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## THE MOVE FROM CATEGORIES TO PROCESS: ATTACHMENT PHENOMENA AND CLINICAL EVALUATION

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**ABSTRACT:** Despite the degree to which attachment theory and research have been embraced by clinicians in recent years, many remain unsure as to what this perspective *adds* to clinical understanding and psychodynamic thinking about the clinical process. In this article, I outline some ways that developments in the study of attachment have the potential to enrich our clinical work with children and families, and may be particularly illuminating with respect to certain aspects of evaluation, formulation, and diagnosis. This added value comes not from formally assessing patients' attachment classification but from sensitizing clinicians to observing the functioning of the attachment system and to the internal and interpersonal functions of attachment processes. Such awareness on the part of the therapist makes it possible for these dynamic regulatory, defense, and motivational systems to be addressed within the context of evaluation and ongoing psychotherapeutic work. Thinking about attachment processes within the clinical situation does not supplant other aspects of dynamically oriented assessment and evaluation, but rather is theoretically consistent with psychoanalytic models of development and offers new levels of richness and understanding to formulations and treatment planning.

**RESUMEN:** A pesar del nivel al cual la teoría de la afectividad y la investigación han sido recibidas por los clínicos en años recientes, muchos no están seguros de qué es lo que la teoría de la afectividad y la investigación aportan a la comprensión clínica y al pensamiento sicodinámico acerca del proceso clínico. En este ensayo, subrayo algunas de las maneras cómo los avances en el estudio de la afectividad pueden enriquecer, potencialmente, nuestro trabajo clínico con niños y familias, y en particular cómo pudieran dar luz con respecto a ciertos aspectos de evaluación, formulación y diagnóstico. Este beneficio adicional no proviene de una evaluación formal de la clasificación de la afectividad del paciente, sino de la sensibilización de los clínicos hacia la observación del funcionamiento del sistema de la afectividad, así como hacia las funciones internas e interpersonales de los procesos de afectividad. Tal tipo de conocimiento por parte del terapeuta hace posible que estos sistemas dinámicos, regulatorios, de defensa y de motivación sean discutidos dentro del contexto de evaluación y del trabajo sicoterapéutico actual. El pensar acerca de los procesos de afectividad dentro de la situación clínica no suplanta otros aspectos de la evaluación y calificación dinámicamente orientadas, sino que se trata de algo que es teóricamente

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I thank the Bridging the Gap Working Group for providing an intellectual home to discuss the issues of integrating developmental theory and clinical practice. Many of the ideas developed in this article grew out of our rich and fruitful group discussions. I also thank the graduate students who participated in the evaluation of the cases described in this article and thus helped me sharpen my thoughts about attachment assessment in the clinical situation. Direct correspondence to: Arietta Slade, The Psychological Center, R8-130, The City College of New York, 138th Street and Convent Avenue, New York, NY 10031; e-mail: aslade@d@earthlink.net.

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**INFANT MENTAL HEALTH JOURNAL**, Vol. 25(4), 269–283 (2004)

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Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/imhj.20005

consistente con los modelos psicoanalíticos de desarrollo, y ofrece nuevos niveles de información y comprensión a las formulaciones y al planeamiento del tratamiento.

RÉSUMÉ: En dépit du degré auquel la théorie et les recherches sur l'attachement ont été embrassées par les cliniciens dans les années récentes, bien des cliniciens demeurent incertains sur ce que la théorie de l'attachement et les recherches sur l'attachement *ajoutent* à la compréhension clinique et à la réflexion psychodynamique sur le processus clinique. J'expose dans cet article certaines des façons dont les développements dans l'étude de l'attachement peuvent enrichir notre travail clinique avec les enfants et les familles et peuvent s'avérer particulièrement éclairants pour ce qui concerne certains aspects d'évaluation, de formulation et de diagnostic. Cette valeur ajoutée ne vient pas de l'évaluation formelle de la classification de l'attachement des patients, mais de la sensibilisation des cliniciens à l'observation du fonctionnement du système de l'attachement et aux fonctions internes et interpersonnelles des processus de l'attachement. Une telle conscience de la part du thérapeute permet à ces systèmes dynamiques régulateurs, motivationnels et de défense d'être abordés au sein du contexte du travail d'évaluation et du travail psychothérapeutique en cours. La réflexion sur les processus de l'attachement au sein de la situation clinique ne supprime pas d'autres aspects de l'évaluation orientée dynamiquement et de l'évaluation en général, mais s'inscrit plutôt dans une lignée de cohérence avec les modèles psychanalytiques de développement, et offre de nouveaux niveaux de richesse et de compréhension de formulations et de planning de traitement.

ZUSAMMENFASSUNG: Unabhängig von dem Ausmaß in dem die Bindungstheorie und -forschung in den letzten Jahren von Klinikern angenommen wurde, bleiben doch viele unsicher was die Bindungstheorie und -forschung zu dem klinischen Verständnis und dem psychodynamischen Denken über einen klinischen Prozess hinzugefügt hat. In dieser Arbeit weise ich auf einige Wege hin, wie die Entwicklung der Studien zur Bindung das Potential haben, unsere klinische Arbeit mit Kindern und Familien zu bereichern. Das mag im Bezug zu bestimmten Aspekten der Evaluation, der Formulierung und der Diagnose besonders erhellend sein. Dieser zusätzliche Nutzen kommt nicht aus der formalen Bindungsklassifikation der Untersuchung eines Patienten, sondern davon, dass Kliniker die Funktionen des Bindungssystems und die inneren und zwischenmenschlichen Funktionen des Bindungsprozess empfindsamer beobachten. Diese Wachsamkeit auf Seiten der Therapeuten macht es möglich, dieses dynamische Regulations-, Abwehr- und Motivationssystem im Kontext der Evaluation und der weiterführenden psychotherapeutischen Arbeit anzusprechen. Indem man über den Bindungsprozess in der klinischen Situation nachdenkt, ersetzt man nicht die anderen Aspekte der dynamisch orientierten Untersuchung und Evaluation, sondern ist theoretisch ziemlich in Übereinstimmung mit psychoanalytischen Modellen der Entwicklung und bietet neue Ebenen voller Reichtum des Verstehens in der Formulierung und der Planung der Behandlung, an.

抄録：近年愛着理論と研究が臨床家に受け入れられている程度にもかかわらず、愛着理論と研究が臨床過程についての臨床的理解と精神力動的思考に何を付け加えるのかについて、多くの臨床家が自信のないままでいる。この論文では、愛着の研究における発展が持つ、子どもと家族についてのわれわれの臨床的な仕事を豊かにする可能性のいくつかを概説し、そしておそらく、特に評価、定式化および診断についてのある種の側面に関して明らかにするだろう。この付け加えられた価値は、患者の愛着分類を形式的に評価することからもたらされるのではなく、むしろ臨床家が、愛着システムの機能を観察することと、愛着過程の内的および対人関係上の機能とに敏感になることで、もたらされる。このような治療者側の気づきは、これらの力動的な調節、防衛、および動機付けシステムが、評価と進行中の精神療法作業の文脈の中で扱われることを可能にする。愛着過程について臨床状況の中で考えるということは、力動的な診断・評価のほかの側面にとって代わるのではなく、むしろ発達精神分析的モデルと理論的と一致していて、定式化と治療計画に、新たな水準の豊かさと理解を提供する。

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John Bowlby and Mary Ainsworth offered us their complex and compelling theory of attachment over 30 years ago. In the years that have elapsed since they published their seminal works, more and more clinicians have become convinced of the profound significance of both attachment theory and research for clinical work (for reviews, see Fonagy, 2001; Slade, 2000). Nevertheless, many clinicians remain unsure as to what attachment theory and research *add* to clinical understanding and psychodynamic thinking about the clinical process. What can clinicians use of this work that will add to what they already do with patients?

My main thesis here is that the added value comes not from formally assessing patients' attachment classification but from sensitizing clinicians to the functioning of the attachment system and to the internal and interpersonal functions of attachment processes. Such awareness on the part of the therapist makes it possible for these dynamic regulatory, defense, and motivational systems to be addressed within the context of evaluation and ongoing psychotherapeutic work.

Rarely is there a place in everyday clinical work for the formal implementation of attachment assessments. However, as I hope to demonstrate here using material from two cases presenting for evaluation at a community mental health center, we can use the principles and constructs that are central to these assessments to guide us in our clinical work. Doing so will not supplant other aspects of dynamically oriented assessment and evaluation but instead will offer new levels of richness and understanding to formulations and treatment planning (Slade, 1999a, 1999b, 2000).<sup>1</sup>

### THE ATTACHMENT SYSTEM

Bowlby believed that children are born with an inherent predisposition to form and maintain attachments to their primary caregivers *because* the development of attachment relationships is key to the continuation of the species and thus intrinsic to survival (Bowlby, 1969, 1973, 1980). Thus, children are born with an inherent mechanism—the *attachment behavioral system*—that drives them to seek proximity and comfort from attachment figures when frightened or in need of protection and security. When children feel safe and are not frightened, their attachment system is deactivated and they feel free to explore the world; when frightened or endangered, however, the attachment system is activated, and children will seek closeness to the caregiver. Thus, attachment theory is centrally concerned with the regulation of fear and distress within the context of ongoing primary relationships (Lyons-Ruth, 2004), and the internalization of such regulatory processes in the form of attachment representations.

Because children are motivated to preserve attachment relationships, they will adapt to their primary caregivers' minds (wishes, desires, projections, etc.) as a means of ensuring a continuing source of comfort and proximity, however distorted this care may be. These adaptations are manifest in the development of organized or disorganized patterns of defense and affect regulation, known as attachment representations, which both *protect and maintain critical primary relationships and, in pathological situations, insure the continuing distortion of the child's capacity to directly express attachment needs when the attachment system is acti-*

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<sup>1</sup>I am not, in any sense, advocating "attachment therapy." A variety of approaches to working with attachment-disordered children, including holding therapy, have unfortunately co-opted the term "attachment therapy" to describe what may potentially be very harmful therapies that, rather than helping parents to recognize child cues and attachment motivations, appear to directly violate children's signaling mechanisms, causing devastating anxiety and potentially harmful psychic disorganization.

vated. At a deeper level, such distortions also profoundly disrupt the development of mental structures that are essential to the regulation of affect and self-experience, and compromise basic capacities for interpersonal knowing and understanding (Fonagy, Gergely, Jurist, & Target, 2002). The experience of seeking care and the regulation of affect and thought are inextricably intertwined.

Just as the child is born with the capacity to signal and seek care from the caregiver, the caregiver should have the inherent capacity to provide a secure base for the child's intentions, needs, and mind, particularly when the child (or the caregiver's) attachment system is heightened (Slade, Belsky, Aber, & Phelps, 1999; Slade & Cohen, 1996; George & Solomon, 1996). But, whereas the child's attachment system emerges *de novo* out of the child-caregiver relationship and is thus free of the burdens of any past history, the parent's "attachment" to the child arises out years and years of experience in relationships, of being parented, and of being loved, cared for, betrayed, or rejected. Thus, it is sadly the case that many of the distortions in the child-caregiver relationship that we see clinically arise initially out of the caregiver's disrupted capacity to care and provide security for the child (Slade & Cohen, 1996). While the child and his or her inherent capacities can certainly contribute to such early disruptions in the relationship, it is the synergy with a caregiver's internal world that creates most early relationship disturbances (Lieberman, this issue, 1997; Lieberman & Pawl, 1993).

### ATTACHMENT PHENOMENA AND PROCESSES

As brilliantly elaborated in the work of Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978) and Main (2000; Main, Kaplan, & Cassidy, 1985), the nature and functioning of the attachment system is *revealed* through the observation of attachment phenomena in both child and parent, both at the behavioral and representational level. These can include child or adult behaviors that establish or disrupt contact and function to regulate fear as well as child or adult representations of the experience of seeking comfort and care. The thrust of attachment research over the course of the past 20 years has been to *categorize* or *classify* patterns of attachment in children or adults as secure, insecure, or disorganized/unresolved on the basis of such attachment phenomena.

As a result of these efforts, many researchers and clinicians working outside the domain of attachment theory think of these categories and their stability and predictive validity as the *essence* of attachment research. Indeed, child and adult attachment categories (and all their derivatives) have become, in a sense, the sacred cow(s) of attachment research. Certainly, these have been crucial to the scientific evolution of the field, and to the range of empirical validations that have carried the field forward immeasurably. At the same time, the focus on classification has reified and oversimplified the meaning and dynamic functions of attachment processes, resulting in an overemphasis on classification within the research domain and a failure to appreciate the complexity and depth of attachment processes as they are manifested within the clinical domain. In particular, it has taken the focus off the clinical evaluation of the attachment system and attachment processes; indeed, the nature and functioning of the attachment system, and particularly the dynamic significance of disruptions in attachment relationships, are aspects of attachment theory that seem the *least* well understood by clinicians (K. Lyons-Ruth, personal communication, April 23, 2003).

Attachment categories are simply ways of describing and organizing attachment phenomena. From a clinical standpoint, it is these *phenomena* and the processes they represent that are the focus of our work, not the *categories*, *per se*. The clinical application of attachment theory lies in sensitizing clinicians to observe and recognize attachment phenomena at multiple levels of behavior and discourse and to understand how the attachment system works rather than to

be able to formally administer attachment assessments or assign formal attachment categories to their patients. While knowing an individual's attachment classification does tell us a great deal about how that individual's psychological and interpersonal experiences are organized (Slade 1999a, 2000), learning to observe attachment phenomena within the context of understanding the dynamic nature of the attachment system often tells us what we need to know clinically about attachment "status," per se, and much more. For instance, observing the ways a child seeks or avoids proximity or manages fear in relation to an attachment figure or that an adult organizes and reflects upon his or her affective experience and primary relationships is critical to our understanding their particular way of regulating affective and interpersonal experience. Thus, just as we use other forms of listening and observing to inform our work with patients, we use our sensitivity to attachment phenomena to help us understand what matters to our patients and to connect with them in meaningful and experience-near ways. Various of the article in this issue offer lovely examples of how attachment constructs and measures can be used flexibly and creatively in the clinical situation. It also is important to mention the Circle of Security intervention described work of Marvin, Cooper, Hoffman, and Powell (2002) in this regard.

### THE TRANSLATION TO THE CLINICAL SITUATION

So how do we help clinicians become sensitive observers of attachment phenomena? How do we help them keep attachment in mind? In the following sections, I discuss these questions within the context of a particular clinical situation: the evaluation of parents and children for treatment in a traditional outpatient setting. I believe that we help clinicians think about attachment by helping them find ways to incorporate an attachment perspective into the evaluation process. One way to do this is to flexibly adapt aspects of attachment assessments for the clinical situation. One of the most useful things to do, for instance, is to activate both the parent's as well as the child's attachment system over the course of the evaluation to observe their modes of managing distress, fear, and the need for proximity. As I will describe using case material, this can be accomplished in a number of ways. The clinician can ask questions that are intrinsically activating of the parent's internal working models of caregiving and care-seeking, which allow for the evaluation of the dynamics of the parent's internalized representations of attachment, capacities for reflective functioning, and representations of the child. The clinician also can introduce a brief separation into the intake procedure, usually during the first session with the child, to observe parent and child responses to both separation and reunion. It also can be accomplished by observing patterns of proximity seeking, contact maintenance, distal communication, and comfort seeking on the part of the child during free play and both pre- and postseparation. It can come from observing how comfort seeking and exploration are enacted in play. In all instances, the clinician must continuously judge whether such efforts can be tolerated by the parent and child. Thus, for example, some children will not tolerate separations, and some parents simply will find it impossible to talk at all about their early childhood experiences. Nevertheless, all outcomes tell us something useful about attachment processes, and this—rather than any kind of rigid adherence to assessment procedures—is what is clinically important and relevant.

The capacity to incorporate the evaluation of attachment processes into clinical situations obviously requires a basic understanding of attachment theory and research. This can be accomplished, in part, by becoming familiar with the literature that describes these procedures and scoring approaches. There are several very useful volumes that outline the development of attachment theory and research in a broad and comprehensive way (Cassidy & Shaver, 1999; Goldberg, 2000; Goldberg, Kerr, & Muir, 1995; Solomon & George, 1999); there also are a

number of review articles that outline the basic findings and methods of attachment research (Belsky & Cassidy, 1994; Carlson & Sroufe, 1995; Slade & Aber, 1992). These can be extremely useful in developing an understanding of the nature and function of the basic methods of attachment research such as the Strange Situation (Ainsworth et al., 1978) and its “upward” extensions, such as the story stem and doll play assessments (for reviews, see Emde, Wolf, & Oppenheim, 2003; Oppenheim, Emde, & Warren, 1997; Solomon & George, 1999), the Child Attachment Interview (Target, Shmueli-Goetz, & Fonagy, 2002), and for adults, the Adult Attachment Interview (Main et al., 1985) and the various representational interviews that are its conceptual “cousins,” the Parent Development Interview (Slade et al., 1999), the Working Model of the Child Interview (Benoit, Zeanah, Parker, Nicholson, & Coolbear, 1997; Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994), and the Current Relationship Interview (Crowell, Fraley, & Shaver, 1999).

These are some of the essentials, but as any perusal of the last decades’ research in attachment will reveal, there are of course many more (e.g., the Insightfulness Assessment described by Goldsmith & Oppenheim, this issue). What is most important in learning about any of these methods, however, is understanding their fundamental functions. What is the Strange Situation meant to assess? How does it do this? What does the Adult Attachment Interview assess? How are the essentials of attachment representation revealed in the clinical situation? What can we learn about parental representations of the child from listening to parents talk about their children? What are the essential markers—in behavior or speech—for disorganized or unresolved attachment?

To bring to light how I use these methods to think about attachment in the clinical setting, I now describe the evaluation of two school-aged children and their families who presented for evaluation and treatment in a community mental health setting. These evaluations were conducted by a team. Both of these cases were evaluated using aspects of attachment assessments to create a full picture of a range of dynamic processes including, but obviously not limited to, attachment.

### ***Ruby***

Ruby, age 5 years, was brought to the clinic by her mother at the suggestion of the teachers at the school she had attended for several years. As is customary in our setting, we first interviewed the mother and then scheduled sessions with the child. Initial interviews with parents are typically aimed at gathering family history and developing a beginning understanding of the referral problem. However, these initial interviews also provide an ideal opportunity to begin to listen for attachment phenomena, as they are manifest in the mother’s (or father’s) talk about the child. In their groundbreaking work on the Adult Attachment Interview, Main et al. (1985) taught us to listen to the fluency, coherence, affectivity, and flexibility in narrative descriptions of adults’ own early childhood attachment experiences as a means of identifying their particular way of regulating and defending against attachment-related memories and feelings. Similar patterns can be observed in mothers’ narratives about their children (Benoit et al., 1997; Slade et al., 1999). Such narratives also can tell us a great deal about an individual’s reflective capacities, namely, their capacity to hold and reflect upon their own and their child’s mental states in making sense of behavior and relationship patterns (Fonagy et al., 2002; Slade, 2002a). Finally, they offer an opportunity to evaluate what Lieberman (1997) described as the mother’s attributions of the child, namely, the nature and affective quality of her representations of the child.

Ruby’s mother came in by herself for the initial interview. Ruby had been born when she and Ruby’s father were both teenagers, and they had each lived with their own families since

her birth. Ms. R, a pretty and articulate but obviously tired and burdened young woman who worked full time and attended college, presented a series of paradoxes to the interviewer. On the one hand, Ms. R recognized both that her child was suffering and that she did not understand her. She reported that Ruby seemed very unhappy, and often talked about how stupid and ugly her child was. Ms. R described Ruby as a little odd and unable to make clear sense of the world around her. She reported that Ruby was extremely uncomfortable and awkward with her peers, and seemed unable to interact genuinely or empathically. Ms. R found Ruby quite provocative and difficult at home, and it was evident to her that their relationship was in serious trouble. It was impressive that this young mother had found her way to our clinic, and made it a priority to complete the evaluation and engage in treatment to both help and better understand her child.

On the other hand, it quickly became clear over the course of the evaluation that Ms. R was detached from Ruby (Benoit et al., 1997) and dismissive of her own childhood experiences of abandonment and loss (Main et al., 1985). And, as would be expected given a dismissing attachment organization, these losses were being replayed in a dramatic way with Ruby, despite mother's efforts to keep them out of her consciousness. Ms. R reported that Ruby had been largely raised by her own aunt while her she attended school and worked full time to make ends meet. During this time Ruby would often not see her mother or father for days at a time. Mrs. R's aunt died when Ruby was 4 years old. Ms. R denied having any particular reaction to her aunt's death nor did she recognize any grief or mourning in Ruby, whose symptoms had worsened since the death.

Following this death, Ms. R took over more of the caretaking, although Ruby was still largely cared for by the extended family. When faced with truly mothering Ruby for the first time, Ms. R was completely at a loss. She clearly did not "know" her child, and was not at all sure she wanted to. She readily acknowledged that she did not know how to play with Ruby and, in fact, did not enjoy it. Her talk about Ruby was laced with negativity and hopelessness, and it was clear that there was little pleasure between them—only a nasty mix of anger, avoidance, and disappointment. She saw Ruby as damaged and odd, disappointing her dreams of redemption and success. She had no sense of how Ruby's troubles evolved out of their failed connection and were foretold in her own history.

While this is a story typical of so many mothers and children presenting for treatment, what I would like to focus on here is what we can learn about the attachment system in listening to Ms. R's opening tale. The degree to which Ms. R is "hardened" to Ruby—from her earliest decisions to essentially relinquish her care to others, to her inability to recognize Ruby's attachment to her aunt, and to her current sense of anger, disengagement, and disappointment—tells us that Ms. R has had to diminish her awareness of Ruby's attachment needs to contain her own feelings of loss and abandonment. It is likely that feeling Ruby's needs for comfort and safety, holding them in mind, and allowing herself to imagine what it might have been like for Ruby to lose her beloved caretaker would mean opening herself to the intensity of feelings that were likely never regulated and held in her own early attachment relationships. To preserve her own state of mind in relation to attachment, which maintains her own sense of equanimity (and likely allows her to single-mindedly pursue her education and financial security), she must separate herself from Ruby, experiencing her as something alien and bad. And Ruby was indeed a little alien, strange and disconnected from the world around her. It seemed likely that she had learned early on that a direct expression of her need for comfort and closeness would only result in further distance from her mother, and so she distorted these in ways that might be less disruptive to her mother's fragile attachment system.

So, from the first interview with the mother, listening for coherence, for themes of loss

and abandonment, for reflective capacities, and the quality of attributions, we had already begun to develop a sense of how complex it must be for this child to feel safe and secure in relation to those around her.

As described earlier, there is not a typical place for administering the Strange Situation, Adult Attachment Interview, or Parent Development Interview within the context of a clinical assessment in a nonresearch setting; however, just as attachment phenomena can be elicited in parent interviews, so can they be observed within the context of the child's visits. One of the best ways to do this is to build a separation as well as a period of parent-child play into the child sessions. In both cases described here, we began the first child visit with a period of unstructured parent-child play, so that we can observe how the mother and child navigate coming into an unfamiliar playroom in which age-appropriate toys are available. After approximately 15 to 20 min have elapsed, the mother tells the child she will be waiting outside and leaves the child with the intake therapist. (This time is varied according to the clinician's judgment.) The mother remains outside for approximately 30 min, at which time she returns to the room, alerting the child to her return by knocking on the door. The child is told that she is outside and can be fetched if necessary. For the remaining 10 to 15 min of the session, the parent and child reunite and play together.

This procedure is obviously modeled after, but not the same as, the Strange Situation. What it does is give the clinician an opportunity to observe the dynamics of mother-child play and the child's response to the stranger once the mother has departed. Most important, it allows the clinician to observe the quality of reunion between mother and child as well as their efforts to reconnect in the minutes following the reunion.

When we saw Ruby in her first session, she was an appealing, but decidedly odd, child whose affect, language, and motor development were—each in its own way—somewhat peculiar. She spoke in a singsong way, moved awkwardly, and smiled continuously in an anxious grimace. When observed with her mother, there was little ongoing, pleasurable contact between them. They seemed unable to play together. Mother was overly directive and could not spontaneously give herself over to the play; frustration and distance were palpable in her demeanor. She clearly struggled not to withdraw. When mother left the room, Ruby began to relax, her grimace becoming less pronounced. She seemed more comfortable, and took pains to respond to the intake therapist. She relaxed a bit, smiled, and played more freely; themes of anger and nurture pervaded the symbolic play that emerged with much more force once her mother left the room. There had been little symbolizing before her mother left.

When her mother returned, Ruby gave her a full grimace, and turned away stiffly; once again, her play became disjointed. Mother's smile and approach were strained and tense, and she began urging Ruby to clean up, put her coat on, because *she* (mother) was hungry and ready to leave. Ruby, obviously unhappy to leave the therapist, dawdled provocatively.

There are many things to say about this vignette. First, in the juxtaposition between mother play and stranger play as well as in Ruby's avoidance upon reunion, we see clearly the signs of an insecure-avoidant attachment, although given Ruby and her mother's history, this in itself is no surprise. What it does tell us, though, is that Ruby can only approach her mother in oblique ways, and has learned to disguise and dampen her careseeking and longing for closeness with her mother. We also see that Ruby's capacity to think and play (and likely express herself competently in the linguistic domain) is profoundly inhibited and distorted by her attempts to manage her mother's aggression and withdrawal. Thus, although her oddness led us to wonder about biologically based neurocognitive difficulties, we began to consider the possibility that both cognition and affect had been co-opted by Ruby's efforts to manage her attachment needs within the framework of a hostile and rejecting relationship with her mother. Ruby's grimace—mixing approach, avoidance, and fearfulness in a vivid way—was enormously telling. She



wanted to greet her mother, but was girding herself against Ms. R's intrusiveness, hostility, and intermittent withdrawal. In this moment, it was possible to see how complex Ruby found it to regulate her fear and anger while maintaining contact and proximity (Lyons-Ruth, Bronfman, & Atwood, 1999; Main & Hesse, 1990).

We began to hypothesize that disruptions in the mother–child relationship were likely at the heart of the clinical picture. Indeed, there were no hints of neurocognitive deficits in Ruby's psychological testing, and as the evaluation proceeded, she became increasingly direct, appropriate, and expressive. Her anger and need became palpable in her play and in her relationship with the therapist. While Ruby did not meet criteria for an attachment disorder (Lieberman & Zeanah, 1995; Zeanah & Boris, 2000), we began to think of Ruby's oddness as a manifestation of defensiveness and anxiety in relation to attachment, her grimace a way of maintaining contact while holding back waves of anger, fear, and despair. As best she could, she worked to maintain (an albeit insecure) contact with her mother, struggling against the fragmenting effects of anger and fear that would disrupt their tenuous connection. Her defenses (including her provocativeness) arose directly from attempts to maintain whatever frustrating contact she could with her mother. Her efforts to seek care were distorted by her efforts to get what she could from her mother while forestalling a direct attack. The understanding of this kind of distortion of the attachment-behavioral system (and the caregiving system on the part of the mother) is precisely what is offered by attachment theory.

It became clear that once initiated treatment should be aimed both at helping Ruby become less defended and frightened of her own feelings and desires, and at softening Ms. R's negative representations, such that she could be more aware of Ruby's internal experience and less overtly rejecting of and hostile toward her. Ms. R's own stated desire to do better gave us enormous therapeutic leverage because her concern had already helped her try to identify with Ruby rather than reject her. She wanted to find ways to care for her child. Indeed, once individual (for Ruby) and dyadic treatment began, Ruby seemed less and less odd, and her mother increasingly found holding and nurturing ways to be with her child.

### ***Kamal***

Let us now turn to the evaluation of Kamal, age 6 years, who was brought to the clinic by his mother. The evaluation with Kamal proceeded just as Ruby's had; the intake therapist first met with the mother twice, and then saw Kamal and his mother for a joint session that included a half-hour separation.

From the moment she stepped into the consulting room, Ms. K dripped anger and hostility; she had a hardness that at first seemed impenetrable. She made little eye contact with the intake therapist and instead aimed her eyes up and over the therapist's shoulder. She quickly launched into a diatribe about Kamal, whom she described as angry, defiant, stubborn, selfish, and mean-spirited. She detailed violent temper tantrums in which he cried, screamed, covered his ears, ran away, and threw things. She described times that, when forbidden to do something, he would cry uncontrollably. She mused about the possibility of terminating parental rights so that she would not have to be burdened by this unbearably difficult boy. And despite the fact that she offered numerous examples of his having been upset by separations and moves, she did not appear to have any capacity to recognize his sadness or distress.

Unsurprisingly, Ms. K was angry about everything. She was angry at the men who had hurt and betrayed her, at her employers who were unfair and demanding, and at the school system that had misjudged and scapegoated her children. Most infuriating had been their suggestion that Kamal needed more maternal attention. Kamal, at only 6 years of age, was in his third elementary school. Her representation of Kamal was overwhelmingly negative; she saw

none of his needs, his sadness, or his losses. He was just bad. It was obvious that she had truly sealed herself off from his internal world and could not mentalize any aspect of his experience. Indeed, it was painful to imagine what it must be like for Kamal to take in and metabolize her hatred. Her rage felt heavy and ominous, and it seemed that she must be very frightening and threatening to this boy.

It was quite evident to the therapist that this mother's capacity to represent her child in any kind of textured way, as needing her, as frightened by separation or disruptions in his life, was distorted by negative attributions that were deep and broad. It also became clear that the weight of these attributions and projections disabled her capacity to hold him in mind and to imagine what might be provoking his clear unhappiness. When the interviewer gently asked how she understood Kamal's angry and desperate behavior, Ms. K said she thought it had to do with his father, whom he did not know and had never met. There were many implicit challenges embedded in Ms. K's interactions with the therapist, such as "Don't you dare suggest this has anything to do with me," and "Don't you dare suggest I do anything differently."

Ms. K had had a life of disappointments and trauma. She described a childhood in which she rarely saw her parents, and experienced her mother as having no concern for her physical or emotional well-being; in fact, her mother betrayed her in a number of significant instances in her childhood, all of which fueled Ms. K's sense of anger and alienation. Despite the fact that she had completed college, she became mired in a life of domestic violence and tragedy, and had spent much of her adult life overcoming a series of traumas and losses. The father of her first child had died of a drug overdose. Kamal's father had abandoned her upon finding out she was pregnant, and provided no support for her or the children whatsoever.

There were several important aspects of Ms. K's telling of her story. First, it was a story without texture or dimension, without a range of emotions, and specifically, without the capacity to articulate the sadness, fear, and confusion that must have been palpable beneath her hard veneer. There was not any sadness for herself or Kamal, or concern for a child so obviously miserable. Hers was a story driven and shaped by rage, incoherent in the fragmentation that seemed the inevitable result of its intensity. This kind of life history, alive with what Main (2000) refers to as "current anger," and without any indication of a capacity to metacognitively monitor her discourse combined with the obvious evidence of unresolved trauma certainly indicates a preoccupied and unresolved attachment organization. For Kamal to find any safety or comfort in relation to her, he had to enter the maelstrom of her rage and chaos, from which he then dissociated. This made it evident that Kamal's progress in treatment would depend upon her capacity to become engaged in the process of working through and containing these horrific hurts.

Kamal was a heartbreaking boy: unkempt, shut down, absent, and defeated. When we observed him with his mother, he shuffled into the playroom, avoiding eye contact with either mother or the therapist. He refused to remove his coat and kept himself physically turned nearly completely away from both of them. He approached the toys in a desultory way, picking them up and putting them down without affect or engagement. Most important, he had long moments of apparent dissociation when he stared into space without any focus. Mother vigorously regaled the therapist with stories of Kamal's badness, apparently taking sadistic pleasure in humiliating him. Kamal had little apparent reaction when the mother left and continued to sit sideways, his entire body averted from the therapist, who gallantly tried to establish contact with him. Slowly, he softened and relaxed a bit, choosing a few new toys, playing in a slightly more enlivened way, cheating on board games, and smiling dimly at the therapist's gentle comments.

When Ms. K returned to the room, she displayed a wide clenched-tooth smile, her aggression barely disguised. It would be hard to distinguish this smile from a sneer or a threat.

Kamal, in turn, froze in his seat and bared his teeth in a grimacelike smile. He raised his hands and curled his fingers forward in clawlike fashion in a gesture that combined pushing away, raw submission, and fear. Her behavior was the epitome of what both Main and Hesse (1990) and Lyons-Ruth et al. (1999) described as maternal frightening behavior while Kamal looked frozen and frightened—the epitome of a child disorganized in relation to his attachment.

The evaluation continued with the therapist meeting a number of times with Kamal, both for play sessions and psychological testing. On the one hand, Kamal seemed to slowly warm to the therapist's gentle efforts to engage him and gradually began to play symbolically. He got to the point that he would take off his coat and fully face her. Nevertheless, there were still moments at which he would completely dissociate and stare off into space, unable to monitor his behavior or his interaction with the therapist. She would have to remain present, but unintrusive, and eventually he would re-engage. On two occasions during the evaluations, notably during psychological testing, Kamal completely broke down, sobbing uncontrollably. He was able to say very little after these outbursts, and it took a very long time to reestablish any kind of real contact with him.

This was a child utterly helpless and dysregulated in the face of his affects. He could find no comfort or safety in his relation to his mother and could not contemplate her mind because it was utterly terrifying. This left him trapped in a dreadful paradox. To seek care was to risk her wrath and cruelty, and yet he needed her. He had to maintain some contact to continue to survive (in both the absolute and metaphoric sense), and did so via dissociation and desperate provocation. At times he had no strategy at all and just collapsed. He had clearly learned that she could not tolerate his needs or his fear of separation or loss (as she could not tolerate her own). Fear was an enormous part of their relationship. Kamal's behavior—both his response to her return and his chronic dissociation—told us that he was likely quite frightened of his mother. This, combined with Ms. K's own anger and frightening behavior upon reunion, made us immediately sensitive to the potential for verbal and physical abuse. The mother's musing as to whether she should terminate parental rights made dramatic the degree to which her capacity to care for this child, either literally or figuratively, had been disabled. Additionally, it placed work with her as vital to the success of his treatment (and his capacity to function in any setting).

## DISCUSSION

The past 20 years' advances in attachment and infant research have demonstrated unequivocally that psychological organization is an adaptation aimed at preserving critical, life-sustaining relationships. What attachment theory and research offer us are the means to elicit and observe the dynamics of such organization in direct, experience-near ways within the clinical situation. They allow us to elicit attachment phenomena by activating adults' and children's attachment systems in a variety of ways, and to listen for and observe attachment processes in adult speech and behavior and in child play and behavior, notably during and following separations from the caregiver. They allow us to observe the attachment-relational matrix *in situ*, so beautifully described by both attachment and infant researchers.

In the cases described here, aspects of attachment assessment procedures and scoring were used to assess the nature and functioning of the attachment system, as they informed the development of symptoms and conflicts in the parent-child relationship. Specifically, we used the principles central to the Strange Situation, Adult Attachment Interview, and other representational and behavioral assessments to evaluate the attachment-exploration balance in each dyad, the nature of the distortions in the parent's capacity to provide a secure base for the child,

the nature of the distortions in the child's capacity to seek care and proximity (both at a behavioral and a representational level), and the regulation of fear and other negative affects within the parent–child relationship. These assessments were used to directly inform our understanding of the central clinical issues in each case, and shaped the way the therapists conceptualized both the child and the parent work.

Ruby's difficulties managing both her fear of and anger toward her mother had profoundly impinged upon her capacity to function socially or academically. She had learned to distort her direct expressions of need to protect her mother's own dismissive stance, and she had developed a sense of alienation that grew directly from her mother's inability to hold her in mind (Fonagy et al., 2002). Thus, her capacities to think independently, to symbolize, and to explore the world of ideas and people had been profoundly inhibited by her struggles to manage and regulate her affects in relation to her primary caregiver. Her wishes for care and proximity had been powerfully distorted, and were disguised in provocativeness and oppositionalism. Her mother felt detached from her and could not provide a haven of safety or trust. These fundamental disruptions were necessarily going to be the central focus of therapeutic work with Ruby and her mother.

Kamal's capacity to explore the world also was disrupted in an even more profound way. Left with the choice to enter into his mother's chaotic and frightening internal world or to dissociate, he would most often dissociate, but also engage, through anger and heightened negative affect in struggling to connect with his mother. Preoccupied, traumatized dyads maintain proximity through heightened negativity, fear, and chaos (Cassidy, 1994). But he could not find any comfort, and she could not bear his needs nor recognize the realities of his separation anxieties. In addition, her capacity to provide care was utterly disabled by her own rage and projections. The work with Kamal would have to first and foremost allow him to feel that he could be held and known by another outside of the context of fear and anger. It also would clearly involve work with Ms. K; without such work, the chances of Kamal's being able to develop any healthy relationship with himself, with others, or with the world of knowledge and ideas was severely limited.

On a more positive note, there were many signs in both children that—despite these significant disruptions in relational and cognitive development—were able to connect with the therapist in ways that suggested that real therapeutic gains, marked especially by shifts in symbolic functioning, were possible. More importantly, both mothers slowly began to soften their rigid stances over the course of the evaluation, and agreed to be an active part of their children's treatment.

An attachment perspective can be especially useful in enlisting parents in the treatment process. When an evaluation reveals a significant disruption in the child's capacity to feel safe and cared for by the mother or other caregiver, as was the case with both Ruby and Kamal, it is of vital importance that the caregiver be engaged in the treatment process (Slade, 1999b, 2002b). Parent work is largely about engaging parents in the process of reflecting upon the nature and meaning of their representations of the child and of themselves as parents. This is a crucial first step in changing these representations, and thus changing the fundamental dynamics of the parent–child relationship. Linked to this is the fact that an attachment perspective provides clinicians with a way to meaningfully link the child's struggle for closeness (which most parents have long ago lost sight of) with provocative, disruptive, or incomprehensible behavior. Parents fail to understand provocativeness or avoidance as forms of proximity and careseeking (as it was for both Ruby and Kamal); clinical work that addresses the attachment needs underlying the child's overtly distancing and rejecting behavior can profoundly shift parental representations and allow them to both respond to their children's careseeking and express attachment needs and caregiving longings of their own.

In closing, I would like to note that cases such as these are the rule rather than the exception in community mental health settings, with the vast majority of families coping with trauma, loss, and ongoing chaos in their lives. In these instances, disruptions in attachment are inevitable, and as such, must be central in clinical formulation and treatment. The evaluation procedures I have described here depart little from what are typical evaluation procedures in most clinical settings. Indeed, the attachment “spin” I have offered does not radically change what we do or the questions we ask; rather, it adds a number of dimensions to what we listen and watch for, and to how we dynamically link the child’s behavior with the mother’s internal representational world. It is my belief that such elaborations of the clinical repertoire are crucial to broadening and deepening the therapeutic dialogue and greatly enhance our capacity to help the patients we treat.

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