentalization Theory (Fonagy et al., 2002; Allen, 2006), and consists of a later-forming, verbal-reflective, slow, deliberate, conscious cognitive processes.

Both theories complement each other and take place in two distinct periods of the individual development. One leads to the other.

In the next chapter of this study these theories will be explored in more detail.

Attachment Bond vs Affectional Bonds

The attachment bond is a subclass of affectional bonds or ties, i.e., when an individual has great emotional significance for another. Closeness to this individual is desired and distress follows separation. An affectional bond becomes an attachment bond when the individual seeks security or comfort from the relationship (Ainsworth, 1989).

Children could form a number of attachment relationships in early life and there appears to be an hierarchy of major caregivers and a preferred principal attachment figure (Bertherton, 1980). The factors that might contribute to being at the top of hierarchy as an attachment figure are: amount of time the infant spends in that person's care, the quality of the care, the emotional investment of the adult in the child, and the frequent reappearance of the person (Cassidy, 1999).

A secure infant-mother relationship predicts the way the infant will operate in other close relationships, for example, more harmonious interactions with siblings are observed (Teti & Ablard, 1989; Volling & Belsky, 1992). The securely attached child expresses an appropriate relationship with teachers and counselors at age of 10 (Weinfield et al., 1999).

A secure attachment predicts more positive parent-offspring interactions (Slade, 1987) at age of 6 and youth.

Attachment influence in adult emotional perception and expression

Adult attachments may be more reciprocal and less centered on physical contact, but the nature of the emotional bond is the same (Jordan, 2008).

Data suggests that secure individuals are more spontaneously expressive and more accurate in reading emotions than those in other categories. Avoidant/dismissing individuals are minimally expressive, observed to restrain expression of negative emotions, and appear to underestimate the intensity of negative emotions in others. Data is less conclusive for

resistant/preoccupied individuals but suggests that there is confusion in both reading and expressing emotions. Predominant expression of a positive affect, even in response to negative signals is often observed. Interestingly, the differences in the several groups in expressing and interpreting negative emotions are generally more consistent than the differences for positive emotions.

Research on dating and marriage in adulthood (Crowell & Treboux, 1995) shows some evidence that there is more conflict among couples with at least one insecure pattern, and when both have insecure patterns may be most conflictual. For example, among engaged couples, insecure women report more verbal and physical aggression from partners, and both partners reported heightened jealousy compared to couples in which the women were autonomous. In the same sample, after 15-18 months of marriage, women who were insecure were more likely to report marital conflict, physical and verbal aggression and threats of abandonment from spouses than those who were autonomous. Another interesting finding is that the husband's attachment status affects the quality of the marriage more than that of the wife's.

Current relations are viewed and experienced as attachments, and depending on which style each individual identifies with, the attitudes towards relationships and the emotional behaviors expressed in different situations within the relation vary.

To understand relationships in a stability perspective connected with attachment, we need to refer back to the concept of internal working models, defined by Bowlby. Applying this concept to adulthood, two main characteristics were studied: first, how early attachment experiences shape the intimate relation and second, how potentially working models are influenced by other relationship experiences (Feeney, 1999).

In an interesting study, Collins and Read (1994) suggested that adult internal working models are influenced by four interrelated components:

1. Memories of attachment-related experiences.
2. Beliefs, attitudes, and expectations of self and others in relation to attachment.
3. Attachment goals and needs.
4. Strategies and plans to achieve these goals.

According to these authors, these models shape individual's cognitive, emotional, and behavioral responses to others. Working models affect cognitive responses by directing people to pay attention to certain aspects of the stimuli, or by creating biases in memory encoding and retrieval, and by affecting explanation process. For example, secure adults show faster recognition of positive out-come words set in an interpersonal context, whereas avoidant adults show faster recognition of negative outcome words. Secure individuals have a stronger perception of security and greater confidence in their partner's availability.

With regard to emotional response patterns, IWM (internal working models) are thought to affect both primary and secondary appraisals. Primary appraisal refers to the immediate emotional reaction to a given situation. In secondary appraisal, cognitive processing may either maintain, amplify or lessen the initial emotional response, depending how the individual interprets the experience.

IWK affect behavioral responses throughout the activation of "stored" strategies learned before in a given context. For example, in a spouse conflict situation, seeking refuge 'in running home to mom' rather than exploring the situation and alternative ways to deal with situation.

This is important for relation stability, quality and has particular importance in relationships under stress.

Reactive attachment

When secure attachment is not possible the individual will try to adapt in several ways- such as avoidance, ambivalence or disorganization as described above. Nevertheless, there are situations that don't fall in those categories. At the extreme of attachment situations there are people who don't attach to any consistent figure. In these situations, the term Reactive attachment is used. These people have trouble with emotions and relationships. They establish rapid connections with a wide array of individuals but have difficulty with deep and long-lasting ones (Siegel, 2010).

Earned secure attachment

Earned secure is defined as the attachment style of adults that currently present a secure attachment style and have a story of insecure attachment that changed over time and/or had endured negative childhood circumstances or harsh parenting experiences (Roisman, 2002).

There exists extensive published research on earned secure attachment. It was suggested that although they had overcome poor childhood experiences and have a current secure attachment, their past might still have some impact on the quality of their romantic relationships, internalized distress and potential higher risk for depressive symptomatology.

Roisman, 2002, after an extensive analysis of a 23-year longitudinal study, found that earned secures enjoy success in their close relationships in adulthood with comparable quality to continuous secures. Moreover, the earned secured were not in greater risk for internalizing distress in adulthood when compared to other secure groups.

Another interesting finding is that one may have many models of attachment, one for each relationship we had with our caregivers (Siegel, 2010)

When securely attached children grow up, they will be more likely of having a way of making sense of their lives and creating a coherent life narrative. They will have a sense of who they have been, of who they are now, and of who they would like to become. They will also have a coherent sense of being themselves while also having close, meaningful relationships with others.

“That’s what secure attachment can offer, whatever age you are you have developed an integrated way of making sense with our life” (Siegel, 2010, p. 142).

“In a Different Voice”

Later on, some of these conceptualizations were widely critiqued mostly by followers of the feminist movement. Freud, Piaget, Erickson, Bowlby, just to mention a few, were all men defining their theories of life cycle from a patriarchal perspective.

“In a Different Voice” is a book by Carol Gillian published in 1982 and it is an open statement to the different voices that need to be heard, voices invisible at the time. One of her many critiques is that the majority of studies in psychology, and in particular human development, were a problem of method: only boys or men were chosen to integrate the research studies (Gillian, 2011). Women and children were invisible/inexistent in the studies, as such an enormous bias was introduced in those theories, which were then used to shape minds.

According with authors Carol Gillian, when analysing and making assumptions in their theories, these authors projected their experience as men and by doing that “have failed to account for the experience of women” (Gillian, 1979, p. 431).

Burman and Stacey, in their article “The child and childhood feminist theory” (2010) write a very elusive critique to these theories: “In the North, and globalized through the

international development policies, the model of child development inscribes on ideal-typical white, middle class childhood that is also culturally masculine” (p. 3).

Summary

In conclusion, attachment theory provides a useful and solid conceptualization when it comes to understanding relationships. The early attachment is a foundation upon which subsequent social encounters build. However, these basic attitudes and skills may well be modified by experiences with peers, teachers and other adults.

Research on this field is evolving and the intersection with other areas of knowledge might be proof of interest. One of those expanding areas is psychoneurobiology, and the affect regulation theory is one of its examples. In the following chapter, the author will give an overview of this theory.

Chapter 3: Affect Regulation Theory

Introduction

The central tenants of affect regulation theory were published in 1994 by Alain Shore in his first book called “Affect Regulation and the Origins of the Self: The Neurobiology of Emotional Development” (Schore, 2015). Shore explains his psycho-neurobiological model of early emotional development. In the preface of Daniel Hill’s 2015 book, “Affect Regulation Theory,” Schore writes that “as of this writing, regulation theory has been cited more than 12-13,000 times in Google Scholar.” A great deal of researchers in various fields have not only validated the theory but also expanded and applied it to psychotherapy approaches in a diverse number of situations.

This chapter will review the fundamentals of affect regulation theory, highlighting its connections to attachment and the therapeutic process.

The Beginnings

Allan Schore is an American Psychologist and Researcher in the field of neuropsychology at University of California, L.A. His work on the fundamentals of human emotional development was published in 1994 in his first book “Affect Regulation and the Origin of the Self: The neurobiology of Emotional Development.” His regulation theory is grounded in developmental neuroscience and developmental psychoanalysis, and integrated with attachment theory; he is considered to be “the american Bowlby” (biography: allanschore.com, 2009).

According to Schore’s ideas, a developmental theory about human functioning must integrate psychological and biological dimensions and, in order to understand the psychological

processes, we should try to grasp the mechanics of biological structural brain development. Another important element in Schore's theory is that "emotion is central to a deeper understanding of human condition and that unconscious processes lie at the core of the self throughout lifespan" (Schore, 2012, p. 1). By combining all these main concepts: psychological process, biological brain structures development, emotions and unconscious process, Schore developed affect regulation theory. Since then, he has been working on expanding his concepts and its applications to the therapy room and, in particular, to trauma psychology.

Affect

Affect is "at the core of our being, a measure of our heart. It excites and deflates us, connects and distances our relations with others" (Hill, 2015, p. 1). Affect can be understood under two categories: primary and categorical affect.

Primary affect is the somatic representation of the state of the organism: what is perceived in our body by the sensorimotor receptors and the physiological sensations which are collected and transmitted to the central nervous system. This generates a "felt sense" and it is represented as a nonverbal state of the body. There are either positive or negative states of hyperarousal and hypoarousal which are perceived as pleasant or unpleasant (Hill, 2015, p. 5).

Categorical affects are ones we think of when we talk about emotions. Based on Darwin's (1965) definitions of affects, we can consider seven affects: shame, sadness, joy, anger, surprise, fear, and disgust. In his studies, Darwin found that each emotion corresponds to a facial expression that is uniform across cultures. He concludes that if these are the findings, then these emotions must be crucial for human survival. He speculates that these emotions must have evolved through an inherited neurological basis.

The categorical affects can be hyper-aroused such as joy, pride and anger or hypo-aroused such as sadness, disgust, and shame, and they are expressed in different intensities.

Categorical affects might have become to exist by a combination of a primary affect in a particular context. For example, if someone is in a negative hyperarousal state and had lost someone, or something that is valuable, that person might internally organize a state of sadness.

If we take this above example, we can see that a primary affect (negative hyperarousal) that is perceived as a somatic event (the emotive sense in that moment) evolves to a secondary or categorical affect in a certain context (the loss of someone / something) and becomes a cognitive-affective experience (sadness). Normally, affects have a combination of both events: experiential and cognitive.

Damasio (1994) defines affect as “an expression of the body read by the mind.” In this duality of body and mind, the body analyses all the information that arrives from the peripheries (all organs and systems). In this process, there are different levels of information according to the vital role of that system for our primary need of survival. The most vital organs and systems in our body are the heart, lungs, and digestive system. The information generated in those organs are received by the limbic system and can be perceived as a somatic expression of hyper or hyperarousal. So, Damasio concludes, that affect is “somatic-based information signalling arousal level of the vital organs. Therefore, to regulate affect is to regulate the body.”

In his Affect Regulation Theory, Schore (1994, 2003, 2012) states that the regulation of affect is foundational for optimal functioning, that “there is nothing more basic to survival than the regulation of the organism.”

When affect is regulated, we are more alert, more predisposed to engage, and we can focus and reflect. In a self-regulated state, we feel good: we feel safe, and we can exercise our authenticity, agency, flexibility, and the capacity for adaptive responses.

In a dysregulated state, we do not feel safe. Our sense of well-being is diminished and so too is our sense of authenticity and agency. Our capacity to reflect and adapt creatively, flexibly, and spontaneously, is diminished or inaccessible. We are less predisposed to engage and relate with others.

In other words, the organization of the self is affect state dependent. We organize and disorganize depending on whether or not we are regulated (Hill, 2015, p. 28).

The affect regulation has an impact on the cognitive systems: attentional, perceptual, representational, memory, and reflective. It affects our subjectivity and intersubjective experiences (Hill, 2015, p. 28), meaning the way we experience the world and the way we experience and relate to others.

Viewing regulation through this lens, our state of regulation will have an enormous impact either in the way we experience the self or others. Therefore, we can understand that regulation of the organism is a vital mechanism, and the ability to remain regulated during a strong affect and the efficient return from a dysregulated state to a balanced one is an important adaptive mechanism and determinant for our wellbeing (Hill, 2015).

There exists, in our biological body, a tendency to keep balance; this is called the homeostatic state.

Additional Concepts

Before explaining affect regulation theory in depth, it is important to briefly mention other concepts that Schore borrowed from other authors which are essential to understanding his theory.

One of these concepts is the understanding of non-verbal communication associated with the expression of emotions and how others can mirror our own emotions. It is a common lived experienced that laughter or sadness seems to be contagious. How this is transmitted among individuals without verbal communication?

Affect is expressed in the body in many different ways such as facial displays, speech rhythm, intonation, and speech stress, as well as posture and gestures. We are wired to match one another's affect states. This is a neurobiological way to experience the subjective experience of others. (Hill, 2015, p. 7).

Porges (2012) argued that the interpersonal transmission of affect occurs so rapidly that it is not seen at a conscious level. The mechanism behind this is a perception received in our nervous system that quickly detects slight changes in our non-verbal language. We have a unconscious brain-to-brain communication mediated by the face (Hill, 2015, p. 8). My affect is perceived at an unconscious level by another, mostly through my nonverbal communication, and mainly by my facial expressions. The other individual will match my affect and respond accordingly. These reciprocal exchanges are biological (the sense) and psychological (it will generate a meaning). This communication happens in the here and now of the being together (inter-subjectivity). During these unconscious reciprocal communications, there will be positive and negative hyper and hypo arousals experiences.

The mother-infant interactions are examples of these types of communications.

Trevarthen (1993) called the specific interactions in early childhood “primary inter-subjectivity”.

Another significant example of this type of communication is the therapeutic relationship.

Two other key concepts in affect regulation theory are attunement and dyadic regulation.

Schore (1994, 2012) describes “attunement” as a “synchronicity of affect states” and he argues that it is crucial to regulate the infant as it sets up the ideal metabolic conditions for neuronal development. Attunement is the heart of attachment bonding? and of the positive therapeutic relationship (Hill, 2015, p. 9). Attunement is a “psychobiological synchrony” involving micro adjustments to one another’s arousal states. We are constantly and mutually calibrating our arousal levels to be in emotional synchrony with each other. Therefore, “attunement is essentially a synchronization of nervous systems as we match the ebbs and flows of one another’s arousal” (Hill, 2015, p. 120).

When the shared affect states are regulated, the resonance is pleasurable and energizing. Even when shared affects are negatively toned, there is something positive about regulated attunement. Such visceral experienced empathy offers a reassuring and vitalizing connectedness. One feels felt, known, and accepted, as well as nurtured.

In his theory, Schore refers to exchange of attuned experiences in the dyadic relation as an essential element for the development of the brain structures that have the function of regulating the affect.

Siegel (1999) emphasizes that attunement allows the parent to help the infant organize its own mind.

Dyadic regulation refers to the reciprocal affect attunement between mother and infant. At birth, a baby is dependent on others for many of his/her vital functions (ex: eating). The infant

is also dependent on affect regulation for soothing. In the human, the affect regulation structures are part of the limbic system and its development will occur during the first years of life.

Babies have rudimentary forms of self-soothing, but to further brain development both epigenetic (genetic/biological imprinting) and experience-dependent components are necessary. The regulatory theory explains that brain development is the result of nature and nurture experiences. This theory looks particularly at the nurture experiences and how they impact human brain development. In terms of nurture experiences, the first human bond connection, normally infant-mother interactions (dyadic relations), is the main development stimuli for brain differentiation. (Schoore, 1994, 2003, 2012; Siegel, 1999).

The dyadic regulation of affect involves the processing of emotional information communicated nonverbally (Hill, 2015, p. 11).

The brain structures involved in regulating the affect

This study does not present an in-depth understanding of the brain structures. In this section, the author will emphasise some of the most important structures involved in affect regulation and their role in regulation. Including this section in this study as as the main goal to highlight that the development of biological structures and physiologic events in human body are interconnected with life events of the individual, in particular in the first years of life. Therefore, it becomes difficult in complex systems and behaviors to fully understand what is nature or nurture driven. Eventually a good combination of both!

Evolution has provided us with two brain hemispheres so different from each other that they are commonly referred to as the right and left brains.

Our right and left brains process distinct kinds of information in diverse ways and therefore the left and right brains perform different functions (Gazzaniga & LeDoux, 1978). This brings us enormous adaptive advantages. A brain with hemispheres that process information differently allows for greater complexity and flexibility (Hill, 2015, p. 70).

The brain is a complex system and complexity theory provides some principles that allow us to understand the dynamics and development of the brain (Thelen & Smith, 1996; Siegel, 1999; Tronick, 2007; Boston Change Process Study Group, 2010; Schore 1994).

The first principle of complexity theory is that complex systems function best in states of maximum complexity and this allows the brain to work towards entropy. In states of maximum complexity, all the different modules that constitute the brain are available for reciprocal exchange of information with other modules. The more integrated the state of the system, the more flexible and stable it is.

Another principle is that complex systems shift states in a nonlinear fashion. Change doesn't occur in a step-by-step manner but instead emerges all together; there is no primer organizer of the changes.

Complex systems self-organize into new systems organizations. Perturbations anywhere in the organism (brain, body, mind) can cause a qualitative state shift in the overall system.

Finally, the brain is an open system that receives and transmits information. This openness allows connection with others (shared states) in which there is a blending of subjectivities. This capacity is of particular importance in the establishment of early relationships and in the therapeutic relationship (Schore, 1994; Trevarthen, 1993; Tronick, 2007).

Schore (1994, 2003, 2012) proposes that the right brain is dominant in early attachment development as well as the development of the primary system of affect-regulation.

According to other authors, the secondary system of affect-regulation is a left brain dominant, cortically based, voluntary, conscious, slow affect regulation mechanism (Fonagy et al., 2002; Allen & Fonagy, 2006). The two systems work in a complementary way.

The primary system is right brain based. The right brain mediates implicit process: implicit memory, implicit cognition, and implicit communication of affect. These processes are fast, unconscious, nonverbal, and automatic. The brain receives the information felt by the body. It reacts instantly to keeps us safe. It is a more primitive system when compared with the secondary one.

The left brain is verbal, linear, and involves a deliberate process of mentalization which is too slow for real-time interactions; however, it will provide additional complexity, flexibility, and stability for affect regulation.

Implicit processes are primary and precede the secondary explicit processes. They are unconscious, mostly because they are too fast to be taken to the level of consciousness.

We can say that one process is sensitive/emotion-based and the other cognitive based. For a complete affect integration and mature development, both come together: “the primary affect, processed in the right brain, is further processed in the left; where somatic experiences become words in the mind; where the non-mental becomes mental; where preconscious, right brain implicit processing is complemented by the conscious, explicit processing of the left” (Hill, 2015, p. 110).

Another interesting finding is that the processing of affect by the secondary system depends on the way the affect is regulated by the primary system. If the affect (the “felt sense”) is not regulated or dissociated it will not be available for conscious processing (for example a traumatic experience).

The affect processed by the secondary system opens the possibility for multiple assessments of experienced realities and provides us with a deeper understanding of affects, and corrects or confirms the gut reactions generated by the primary system.

The limbic system has the function of receiving emotional information and responding accordingly. The central organizing system is located at the center of the brain, that way it can operate more efficiently. It mediates involuntary motor and sensory systems, as well as physiological needs and drives: temperature, hunger, sexual drives, the sleep cycle, the pulmonary and cardiac systems. It is fully developed at birth, although it keeps growing and matures, and the first year of life is the most crucial moment for myelination. According to Schore's theory, the interaction between the infant and the caregiver plays an important role in the way this process happens. One can say that nurture becomes nature.

As referred to above, the limbic system receives information from the vital systems of the body through the sensorimotor receptors (sensation, movement and position) spread through our skin and organs. The information captured in the vital organs is sent to the limbic system, which after analysis, processes a response. The limbic system does not process words, but it processes somatic states: it accesses the image of the face, the sounds of the voice, and the non-verbal cues of the body.

When optimally developed, the limbic system can flexibly regulate affect in response to information from the internal or external environment: if the stimuli is perceived as a threat it activates the attachment system and triggers states of hyperarousal (flight or fight) or hypoarousal (freeze) (Hill, 2015, p. 56).

The limbic system is composed of several structures. The information below describes the functions of these structures that are connected with affect-regulation: (Hill, 2015, p. 59)

The **orbitofrontal cortex** is considered the “thinking part of the limbic system”. This structure does the final and most complex integration of the information processed by the limbic system (Schore, 2003). It is where affect, memories of relevant events, and the evaluation of the current context are integrated. The final integration is used to regulate affect and connect with superior functions of the brain if necessary. It is the center for the reception and expression of implicit communications of affect. It not only assesses individual subjective experiences, but also mediates our subjective interactions with others, therefore regulating our own affect. As Schore stated, it is the executive center of the self: it integrates the mind with the body, and the body and mind with the other body and mind.

The **amygdala** or the “red phone” of the brain constantly checks for threats. Memories of threatening experiences are stored in the amygdala and function as a reference for possible danger either from the external or internal environment. When triggered, it leads to states of hyperarousal. Amygdala fear based responses are, therefore, activated quickly, before the perception of danger becomes conscious.

The **anterior cingulate** mediates maternal behaviors such as nursing and serves to regulate aggression and affect arousal. It is linked to facial recognition and direction of attention.

The **insula** is responsible for integrating somatosensory information with the autonomic nervous system and the hypothalamic-pituitary-adrenal axis, providing embodied experiences. It is the felt sense of subjective experience. In dissociative states it is deactivated; is responsible for the feelings of numbness and emotional detachment associated with traumatic experiences (Schmahl et al., 2010).

The **hippocampus** mediates the recording and retrieval of memories. It assesses the emotional significance of an event and places a time and date. Memories stored in the hippocampus are used to inhibit the amygdala.

In intimate connection with the limbic system, there exist two systems of response. The first is called the Autonomic Nervous System and the second is the hypothalamic-pituitary-adrenal axis.

The **autonomic nervous system (ANS)** has two ways of functioning: either by generating an upregulating response (the sympathetic system) or by a down-regulating response (the parasympathetic system). Hill used a metaphor that helps understand the way both systems operate: the first is the accelerator and the other is the brake of the organism (Hill, 2015, p. 6). These systems regulate the heart and lung rate, as well as the metabolic rate and the corresponding experience of vitality.

The neuroendocrine system called the **hypothalamic-pituitary-adrenal (HPA)** axis, and also called the “stress system”, is composed of a series of glands which produce neurochemical reactions that will either hyper-regulate or hypo-regulate the body. These reactions are detected by the individual as positive or negative experiences.

Primary Affect Regulating System

Schore proposes a biphasic critical period in the development of the primary affect-regulating system: a neurological growth that starts prenatally and continues through from 16 to 18 months of age. During this period the limbic system is developing and becoming organized in a hierarchical manner. During the same period, circuits that connect the limbic system and the autonomic nervous system (sympathetic and parasympathetic) develop and mature. The way

these systems will organize and mature depends on the infant's body experiences and the way he/she becomes regulated. At this age level, although there exists some internal ability to self-regulate, most of the regulation is based on dyadic regulation (mother-baby). It is at this level that affect regulation meets attachment theory.

During the first period of growth and until 12 to 14 months old, the baby will increase in mobility, and, at the same time, the mother and baby will engage in repeated interactions of stimulation. Altogether, they forge automatic procedures of upregulation during the period when the sympathetic nervous system is undergoing innervation.

Mother-infant dyads begin prolonged face-to-face play and mutual gaze transactions from the early days of an infant's life. These situations of intense gaze generate states of joy (hyperarousal). The shared moments of joy by mother and baby have both an effect on positive attachment bond and learning how to regulate the sympathetic nervous system in a situation of arousal. During these intense moments, there is a synchrony between a baby's body reaction and the mother's response. The mother attunes to the infant's level of arousal, is sensitive to the infant's affect tolerances, and makes room for the infant to down-regulate by adjusting her gaze to the baby's desire to be or not in face-to face-interaction. The repetition of these behaviors leads to the development of adaptive strategies related to interaction and generates metabolic conditions that support and promote nervous structures' growth and maturity. Normally this stage is marked by positive interactions with the caregiver and amplifying joyful mirroring.

In the 12 to 14 to the 16 to 18 month old stage, the infant becomes mobile and the mother-baby interactions become encoded as automatic procedures of either downregulation or upregulation. For the infant's safety, the mother needs to impose some restrictions on the exploratory behavior of the child.

During this time, the parasympathetic system undergoes innervation. At the same time, the orbitofrontal cortex is forming connections to subcortical structures of the limbic system. This structure introduces the possibility of inhibiting body-based urges. At this point, it is possible to recognize opportunities for exploration and possible dangers and provide instructions to the autonomic nervous system for up or down regulation to support engagement or disengagement from the environment.

When this stage arises, the baby becomes more interested in exploring and being active. The caregiver will assess the safety of these explorations. It is through the facial expressions, mostly eye contact, that the infant checks for their mother's approval. According with Schore, there is no more intense implicit communication than eye contact; it directly links two nervous systems.

The face is the richest source of affective information, and the baby looks at the mother's face in search for clues for reassurance. In the many explorations of the environment by the infant, in his attempts towards autonomy, he / she needs to be seconded by the mother's supervision. Their eyes meet, and the baby knows, through his / her mother's expression, if the exploration should continue or not or if it is safe or not.

If the environment is safe, a securely attached mother will support her child's adventures. Through her facial expression, the infant will get the implicit message to continue exploration. The sympathetic nervous system, temporarily on hold, enters hyperarousal (excitement) and the adventure continues. Hill (2005, p. 118) calls this type of gaze the emotional refueling, meaning being recharged and empowered. The mother, through her implicit communication, is providing the baby with a sense of self.

As Hill (2015) states:

The contingently responsive, exploration-supporting mother provides just the right amount of help needed. She has the capacity to shift states and calibrate her arousal levels with her infant's as she shares the joy of her child's exploratory adventures and the ups and downs of getting there. She does not intrude yet helps maintain a positive state of optimal arousal. She allows the baby to develop competences while acting as a backup when needed. In doing so she instills pride, positive expectations, and the disposition to keep going.

The mother acts intuitively and spontaneously. No words are spoken. Schore (2012) called this "vitalizing attunement", and it is a right brain-based process (non-verbal, fast, implicit communication). One feels through the shared emotional resonance and experiences an immediate sense of safety. Schore proposes that attunement involves a "psychobiological synchrony" involving micro adjustments to one another's arousal states. We are constantly mutually calibrating our arousal levels to be in emotional synchrony with each other. By linking her nervous system to the infant's, the mother is able to up or down regulate the infant's level of arousal.

It is clear that a "good enough mother" is not always able to attune, and not all the interactions will be felt as positive experiences by the infant. When the exploratory situation is not safe or not in the best interest of the child, the mother, through her facial expressions, tone of voice and body behaviors, will give a message of disapproval.

During the second period (12 to 18 months) the parasympathetic regulation myelinates (matures) and permits the processes of downregulation. The optimal outcome enables infants to inhibit themselves through the activation of the parasympathetic nervous system, meaning it is possible to delay the action and remain regulated. When this system is fully developed, it permits

access to memories, to thinking and feeling clearly, and it maximizes response flexibility while down regulating.

The caretaker must now enforce restrictions on exploration by inhibiting the infant through activating and modulating parasympathetic arousal. Nevertheless, at this second stage mother-infant interactions go from 90 percent positive caretaking, play, and affection, to prohibition every nine minutes (Schore, 1994, p. 199).

When the infant looks to his mother's face, she expresses disapproval, fear, disgust, and sometimes anger. The infant drops the activity and might react with helpless, downregulated crying. The infant goes to his mother expecting to be picked up, soothed and brought back to a regulated state. In securely attached mothers, the expectations of the baby are met. The mother is able to restore the infant to a regulated affect state. Her state of hyperarousal (anger, disgust, fear) drops to align with the infant arousal state and regulates it. This negative hypoarousal is perceived by the infant as a shamed experience.

In a secure attachment relationship, the sequence is mis-attunement-shame-collapse-repair. The re-attunement returns to the infant the sense of connection, safety, and well-being, with a refreshed capacity for interest in the world. According to Schore, this moderate shaming (frustrating the child) is critical to the development of tolerance for negative affect and resilient shifting from dysregulated to regulate affect states. Another important element is the need to repair in order to process shame (frustration) adaptively. To attune the infant in these situations, the caretaker must be able to tolerate shame herself (using other words, being able to handle frustration or negative feelings).

These negative feelings are stored as implicit memories into the limbic system and encode neurobiological procedures for tolerating and bouncing back from states of negative hypo-arousal.

Schore states that the rupture-repair process is a key element in the organization of the internal working models defined by Bowlby (Chapter 2 of this thesis). In a secure attachment style, the way repair is obtained establishes a positive expectation, characteristic of securely attached persons.

Schore also proposes that secure attachment experiences facilitate the optimal organization of the limbic structures and obtain a balanced autonomic nervous system response in regulating affect, at the same time.

In these multiple sequences of rupture-repair of dysregulation and re-regulation the neurobiological structures are being “wired” in certain patterns with respect to responding to emotions (Schore, 1994). These will become implicit memories in the limbic system. The infant is now on the road to building resilient self-regulation, affect tolerance, and flexible responsiveness when stressed.

The secure caretaker’s capacity for autoregulation and range of affect tolerance is crucial. The primary affect regulation system of secure attachment figures is robust enough to cope with the stress of regulating an infant: to tolerate the infant’s dysregulation, to modulate their own disgust and anger, and to attune to the highly stressful, hyperarousal shame states induced in the infant. Secure attachment figures have tolerance for both hyper and hypoarousal affect and, when dysregulated, are able to repair ruptures in the attachment relationship.

The regulation of positive hyperarousal allows us to experience pride states without crossing over to grandiosity. It is equally important to regulate negative hyperarousal states as

this allows us to process anger and modulate its expressions (Hill, 2015, p.129). Finally, it is important to manage states of negative hypoarousal in order to manage the level of shame and keep a sense of self-worth.

With the completion of the development of the right-brain-based primary affect regulating system, the development of the left-brain-based, secondary affect-regulating, mentalization system begins (Schoore, 1994; Fonagy et al., 2002; Jurist, 2005).

Secondary Affect-Regulating System

Mentalization is considered to be the secondary affect-regulating system, and it is a “left-brain-dominant, cortically based, voluntary, conscious, slow system that develops later than the primary affect-regulating system” (Hill, 2015, p. 98).

Mentalization theory, developed by Peter Fonagy and colleagues, has its foundations on Mary Main’s work and on her findings during the process of using adult attachment interviews. Basically, she observed that securely attached adults had a reasonable capacity to review their own stories in a coherent, clear manner, and they were also able to understand other person’s stories in a similar way. Securely attached adults produce coherent whole narratives, no matter the type of situations they had experienced. She called this “metacognitive monitoring” (Main, 1991). Main theorized that a breakdown of coherence occurred when a narrative touched on unresolved and / or traumatic losses (Hill, 2015, p. 99).

Fonagy and colleagues, in a book called: “Affect Regulation, Mentalization, and the development of the self” (2004), set for themselves the task of linking attachment theory to complex ideas about intersubjectivity and theory of mind that derive ultimately from hegelian philosophy. The authors state that *mentalization*, which they define as “the capacity to envision

mental states of self and others” (p. 23) and operationalize as *reflective functioning*, arises as a higher-order transformation of the attachment system in humans and in turn helps organize human attachments.

In a different publication, the same authors explained mentalization as “the mental process by which an individual implicitly and explicitly interprets the actions of self and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons” (Fonagy & Bateman, 2004).

Mentalization emerges in the context of the infant-caregiver relationship through early affect mirroring and is essential to the development of inter-subjectivity. That is, infants become independent subjects only if they are recognized as such—as beings with minds, wills, and feelings of their own—by their caregivers. Thus, a sensitive caregiver relates to her baby as a subject long before an infant has any conception of other minds and other subjectivities. To paraphrase Fonagy et al., an infant develops a mind because the caregivers have the baby’s mind in mind.

Fonagy et al. propose a social biofeedback model of affect mirroring as the mechanism through which infant affect regulation develops and attachment security (or lack thereof) is consolidated. According to this theory, sensitive caregivers respond to their babies’ affective displays with contingent marked affective displays of their own, and this contingent marked mirroring of the infant’s emotions is what enables the baby to modulate his or her own affect states.

Psychoanalytic developmental research (e.g., Jaffe, Beebe, Feldstein, Crown, & Jasnow, 2002; Stern, 1985) has determined that moderate degrees of caregiver-infant contingency or coordination in affect states are optimal for the infant’s eventual development of adequate affect

regulation and attachment security and that a caregiver-infant system with too much or too little contingency - too little or too much mirroring -results in developmental psychopathology.

Caregivers also help babies find their own emotional states in the parent's face, much as Winnicott (1971/1982) describes, and the baby therefore experiences the parent's displayed affect as his or her own, rather than as the caregiver's. Fonagy et al. argue that this process is especially important in the modulation of negative emotions and in the infant's formation of a constitutional self. If, however, the caregiver fails to mark his or her emotional displays, the infant will see the parental response as reflecting the parent's actual emotional state and the infant can be traumatized by the uncontained affect if the caregiver's response is negative. Or, if the caregiver's response is marked but incongruent with the baby's affect, the baby will identify with the incorrectly mirrored affect that he or she sees in the parent's face and the infant will begin to develop a false or, in Fonagy et al.'s terms, an alien self. It is important to stress that it is the repetition of these missing mirror situations that leads to other forms of attachment.

In other words, we can understand mentalization as a self and others awareness, insight, empathy or understanding. Each person has the other person's mind in mind, as well as their own. The mentalization process developed by a secured attached person is responsible for a better interpersonal functioning, a meeting of minds or a connection through shared understandings.

Mentalization and attachment are intimately united since both processes are formed during the dyadic relationship. Mentalization is a more developed way of self and other's affect-regulating mechanism.

In the beginning, the mind takes form from the outside-in; its state is reflected in the caretaker's face (Hill, 2015, p. 102). Once language is developed by the child, the outside-in

process takes the form of mind talk, in which the mother represents the child's mind through words. The mother's capacity to verbally represent and reflect back her child's mind with reasonable accuracy is crucial. Slade et al. (2005) call this process "minding the baby".

A mother's capacity for mentalizing her child is at the heart of the mentalization theory (Allen et al., 2008; Fonagy et al., 2002).

The importance of mentalization and affect regulation is of utmost importance. The mentalizing system regulates affect first by identifying it, and by naming the body-based experience. Once the affect is identified, a process of elaboration is possible, which means the fine-tuning of the meaning of that affect takes place. It is "the thinking through the feeling in the midst of live affect" (Hill, 2015, p. 108).

Thinking in terms of brain structures, effective mentalization requires optimal hemispheric integration: the felt affect is first processed in the right brain only after it is possible to process in the left brain the cognition component of the felt affect (thoughts about emotions; emotions about thoughts; emotions about emotions).

Affect Regulation and Attachment Theory

An attachment theory overview was presented in the first chapter of this study. In this chapter, the author will explore how the affect regulation and attachment are interconnected.

The previous explanation concludes that the infant needs the care and attention of the primary caregiver for basic vital functions and that besides some self-regulation biological mechanisms, the caretaker plays an essential role in the infant's affect regulation.

From the attachment theory perspective, we can see that the mother (primary caregiver) was, for the child, the "secure base" and "safe haven" of protection and world exploration. This

theory also explains that the mothers' availability is an essential element to read the infant's needs and respond accordingly.

In such dyadic interactions of the mother-baby, not only is a secure bond developed, but the brain structures mature as well. The mother's response, available and consistent, is essential to acquire strategies both at the psychological and biological level that will be responsible for regulating the affect.

Secure attachment depends upon the mother's sensitive psychobiological attunement to the infant's dynamically shifting internal states of arousal (expressed by crying or other signs of discomfort, or body expressions of joy or excitement). Through visual-facial, auditory-prosodic, and tactile-gestural communication, the caregiver and infant learn each other's rhythmic structure, and modify their behavior to fit that structure, creating a specific response. These processes are based on affects sensed at somatic, nonverbal levels, mostly intuitive and unconscious. This type of interaction between the infant and mother is what researchers call "nonverbal intersubjective communication" (Papousek, 1987, p. 258).

During these bodily based affective communications, the attuned mother synchronizes her own sensorium stimulation with the infant's spontaneous expressions of his/her biological rhythms. Through this contingency response, the mother regulates the internal arousal and affective states of the baby and communicates them to the child in away that the infant is soothed, which is perceived as pleasant. The mother will perceive the low or hyper arousal signs of the baby as non-pleasant and, with her synchronic response, she will modulate to successfully create a state perceived by the infant as pleasant. In these episodes of affect synchrony, the pair are in affective resonance and, as such, an amplification of vitality affects and positive state occurs.

In moments of interactive repair, the “good-enough” caregiver (Winnicott, 1971), who has perceived the infant’s negative state and accurately re-attuned in a timely manner, is building the blocks of attachment, affect regulation, and resilience (Schoore, 2005).

With the repetition of these experiences of mother-infant attunement, infants become neurologically engrained-internalized and the child is able to self-regulate (Hill, 2015, p. 11). The capacity for affect regulation is optimal when we are able to alternate between self-soothing and dyadic regulation according to our needs and circumstances.

Note of interest:

Recently, by the hand of Colin Sanders, my thesis supervisor, I encountered the work of Jeffrey Zimmerman. In his amazing articles “Narrative Therapy and Interpersonal Neurobiology: Revisiting Classic Practices, Developing new Emphases” (2011), “Neurobiology for your Narrative: How Brain Science can influence Narrative Work” (2015) and “Neuro-Narrative Therapy: Brain Science, Narrative Therapy, Poststructuralism, and Preferred Identities” (2017), the author integrates the classic narrative therapy concepts and techniques with the knowledge of the brain sciences.

In narrative therapy it is understood that the meaning/story is the problem and not the person, and the therapeutic process is a collaborative process where client and therapist are “interested in talking about these problem-stories in a manner that externalized them, in an effort to counter the common practice of internalizing them in persons, and to create room for the person to notice other possibilities” (2015, p. 60).

Following the advances of brain sciences, Zimmerman realized that to be able to name an experience or tell a story about an experience (narrative) it is essential that first that experience

had been felt, before becoming a left brain process (cognitive process) it needs to be a right brain process (somatic process). Therefore, “naming means bringing forth a relevant (affective-based) experience and putting a cognitive label on it to help contain/quiet limbic firing” (2015, p. 61).

For some time now, Zimmerman has been studying and reflecting on the relevance of neurosciences in therapeutic conversations, and his work keeps evolving.

Summary

In conclusion, affect regulation and mentalization theories provide an understanding of how affect is regulated. The need of emotional connection is crucial either for establishing our first bonds (attachment) or regulating our affect and, ultimately, in the development and maturing of the brain structures and neuronal circuits that will assist us through our life and in the way we experience ourselves and others.

Chapter 4: Therapeutic Relationship

Prologue

She was almost always to be seen with someone sitting beside her, talking earnestly, and those who needed her but couldn't come themselves would send for her instead. As for those who needed her but hadn't yet realized it, the others used to tell them, "Why not go and see Momo?"

In time, these words became a stock phrase with the local inhabitants. Just as they said, "All the best!" or "So long!" or "Heaven only knows!", so they took to saying, on all sorts of occasion, "Why not go and see Momo?"

Was Momo so incredibly smart that she always gave good advice, or found the right words to console people in need of consolation, or delivered fair and farsighted opinions on their problems?

No, she was no more capable of these things than anyone else her age.

So, could she do things that put people in a good mood? Could she sing like a bird or play an instrument? Given that she lived in a kind of circus, could she dance or do acrobatics?

No, it wasn't any of these either.

Was she a witch, then? Did she know some magic spell that would drive away troubles and cares? Could she read a person's palm or foretell the future in some other way?

No, what Momo was better at than anyone else was *listening*.

Anyone can listen, you may say – what's so special about that? – but you'd be wrong.

Very few people know how to listen properly, and Momo's way to listening was quite unique.

She listened in a way that made slow-witted people have flashes of inspiration. It wasn't that she actually said anything or asked questions that put such ideas into their heads. She simply sat there and listened with the utmost attention and sympathy, fixing them with her big, dark eyes, and they suddenly become aware of ideas whose existence they never suspected.

Momo could listen in such a way that worried and indecisive people knew their own minds from a moment to the next, or shy people felt suddenly confident and at ease, or down-hearted people felt happy and hopeful. And if someone felt that his life had been an utter failure, and that he himself was only one among millions of wholly unimportant people who could be replaced as easily as broken window panes, he would go and pour out his heart to Momo. And, even as he spoke, he would come to realize by some mysterious means that he was absolutely wrong: that there was only one person like himself in the whole world, and that, consequently, he mattered to the world in his own particular way.

Such was Momo's talent of listening.

(from: *Momo*, by Michael Ende)

Since I came into the "world" of counselling I have been fascinated by the relationship process in therapy. Yalom, in his book "The Gift of Therapy", says that content and process are the two major aspects of the therapy discourse. The content refers to the actual words and concepts expressed. The process refers to the nature of the relationship between the individuals who express the words and concepts.

Although the content interests me as well, I have been reflecting on the” process of therapy” in a particular way. What it is? What does it entail? How can we translate into to words what happens in the here-and now of the therapeutic relationship? What is so special about it that can allow change and growth in clients?

Research consistently came across the idea that therapeutic relationship factors are the second largest contributor to change in psychotherapy, the first being the “extra therapy factors”, (Miller et al, 1997). More than “the technique” or a model of practice, the relation established between therapist and client will determine the progress of therapy.

I started this chapter with a quote from Michael Ende's book, “Momo”. This passage describes what’s happening in the therapeutic process in a very poetic way.

Momo was an orphan girl who one day showed up in a small community. Nobody knew where she came from, her age, her family or the skills she carried with her. She lived in abandoned ruins in the outskirts of the village. She was discrete and silent. Soon enough, she became a support for many villagers. She wasn't outstanding in any area of her life. She didn't do anything special, apparently. But she was a very good listener, and that was her special gift.

I wonder if I can bring to therapy that gift: the gift of listening. A gift that could sustain, support and console. That is my wish.

In this chapter, I would like to focus on the “process of therapy”. I will visit authors that have recently become significant for me as a therapist.

What is Therapeutic Relationship?

When consulting the dictionary of psychology (Oxford Eds., 2015) the definition for therapeutic alliance was the following: “ In psychoanalysis, the implicit cooperative compact between an analyst and a patient whereby the analyst undertakes to offer interpretations and the

patient undertakes to obey the fundamental rule of psychoanalysis and to try to understand the analyst's interpretations.”

This is not exactly my idea of therapeutic relationship, although I am familiar with this way of perceiving it. My preferred way of seeing is more a felt bond between therapist and client, in the here-and-now of the therapy. It is a process of companionship: being companions in the therapeutic journey.

I was surprised to find such definition in that dictionary, especially in such a recent edition (2015). It made me look into the historical evolution of the concept.

According to Horvath and Luborsky (1993), the concept of therapeutic alliance can be traced back to Freud (1913) when he first explained the process of transference. Initially regarded as purely negative, Freud, in his later works, adopted a different stance on the issue of transference and considered the possibility of a beneficial attachment developed between therapist and patient, and not only as a projection. Along the same lines, Zetzel (1956) defines the therapeutic alliance as a non-neurotic and non-transferential relational component established between patient and therapist. It allows the patient to follow the therapist and use his or her interpretations. Similarly, Greenson (1965) defines the working alliance as a reality-based collaboration between patient and therapist. Other authors (Horwitz, 1974; Bowlby, 1988), made a distinction between transference and the therapeutic (or working) alliance, and this distinction later extended beyond the analytical framework (Horvath & Luborsky, 1993).

Rogers (1951) was the one who shifted the way of looking at therapeutic relationship. He stressed the therapist's role in the relationship, and the essential conditions to promote change in the therapeutic process.

“On the shoulders of Carl Rogers”

“On the shoulders of Carl Rogers” was the title given by Miller et al. to a chapter in their book *Escape from Babel*. I like the metaphoric image of “being” carried by other people's expertise, wisdom, and vision. Something that enlightens what we do, or wish to do.

Carl Rogers had that amazing mind to be able to articulate what we didn't have the words for before. The magical act of creating meaning for something that existed since human existence. I hold the opinion that what Rogers said was not new, he just found the right words to express that magical process between client and therapist and with it, shift the perspective in mental health and psychology fields of looking at the therapeutic process.

What makes the client-therapist relationship so special?

In the early 50's, Carl Rogers, a pioneering psychotherapist and a very influential psychologist in American history was a man ahead of his time. Anderson, in one of her articles about Carl Rogers says:

Rogers had many firsts. He was the first to offer an alternative to psychiatry and psychoanalysis and the first to record and publish therapy sessions. He was among the first to use personal expression and informal style in his writings. He was also the first to challenge the ‘sacred cows’ (Rogers, 1980, p. 235) of mainstream psychology, being particularly critical of research based on logical positivism, traditional modes of education and certification of therapists – challenges he continued until his death. I cannot do justice to the philosophy and practices of a man who authored sixteen books and over 200 articles across a nearly fifty-year span. (Kirschenbaum & Henderson, 1989b)

Carl Rogers had left an incredible treasure and we are all his heirs, that's why I like the expression on being "on his shoulders" so much. Nevertheless, and for this chapter, I would like to focus on the therapeutic process.

Rogers believed and trusted that human beings have within themselves a 'constructive tendency' (Rogers, 1980, p. 121) and 'vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior' (Rogers, 1980, p. 115). In addition, he thought that human beings have 'the tendency to grow, to develop, to realize [their] full potential . . . the constructive directional flow . . . toward a more complex and complete development' (Kirschenbaum & Henderson, 1989b, p. 137). These ideas, in turn, informed the aim of Rogers' approach: to release this directional flow. This explanatory principle became the basis of humanistic psychology. Rogers' approach focused on the construct of self and on personality change: this was the core from which he developed a theory of personality. The goal of therapy was to move the individual towards maturity, 'as being, *becoming*, or being knowingly and acceptingly that which one most deeply is' (Kirschenbaum & Henderson, 1989b, p. 62). Therapy was a 'process of exploration of feelings and attitudes [emotional catharsis] related to the problem areas, followed by increased insight and self-understanding' (Rogers, 1940, p. 133). Rogers believed that 'if a person is fully accepted, they cannot help but change' (Kirschenbaum & Henderson, 1989b, p. 61). This process led to positive choices and increased capacity for problem-solving (Kirschenbaum & Henderson, 1989b, p. 23). The counsellor served as a 'genuine alter ego' (Rogers, 1940, p. 40) and was like a 'a midwife to a new personality' (Rogers, 1951, p. xi). Although Rogers focused on personality change, he did not place importance on the structure or causes of a client's personality.

Initially, Rogers believed that three interrelated therapist characteristics were essential to creating a climate that supported and promoted this client-directed competence and growth: genuineness or congruence, unconditional positive regard, and empathetic understanding (Kirschenbaum & Henderson, 1989a). He later added a fourth characteristic that he called spiritual or transcendental, describing it as the special way a therapist can be spontaneously present with another when the therapist is ‘closest to his inner, intuitive self and is in touch with the unknown me . . . then simply my *presence* is releasing and helpful’ (Kirschenbaum & Henderson, 1989b, p. 137). He believed these therapist characteristics or expressions of attitudes and behaviours were a ‘way of being’, a ‘philosophy’ (Kirschenbaum & Henderson, 1989a). And, when a therapist lived this philosophy it helped both the client *and* the therapist to ‘expand the development of his or her capabilities’ (Kirschenbaum & Henderson, 1989a, p. 138). Rogers considered his approach a philosophical stance and way of being rather than a technique or something that the therapist “does” to the client.

Rogers referred to his theory as an ‘if-then’ variety: If certain conditions exist . . . then a process will occur which includes certain characteristic elements [his conditions for change]. If this process . . . occurs, then certain personality and behavioral changes – reorganization of the self-structure with concept of self becoming congruent with experience of the self – toward an unconditional positive self-regard . . . will occur. (Kirschenbaum & Henderson, 1989a, p. 240).

On the other hand, the therapist is genuine and spontaneous in her way of being; the therapist ‘lives these conditions [characteristics] in the relationship and becomes a companion to the client in this journey toward the core of self’ (Kirschenbaum & Henderson, 1989a, p. 138). For Rogers, there was no therapy like a “recipe”; the relationship could not be duplicated from one client to the next. Each therapy and each client–therapist relationship were unique.

With this new view, the world of psychology moved from techniques/models to the process of therapy, and the therapist as an expert to the perspective as the therapist as a “companion” in this journey.

Later, recognition of the fact that distinct types of psychotherapy often reveal similar results gave rise to the hypotheses that there must exist common variables to all forms of therapy, which increased the interest in understanding the therapeutic alliance.

Luborsky, in 1976, suggested the existence of two phases in the therapeutic alliance: the first, found in the early phases of therapy, was based on the patient’s perception of the therapist as supportive, and a second type, more typical of later phases in the therapy, represented the collaborative relationship between patient and therapist to overcome the patient’s problems – a sharing of responsibility in working to achieve the goals of the therapy and a sense of communion.

The definition of the therapeutic alliance proposed by Bordin (1979) is applicable to any therapeutic approach and for this reason is defined by Horvath and Luborsky (1993) as the “pan-theoretical concept.”

Bordin had a psychoanalytic background and was fascinated by the process of therapeutic alliance. He proposed a novel conceptualization of the alliance that focused on the perpetual negotiation of therapeutic goals and tasks between client and therapist. No matter what modality the therapist uses, all therapists will define goals with clients and work together to achieve it.

As he noted in 1989:

It seems more likely to me that each of many sensitive and creative therapists arrived at methods that were appropriate to the kinds of persons he or she was trying to help who

were different from the persons who were being helped by another equally sensitive therapist.

According to the author, the therapeutic alliance consists of three essential elements: agreement on the goals of the treatment, agreement on the tasks, and the development of a personal bond made up of reciprocal positive feelings. In short, the optimal therapeutic alliance is achieved when patient and therapist share beliefs with regard to the goals of the treatment and view the methods used to achieve these as efficacious and relevant.

Bordin also suggests that the alliance will influence outcome, not because it is healing in its own right, but as an ingredient which enables the patient to accept, follow, and believe in the treatment. This definition offers an alternative to the previous dichotomy between the therapeutic process and intervention procedures, considering them interdependent.

Clearly privileging integration in theory and practice, as well as the person of the client and therapist, Bordin (1979, 1980c) viewed the working alliance as differing in strength and kind. He was central in formulating the alliance as not only the platform for subsequent change, but also as a change product in and of itself via a process of building and repairing alliance breaks. The client, by working with the therapist, will develop new ways of thinking, feeling, or acting with self and others. Bordin, posit that a central component in such relational negotiation stemmed from understanding individual differences in clients' differential abilities to work through different therapeutic tasks depending on the specific problems for which they sought change.

In conclusion, from the previous brief historical background we can notice several changes in a way of seeing therapy and being in therapy. A major shift was the role of the therapist first as the expert and later as a companion. Therefore, therapy was not something that

the therapist “did to the patient” anymore, but instead was a co-constructed, and relational, process between therapist and client. With this idea in mind it was an easy step to consider each dyad client-therapist unique and the same with each therapeutic process.

Another very powerful idea is that the process of therapy promotes change in itself no matter what technique might be used. And, following the research results, the therapeutic process is the most important element in promoting change.

One divergent concept posit by Bordin is how far can we go to separate the process of therapy from the content of therapy? Eventually, it is not possible to detach the therapeutic relationship from a specific modality. They are interconnected and work together.

Reflecting on that, it is my understanding that without a therapeutic relationship the “modality” will not have support to be effective, so the process of therapy in the conditions considered by Rogers might be the common denominator of various therapies. At the same time, if we look to modalities as defined by Rogers, Yalom, or Anderson it becomes obvious that we cannot separate a therapist from a modality or a preferable one. All define that “a modality” is not a technique but a philosophical stance, a way of being in therapy and outside of therapy. It constitutes an identity. Therefore, in therapy, it is always a specific therapist that meets a specific client, and these encounters are unique. If the therapist lives authenticity in the process, he will relate and act according to certain therapeutic philosophical values. This doesn't necessary means that a certain technique will be more effective than another, as long as the therapist is true to himself. As Bordin expressed so well : “ It seems more likely to me that each of many sensitive and creative therapists arrived at methods that were appropriate to the kinds of persons he or she was trying to help who were different from the persons who were being helped by another equally sensitive therapist”. (Bordin, 1989, p. 4).

A Selection of Authors who have Inspired Me

Some views pointing the way...

Below are some views from different authors that had touched me in a special way. All of them are an expansion of Rogers' preliminary ideas. For some, these ideas are seen as elements of a “modality” of therapy, but in reality, and according to their respective authors, they are philosophical stances. It is a lens from which we see the encounters therapist-client, a belief, something lived inside and outside the therapy room. Here in this study, they represent ideas that make the process in the therapy room a special one.

Irving Yalom

In his book, *The Gift of Therapy*, Yalom, (2017) tries to leave a legacy for future generations. This was his intention while writing this book and, in my opinion, it was achieved. It is a transparent and honest book. He was able to share his expertise in a very simple a gifted way.

One passage states his vision of therapy: “Psychotherapy consists of a gradual unfolding process wherein the therapist attempts to know the patient as fully as possible. A diagnosis limits vision of the process. Limits the possibilities to explore” (p. 4). And his position as therapist:

I prefer to think of my patients and myself as fellow travellers, a term that abolishes distinctions between “them” (the afflicted) and “us” (the healers). We are all in this together and there is no therapist and no person immune to the inherent tragedies of existence (p. 8).

Through the several chapters, he shares words of wisdom. Some of these ideas are applicable to the present study, such as what clients value in therapy or the uniqueness of the

therapeutic process: “What patients recall when they look, years later, on their experience in therapy? Not insight, not the therapist’s interpretations. They remember the positive support of the therapist (p. 13)” or “Often the therapist is the only audience viewing great dramas and acts of courage (p. 14)”.

Yalom believes that all therapists will discover their own way of supporting patients (p. 15) and patients profit enormously simply from experience of being fully understood (p. 18). Expanding on the concept of “empathy,” Yalom states that “accurate empathy is most important in the domain of immediate present- that is the here-and-now of the therapy hour”.

He touches on one aspect of being empathetic that I find very interesting:

Being empathetic is so much part of everyday discourse...it is extraordinary difficult to know really what others feels; far too often we project our own feelings onto the other.

The investigation of the past may be important not for the sake of constructing casual chains but because it permits us to be more accurately emphatic (p. 22).

We can all say that we want to be empathetic but being empathetic is, or can be, extremely difficult. Trying to explore the client’s narrative and situate the person in a context it might help us to “see” the person that is with us in the therapy room. Therefore, the exploration of the past serves the purpose of building the therapeutic relationship rather than a “technique” associated with a specific modality.

Another dimension of living empathy in the therapeutic process, is that it is therapeutic itself: “I believe that the here-and-now offers therapist a powerful way to help patients develop empathy. By experiencing empathy with the therapist will provide automatically the necessary tools to the client explore empathy towards other figures in their lives.”

Each client requires us to create a new therapy. Yalom quotes Jung when he describes his appreciation of the uniqueness of each patient's inner world and language, a uniqueness that requires the therapist to invent a new therapy language for each patient (p. 34). He fosters a type of relationship that will itself become the agent of change:

I try to avoid a technique that is prefabricated and do best if I allow my choices to flow spontaneously from the demands of the immediate clinical situation. My point is that every course of therapy consists of small and large spontaneously generated responses or techniques that are impossible to program in advance (p. 35).

According to Yalom, the here-and-now is the major source of therapeutic power:

The here-and-now refers to the immediate events of therapeutic hour, to what is happening here (in this office, in this relationship, in the betweenness-the space between me and you) and now, in this immediate hour (p. 44).

He expands on this concept by saying that the "rationale for using the here-and-now" rests upon a couple of basic assumptions: the importance of interpersonal relationships and the idea of therapy as a social microcosm. Human problems are largely relational, and this will show up in the here-and-now of the therapeutic relationship. Each individual has a different internal world and the stimulus has different meaning to each. This is the "magic" of therapy, to see each client's unique world.

This main idea of the here-and-now of therapy and the uniqueness of each client internal world led me to an idea from the narrative studies that I like in particular.

The narrative studies and definitional ceremony in therapy

From the perspective of narrative theory, psychotherapy represents a unique experience in life—one in which the individual seeks assistance in the telling (or retelling) of his or her story so that events or occurrences that do not fit with the ongoing personal narrative, or that call into question the established story, may be incorporated (Josselson, 2004; Singer, 2005; Spence, 1982; White & Epston, 1990). Thus, psychotherapy can be understood as an unusual personal project in which the individual seeks help working on his or her story in an effort to move closer to a personal narrative that supports desired outcomes. White and Epston (1990) concluded, “When persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings, bringing with them desired possibilities” (p. 15).

In narrative therapy the definitional ceremony is used to express something rather amazing. The origins of definitional ceremony in White’s vision came to be from two main inspirational works: Tom Andersen and Barbara Meyerhoff.

In 1987, Tom Andersen of Norway published his paper *The Reflecting Team: Dialogue and meta-dialogue in clinical work*. This introduced the family therapy world to a very different conception of therapeutic teamwork, and to a very different notion of team member participation. The use of the reflecting team was developed within the therapeutic field and consisted of a group of colleagues (typically 3-6), or other relevant individuals, who are asked to assume an observational position vis-à-vis the conversation between therapist and client (family). The reflecting team adds a meta-position to the therapy.

According to White, “there exist many candidate metaphors for the sort of reflecting teamwork” and he picked up some of the aspects of the reflecting teams of Tom Andersen and

associate with another concept that he borrowed from Barbara Myerhoff's 'definitional ceremony'. He considered that Myerhoff's concept of definitional ceremony provided a particularly appropriate metaphor for his work, and serves to clarify some of the processes involved in it. Myerhoff used this metaphor to describe some of the activities of an elderly, poor, and neglected Jewish community in Venice, Los Angeles. Because the people of this community were relatively invisible to the wider community, they were deprived of important reflections on their own lives, and at risk of becoming invisible to themselves - at risk of doubting their very existence. It was by 'definitional ceremonies' that the people of this community countered this threat.

These ceremonies provided for these people an 'arena for appearing' and for 'opportunities for self - and collective proclamations of being': definitional ceremonies deal with the problems of invisibility and marginality; they are strategies that provide opportunities for being seen and in one's own terms, garnering witnesses to one's worth, vitality and being (Myerhoff, 1986, p. 267). Myerhoff calls attention to the critical role that the 'outsider-witness' plays in these definitional ceremonies. These outsider witnesses are essential to the processes of the acknowledgement and the authentication of people's claims about their histories and about their identities, and to the performance of these claims. The participation of the outsider-witnesses in definitional ceremonies gives 'greater public and factual' character to these claims, serving to amplify them and to authorise them. The outsider-witness also contributes to a context for reflexive self-consciousness - in which people become more conscious of themselves as they see themselves, and more conscious of their participation in the production of their productions of their lives.

In White's words, definitional ceremonies make "it possible for people to 'assume responsibility for inventing themselves and yet maintain their sense of authenticity and integrity', for people to become aware of options for intervening in the shaping of their lives."

In therapy, all clients are searching for visibility and at times some feel marginalized in some way. In therapy, all clients bring their own narratives. Some are looking to re-create their stories. Some looking for a witness to their story.

Seeing the therapist as an "outside witness" is something that resonates with me. Although in a much smaller and humbler expression of what White defined as a definitional ceremony, it makes sense to me to see each therapeutic process as a "definitional ceremony." Considering this, not only makes me reflect my identity as therapist and the way I position myself in therapy but it also provides rich support for what the therapeutic process entails.

The beauty and gentleness of Harlene Anderson

One of the most inspirational works in therapy is, in my opinion, the Collaborative Therapy work developed by Harlene Anderson. As she often expresses, focusing on client voices, reflecting with clients, learning from clients, and using what we learn as we go along with each other in therapy, has been a central element in her work.

My constant question, in one form or another, has been, 'How can therapists create the kinds of conversations and relationships with their clients that allow both parties to access their creativities and develop possibilities where none seemed to exist before?' (Anderson, 1997, p. 13).

According to Anderson, the therapeutic process involves collaborative relationships and dialogical conversations.

The therapist aims to invite, create and facilitate this kind of relational and dialogical space and process, giving life to it inside and outside the therapy room. Both client and therapist are at risk of transformation in this kind of space and process. Therapy of this nature, including the client–therapist relationship and the process, becomes more mutual and egalitarian.

My goal is simple: to be helpful to a client with their want, need and agenda regarding their life difficulty. I accept that there is usually more than one reality about the issue, its imagined resolution and my relationship to it, and I accept that I am always working within these multiple realities. I do not presume to have an idea before I begin therapy about what help should look like during or at the completion of therapy. In other words, I do not focus on content, skills, techniques or methods (Anderson, 2001, p. 344).

These main ideas are what Anderson defined as a philosophical stance, a way of being, that are unique to and differ from therapist to therapist, from clinical situation to clinical situation, from context to context, and from relationship to relationship.

The therapist invites, respects and acknowledges the client's expertise; the therapist trusts and believes the client; the therapist is a learner; the therapist is always on the way to understand; and the therapist is fully present as another human being. Emphasis is placed on the client's expertise regarding his or her life, and the therapist's expertise on how a client should live his or her life is de-emphasized (Anderson, 2001, p. 345)

Anderson had focused on several aspects that she considered essential to establish a dialogical collaborative dialogue.

Client and therapist become conversational partners as they engage in dialogical conversations and collaborative relationships. Such conversations and relationships go hand-in-hand. A dialogical conversation is a two-way conversation, a back-and forth, give-and-take, in-

there-together process where people talk *with* rather than *to* each other. Inviting this kind of partnership requires that the client's story take centre stage. "It requires that the therapist constantly learn, listening to and trying to understand the client's story from the client's perspective. The therapist is listening to hear what the understanding is for the client, not for the therapist" (Anderson, 1997, p. 21). Listening is active not passive, as the therapist offers possible ways to see it.

The collaborative therapist considers the client as the expert on his or her life. A collaborative therapist invites, respects and takes seriously *what* a client has to say and *how* they choose to say it. This includes any and all knowledge, whether those descriptions and interpretations are informed by popular cultural discourse, folklore, spirituality, etc., whether they are expressed in a chronological manner or otherwise, and regardless of the amount of time a client takes to tell the story.

A collaborative therapist does not have a monopoly on the truth, nor superior knowledge.

The collaborative therapist, like the client, simply brings her own expertise, not a better one. The therapist tentatively offers her voice, including questions, comments, thoughts and suggestions as simply food for thought and dialogue (Anderson, 2000, p. 123).

More than ever, the therapeutic process and content are almost the same. As Anderson, multiple times refer, the collaborative approach aims to invite, create and facilitate a generative process, achieved through collaborative relationships and dialogical conversations.

Transformation is inherent in this process; no importance is placed on the direction, content or product of this transformation.

Anderson's view on expertise was related to what she calls "not-knowing" (Anderson, 1997; Anderson & Goolishian, 1988, 1992). Not knowing is a characteristic of the philosophical

stance that is critical to inviting, creating and sustaining collaborative relationships and generative dialogues. Not-knowing refers to a therapist's intent: how they position themselves with what they know or think they know and to a willingness to keep their therapist knowing open to question and change. 'Not-knowing' is an ethical position: I do not know better than a client how she or he should live their lives; I do not want to use my knowing to lead a client in any direction. As therapist, I want to promote dialogue in which possibilities can emerge.

From a collaborative perspective the therapist is not an agent of change. That is, a therapist does not change another person. The therapeutic process is a continuous and mutual process rather than one person being changed from-to by another person. Here, the therapist's 'expertise' is in creating a space for and facilitating a process for collaborative relationships and dialogical conversations. In this kind of transformative process, both client and therapist are shaped and reshaped – transformed –as they go about their work together.

Uncertainty is integral element of the therapy: When a therapist accompanies a client on a journey and walks alongside them, there is uncertainty. Because the newness (e.g. solutions, resolutions, outcomes) comes from within the local conversation, is mutually created, and is more uniquely tailored to the person involved, there is no way of predicting or knowing for sure where one will end up.

Seeing therapy through this lens, "psychotherapy is not a special kind of relationship, different from others that occur in everyday life" (Kirschenbaum & Henderson, 1989b, p. 27). Rather, the therapeutic relationship and therefore the therapeutic process, has many similarities to the other relationships we have in our everyday life.

Summary

The concept of therapeutic process has evolved since was first defined by Freud. In a postmodern view, and follow Anderson's perspective, it doesn't differ much from other relationships we establish in our everyday life. There are certainly many details that apply to therapeutic relationships that are not present in other types of relationships, and vice-versa.

I understand Anderson's statement from the perspective of the universal principles that apply to all human relationships, in which the therapeutic relationship is one of the many kinds. It is from that perspective that I was initially interested in finding the interconnections between attachment theory and therapeutic relationship, and how affect regulation plays an important role in the modulation of human relationships.

The integration of these topics is the subject for the discussion chapter.

Chapter 5: Discussion

In the present chapter the author will integrate the main concepts of the previous three chapters in an attempt to answer the thesis question: “To what extent do attachment and emotional attunement influence the therapeutic relationship?”

Attachment theory provides an understanding of the natural predisposition for human connections since birth: “All individuals need connection throughout lifespan, it is a driving force of development and well-being” (Jordan, 2008, p. 1).

Attachment is not an end, but a system adapted to fulfill a person's certain needs, which sustain the theory that attachment has a biological basis. Feeling secure and protected is a survival need.

Theoretically, the early relationship environment is crucial not because it shapes the quality of subsequent relationships, but because it serves to equip the individual with a mental processing system that will eventually generate representations, including relationship representations (internal working models). Different Attachment styles are nothing more than different internal working models, forged in infancy, that format ways of connecting in adult life.

According to Bowlby (1988), attachment patterns formed in infancy tend to persist in adulthood but may still be subject to change. For example, adults with insecure attachment patterns could develop a secure attachment style when they experience supportive adult relationships (Sroufe et al., 2005), something that a therapeutic relationship can offer to the client.

Although attachment styles may change, it is more likely that they will show up in the therapeutic relationship with the same characteristics as they appear in other relationships in life.

Being aware of these characteristics can be helpful to understand, in the here-and-now of the therapy, some behaviors expressed by the client.

From the vast body of attachment research, it seems that monitoring the physical distance or proximity; being hostile or warm in the relation; the regulation of affects; tendency for loneliness or seeking others for attention and an ability to perceive or read other people emotional states are the main behaviors that we will see replicated in therapeutic relationship that might be better understood under an attachment perspective.

“Fell secure” as an emotional need surpasses the early experiences of infants. Adults express the same need and look for proximity and availability of the other in the relationship as an attempt to reach emotional security. Adults continue to monitor the accessibility and responsiveness of the attachment figure. In the therapeutic relationship, clients will be checking for “*therapist availability*”, in Bowlby words, or therapist congruence, empathetic understanding and unconditional positive regard, in a rogerian conceptualization (Bowlby, 1973; Rogers, 1951).

If clients seek therapy, it is because “their needs” are not met in some way. There is something in the client’s life, in the moment, that makes them feel insecure, unprotected. They don’t have some of their needs met and they reach out to therapy as an attempt to be seen, validated, appreciated; to feel connected and secure. In that sense, the therapeutic relationship creates a strong bond and is a deep connection, and the therapist becomes an attachment figure for the client.

Applied to therapy, if client is in a safe relationship that offers accessibility and responsiveness, especially when enriched by humanistic therapy values of empathy and acceptance, he/she is freer to explore, to be open and take risks, both interpersonal and

intrapersonal, and to increase self-awareness and compassion. A secure relation in therapy helps in the healing process.

On the other hand, affect regulation theory comes into action in therapy by leading the therapist in the here-and-now of the therapy. Feeling the client's states of hyper and hypoarousal in the therapeutic relationship, the therapist co-constructs the process of therapy with the client. Through visual-facial, auditory-prosodic, and tactile-gestural communication, the therapist and client learn each other's rhythmic structure, and modify their behavior to fit that structure, creating a specific response. These processes are based on affects sensed at somatic, nonverbal levels, mostly intuitive and unconscious. This type of interaction between the therapist and client is what researchers call "nonverbal intersubjective communication" (Papousek, 1987, p. 258).

By constant and mutual calibration of emotional states, both therapist and client are playing a synchronic melody that gives the process of reparation a chance. "When affect is regulated, even if the experiences shared are negative, there is something positive in the experience of sharing," and is that not what we call "healing"?

Such visceral experienced empathy offers a reassuring and vitalizing connectedness" one feels felt, known, and accepted as well as nurtured. I think this what being an "outsider witness" can offer to the client, or communities, in White's conceptualization of definitional ceremony (White, 1995).

Later the felt sense, the somatic experience in therapy, become words in the mind, the "vitalizing attunement" (Schoore, 2012).

When affect is regulated, the process of mentalization is possible in therapy. The "primary affect, processed in the right brain, is further processed in the left; where somatic experiences become words in the mind; where the non-mental becomes mental; where

preconscious, right brain implicit processing is complemented by the conscious, explicit processing of the left” (Hill, 2015, p. 110).

The affect processed by the secondary system opens the possibility for multiple assessments of experienced realities and provides us with a deeper understanding of affects, and corrects or confirms the gut reactions generated by the primary system.

As stated by Fonagy, “mentalization is the mental process by which an individual implicitly and explicitly interprets the actions of self and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons” (Fonagy & Bateman, 2004).

Mentalization in therapy emerges in the context of the therapist-client relationship, and it happens in the here-and-now. We can see it as “dialogical conversations in collaborative relationships” as posit by Anderson, or as an opportunity to “reauthorized new narratives” in White’s narrative ideas (Anderson, 2001; White, 1991).

The client working with the therapist develops new ways of thinking, feeling, acting with self and others. Like Yalom, we can say “therapy becomes an unfolding process” that happens in the here-and-now (Yalom, 2017). It is a collaborative journey between therapist and client. It is, therefore, a process that is spontaneous and unique to each client and each therapy.

Similarly, each therapist is unique, shaped by a specific attachment style and dealing with his own emotional regulation. This self awareness is vital in understanding the dyads of the therapist-client relationship and phenomena in the here-and-now of therapy. It is always a unique therapist that meets an unique client in a specific moment.

Naturally, in the process of not-knowing, (Anderson, 1992) miscommunication, misunderstanding and loss of coordination cause mismatched exchanges and rupture the

emotional connection between client and therapist (Tronick, 2007). This process of mismatching and reparation is actually a developmental opportunity to dyadically expand the consciousness of the client, as well as therapist, in other words, healing.

Therapy is essentially a relationship, where process and content became a whole undivided entity.

Therapy is the “*secure base*” and “*safe haven*” of protection and world exploration (Bowlby, 1988).

Chapter 6: Conclusion

Never regard study as a duty but as an enviable opportunity to learn to know the liberating influence of beauty in the realm of the spirit for your own personal joy and to the profit of the community to which your later works belong. (Albert Einstein)

When I first started this study, I knew I had a difficult task ahead. To be able to find what I was looking for in the midst of so vast a bibliography, and to obtain a simple answer to my “felt idea” of the thesis answer would not be easy.

Having arrived at the end of the Thesis and I still think and feel that I haven’t scratched the surface of these topics.

Suddenly, a humble feeling came to reign in my mind. Many of the authors I researched devoted a lifetime to the same topics. Some are still searching for answers. Freud, Rogers, Bowlby, Schore, Segal, Yalom, White, Anderson are just a few examples of how they left (or still are creating) a legacy that is impossible to comprehend in such a short time.

I enjoyed the process of questioning, searching, learning, discovering and not discovering that this study has given me.

As Einstein, I felt the liberation of the spirit and the joy during the process. If this study has something to contribute to the community, I leave that to the reader to decide.

For sure, all three domains attachment, affect regulation and therapeutic alliance will evolve in the future and eventually the interconnections might shine more clearly.

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