**Attachment-focused Treatment With Adults**

An Integrative Approach  
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“Probably in all normal people, attachment continues in one form or another throughout life...”  
- John Bowlby

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**Objectives**

- Participants will be able to describe basic attachment-based model of assessment & treatment for work with adult clients
- Participants will be able to demonstrate fundamental knowledge of the neurobiological/developmental impact of trauma and attachment insecurity through the life cycle.
- Participants will be able to apply clinical case assessment and evaluation to a case vignette
- Participants will be able to utilize treatment planning using an attachment-focused model

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Trauma

- Trauma affects normal developmental trajectory

Stimulus > Orient > Assess > Non-Threat

THREAT

1. Seek attachment system
2. Fight
3. Flight
4. Freeze
5. Shut Down

**TRAUMA, FEAR AND THE BRAIN**

**HPA axis summary**

Mapping stress response to external stimuli that is interpreted as dangerous or life threatening.
1. Traumatic experience
2. Individual's altered brain function
3. Individual's emotional and behavioral dysregulation
4. Increased risk, dysfunctional/pathological response

**Cycle of Trauma and Behaviour Reinforcement**

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**Developmental Trauma Domains of Impairment**

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**Development**
Optimal self development requires:
- Positive models of self/other held in Implicit
  Procedural memory & Implicit Relational memory
- Activation of "...ways of being & relating that reveal the real self experience and expression."

Two parallel capacities:
- Capacity for emotion closeness (attachment theory)
- Development of autonomous self and separation tolerance (object relations theory)
Deviations in Development

Self disorders are fundamentally functions of insecure attachment
- Both attachment quality and separation capacity are impaired
Misattunement in primary relationship between mother and infant result in suppression of the real self
- Real self is procedured not to activate, be expressed or experienced

The False Self

No effective model of managing relationship rupture or procedures to effect relationship repair
- Either inconsistent or nonexistent
- Utilization of the developed false self leading to cycle of:
  - Rupture/despair vs. rupture/repair

Memory

- Implicit memory
  - Can be preverbal so client cannot tell the story, only reacts to the emotional triggers
  - Very important to remember when working with clients with histories of childhood trauma
- Explicit memory
  - Client can tell the story
  - Valuable in co-creating autobiographical narrative
“Attachment Disorders” in Adults

- Insecure attachment correlated with:
  - Personality disorders
  - Substance abuse disorders and codependence
  - Eating disorders
  - Process addictions ($, sex, gaming)
  - PTSD
  - Relational difficulties

Underlying Dimensions of Adult Attachment

<table>
<thead>
<tr>
<th>Secure (Low Avoidance)</th>
<th>Preoccupied (Ambivalent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dismissing (Avoidant)</td>
<td>Fearful (Disorganized)</td>
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Characteristics of Secure Adults

- Easy access to wide range of feelings and memories (positive and negative)
- Balanced view of parents
- If insecure in childhood, has worked through hurt and anger
- Comfortable with interdependence
- More likely to be happy with relationships
Characteristics of Anxious Adults

- Dread abandonment, fear separation
- Unresolved anger and hurt
- Unable to see own responsibility in relationships
- Experience more troublesome relationships
- Addicted to people – can’t let go

Characteristics of Avoidant Adults

- Dismissing of importance of love and connection – ignores bonding needs
- May idealize parents, but actual memories don’t corroborate
- Shallow, if any, self-reflection
- Haunted by fears of loneliness
- Likely to become addicted to work, power, and obsessive rituals

Characteristics of Fearful Adults

- Traits of both Anxious and Avoidant styles
- Lack effective strategies for managing anxiety
- Childhood memories often missing, vague, or confused
- Relationships are often chaotic
Levels of Personality Functioning Scale

- Alternate DSM 5 Model of Personality Disorders
  - Self Functioning:
    - Identity
    - Self-Direction
  - Other Functioning:
    - Empathy
    - Intimacy
- See Table 2 Level of Personality Functioning Scale

Assessing Adult Attachment

- Research-based
  - Three Category Measure (Hazan & Schaver)
  - Relationships Questionnaire (RQ) (Bartholomew & Horowitz)
  - Experiences in Close Relationships revised (ECR-R)
  - Adult Attachment Interview (AAI) (George, Kaplan, & Main)
    - Dynamic-maturational method (DMM-AAI) (Crittenden)

Clinical Use of AAI

- 20 Questions about early childhood experiences and relationship with parents
- “State of Mind” with regard to attachment
- Quality of discourse as well as content
  - Coherence, temporal sequence, use of language
  - Cognitive distortions and affective disturbances
Themes that reflect lack of attachment security include:

- Unexpressed or unmet needs for safety
- Fear of rejection for having certain experiences (thoughts, feelings, wishes)
- Fear of rejection for certain behaviors
- Fear of psychological or physical abandonment
- A nagging sense that love is conditional
- Difficulty relying on others for love, support, and guidance
- Difficulty reflecting on one's own inner life or the inner life of attachment figures
- Difficulty regulating emotional experiences, positive or negative
- Difficulty repairing attachment breaks due to conflicts, discipline, or avoidance

AAI Questions

- When you were upset as a child, what did you do, and what would happen?
- Could you give me some specific incidents when you were upset emotionally? Physically hurt? Ill?
- Did you ever feel rejected as a child, what did you do, and do you think your parents realized they were rejecting you?

WCBP

- We can be present
- With our Self
- With another being
For each of the core emotions (curiosity, joy, sadness, fear, anger, and shame) draw a circle. Place each circle either inside, outside, or partially in/outside the Circle of Security.

In your experience as a child, how much your primary caregiver was able to "Be With" and help organize these six key feelings?

© Cooper, Hoffman, and Powell, 2001
www.circleofsecurity.net

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Pathology
As a result of impairment of the rupture/repair cycle, persons with self disorders may struggle with underlying "abandonment depression".

- Abandonment depression activated by "separation urges or events"
- Abandonment depression triggered by expression of the real self

Masterson (2015) claims:

- "...for the person with a personality disorder, the real self is implicitly procedured primarily to avoid activation and the consequent experience of the abandonment depression."
- "...this person is psychoneurobiologically wired to expect abandonment depression, or 'absence depression'. If the real self is activated, a compensatory implicit relational procedure system evolves; a 'defense system' emerges instead of a 'self system'."

**Abandonment Depression**

**Disorders of the Self Triad**

**Triad Response: Chart**

Self-Activation

Abandonment Depression

Defense
Object Relations: Left-brain Functions

“It seems that object relations therapists have been inclined to emphasize ‘showing what’...”

Attachment Theories: Right-brain Functions

“...whereas attachment-oriented therapists have tended to stress ‘showing how’ demonstrating to be real.”

Both

Successful therapy will involve both implicit and explicit experiences utilizing right and left cerebral hemispheres
Reproceduring of the self, requiring:

- Avoidance of empathic attunement (countertransference) that unintentionally supports patient-initiated transference that's based in the false self
- Repeated “…explicit, conscious, verbal” understanding of [the patient’s] fundamental psychodynamics by tracking of the defensive triad"
Treatment

- Integration of attachment and object relation models

Despair and Depression: Arousal States

Window of Tolerance
Memories, Dreams & Reflections

Learn your theories well but put them aside when you confront the mystery of the living soul.

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Treatment

• Bowlby’s Five Therapeutic Tasks
  • Provision of a secure base for the client to explore relationships
  • Explore current relationships, expectations, & meaning assigned to behavior of others
  • Explore therapist-client relationship in here-and-now
  • Explore how past is still alive and active in the present
  • Enable the client to recognize that their working models of self & others may no longer be applicable

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Current Models

• Integrate Attachment Theory with affective neuroscience, family systems, body oriented approaches, etc.
• Examples:
  • Attachment-Focused Family Therapy (AFFT)
  • Emotionally-Focused Couples Therapy (EFT)
  • Accelerated Experiential Dynamic Psychotherapy (AEDP)
  • Dyadic Developmental Psychotherapy (DDP)
  • Relational Analysis
  • Masterson Approach

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**INTERSUBJECTIVITY**
- Intersubjectivity is shared affect, intention, and attention
- Intersubjectivity can be concordant, when all three elements are in accord, or...
- It can be discordant
- Therapist guides toward therapeutic concordance

**DDP: FOUR PRINCIPLES**
1. Use of P-A-C-E: playful, accepting, curious, empathic
2. Interactive repair: the discordant intersubjective experience in the here-and-now of the narrative is addressed and resolved

**FOUR PRINCIPLES**
3. Therapists' own attachment strategies are organized and resolved before treatment
4. Therapist provides intersubjective experiences that are unfamiliar to insecurely attached clients
**PLAYFULNESS**
- Light exploration of possibilities
- An anecdote for shame
- Facilitates a sense of safety
- Regulates “up” positive affect
- Intimacy without threat of affection
- Balance to therapeutic “work”

**ACCEPTANCE**
- Creates a sense of simply “being,” without having to “do”
- Anecdote for shame
- Facilitates a sense of safety
- Opens the fragmented self to the therapist’s subjectivity (here-and-now)

**CURiosity**
- Active cognitive component of the intersubjective experience
- Exploration of subjective possibilities that make sense to therapist
- Completely non-judgmental
- Process of filling-in-the-gaps of fragmented self
EMPATHY

- Active affective component
- Client has sense of efficacy in “moving” the therapist
- Empathy for shame & terror contains anxiety & reduces dissociation
- Intersubjective experience itself is less threatening

Use of P-A-C-E in Co-regulation of Affect

- Therapeutic premise: that some arousal must be evoked during therapy, in a titrated level of trauma recall
- Therapist helps client stay within the “window of tolerance” by establishing and maintaining a concordant intersubjective relationship with the client

Treatment Goals
**Goals**

Reproceduring
- Development of the real self and accompanying procedures which lead to enhanced relationships and increased attachment security
- Elimination of the need to utilize false self procedures

Containment
- False self is contained through psychotherapeutic intervention

**Goals**

Adaptation
- Taught, through psychoeducation (interpretation), to “...let go of obsolete internal working models that fail to support real self”
- Aided to “...grieve memories of relational loss, absence, neglect or abuse”
- Encouraged to “...consciously choose new reality-based relational patterns uncontaminated by early implicit procedural knowledge...that do support the activation of the real self”

**Clinician’s Role**
Essentially, the “How” begins with you.

Clinician’s Use of Self

Attitude
- Compassion, respect and regard
  - Recognition of the “heroic” in regard to the patient’s effort to uncover their real self
  - Wonderment at how the patient endeavors to share his real self and to prevail over his depressive fears of failure and hopelessness

Attunement
- Promotes the patient’s attunement with the real self, not the false self
- Supports scaffolding development and expression of the real self
- Helps the patient to feel “known” and “recognized” by the therapist
- Enhances affect regulation
- Promotes healthy (therapeutic) attachment to the therapist
Clinician's Use of Self
Therapeutic Space
• Active attunement that provides for replication of the infant's need for feeling "alone in the presence of another"
• Makes possible the deepening experience of the self in context of relationship and shifts the subjective focus from us to me (enhanced sense of true self) with you and our relationship in the present and the experience of reflection

Clinician's Use of Self
Rupture-repair Cycle
• Critical to the emergence and consolidation of the real self
• Needed to support the process of reproceduring of the self from the false self to the real self
• Two levels of relational rupture:
  • Intentional misattunements occur when interventions are focused on defenses that disrupt the patient’s false self relationship to the therapist
  • Unintended misattunements by therapist to patient that provoke the patient’s anticipation of the abandonment depression with experiences of pain, fear, disappointment, etc.

“The therapist must be a real object or person...by manifesting an emotionally warm interest in the patient's problems, sympathizing with his real life defeats, and congratulating him on his triumphs, and being empathic...that coping and adaptation are vital to emotional survival.”
- Masterson
**Diagnosis-Specific Interventions**

**Portals**

to the real self differ amongst borderline, narcissistic and schizoid personality disorders.

**NPD**

- The Narcissistic Triad: Imperfection -> Painful Vulnerability -> Grandiosity
- "The conditions of attachment for the Narcissistic personality disorder render these people extraordinarily dependent on others for a sense of personal value and well-being."
- "They tend to be most responsive to interpretations of Narcissistic vulnerability that communicate an appreciation of both the fragility of self-esteem and the self-protective function of the defenses against that fragility."
**BPD**

- The Borderline Triad: Competence -> Abandonment -> Regression
- Borderline personalities require “…avoidance of self-activation and the enactment of incompetence, interpersonal compliance and clinging and passivity, in general. Consequently, the sensitive offering of confrontations of maladaptive defenses attunes most accurately to the fundamental need of the real self to assume responsibility for his or her life.”
- Clinician expresses belief to patient: I believe you can do and think for yourself.

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**Schizoid PD**

- The Schizoid Triad: Connection -> Danger -> Safe Distance
- The Schizoid personality is intensely “safety sensitive” due to twin fears of being controlled and feeling hopelessly isolated.
- Interpretations of the “Schizoid dilemma” and “Schizoid compromises” address empathically the needs for addressing the real self and the felt need for interpersonal safety.

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**Vignette Practice Exercise**

- Bob—Middle-aged Man—Clinical Vignette
Therapist Self-Awareness and Self-Care

- “We are the tools of our trade, the primary instrument with which we do the work.”
  —David Wallin

- Our attachment patterns intersect with the clients’ and we are both affected

- App: “Provider Resilience” by T2
  iPhone and Android

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Thanks!

Conclusion

For the fullest connection between people, attachment and intersubjectivity are needed, plus love.
  - Daniel Stern