

Attachment, Detachment, Nonattachment: Achieving Synthesis

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Abstract: The intention of this paper is to propose a conceptualization of the relationship between attachment, detachment, and nonattachment in human's lifelong patterns of emotional, physical and spiritual health and growth. The basic premise is that people relate to their environment with attachment (intimacy) and detachment (autonomy) from their earliest (prenatal and perinatal) experiences. Ultimately people strive for synthesis of the two, i.e., balancing attachment (freedom from fear of abandonment) with detachment (freedom from fear of engulfment), resulting in liberation from the subjugation to either (the freedom to explore the external and internal worlds). An example of synthesis is the transcendence of the two opposites of parental responsive engagement and parental acceptance of withdrawal, *rhythmic reciprocity* (Schore, 1999). Another example of the synthesis of attachment and detachment is Lifton's (1979) proposal that a secure attachment to the world is a basic prerequisite for the capacity to "let go" of the world gracefully in approaching one's death. We review the concept of "openness to experience" and its association with that of "freedom to explore." Finally, we suggest expanding attachment theory concepts into the transpersonal realms of the personal and collective unconscious, birth, death, and spiritual nonattachment. One proposal is that the development of internal working models begins earlier than the *clear-cut attachment* phase; through the mechanism of *procedural memory* (Crittenden, 1990, 1992, 1993, 1994), available at or before birth, the infant begins to develop internal models in the *preattachment* and *attachment-in-the-making* phases.

The currently proposed conceptualization launches from an outline offered by Jeremy Holmes in an article published in the *British Journal of Medical Psychology* (1997). Briefly, Holmes suggests that

Attachment, which arises out of a secure base, provides the starting point for intimacy; the capacity for healthy protest and therefore detachment is the basis of autonomy; from non-attachment comes the capacity to reflect on oneself and so to disidentify with painful or traumatic experience (p. 231).

Organization of the Article

Section 1: Attachment theory

Section 2: Holmes' "Triangle of Attachment"

Section 3: Synthesis of polar opposites

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Section 5: Attachment implications in psychotherapy with adults

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Section 1: Attachment theory

Bonding and attachment between parents and their children is essential for healthy human life and growth. *Bonding* generally refers to the parents' emotional investment in their child, building and growing with repeated personally meaningful experiences. *Attachment* usually refers to the tie experienced by the infant toward the parents, which the child actively initiates and participates in, and which largely determines the child's developing sense of self and approach to the world environment.

Beginning with the seminal work of John Bowlby (1979, 1988), we find the themes of (1) a psychology based on the opposing tendencies of attachment and separation/loss; (2) the individual's need for secure attachment in order to successfully reach out and explore one's inner world and outer environment; (3) the persistence of attachment needs throughout life; (4) the negative consequences of early disruption of affectional bonds, or attachment; and (5) the vital importance on a child's mental health of the caregiver's capacity to maintain loving presence (intimacy, avoiding separation/loss) as well as to accept protest (autonomy, avoiding engulfment).

The "co-founder" of attachment theory, Mary Ainsworth, expanded on Bowlby's original theory, contributing the concept of the caregiver as a secure base from which the infant explores its environment, as well as an appreciation for the role of caregiver sensitivity in the development of attachment patterns. Ainsworth implemented Bowlby's theoretical approach with an experimental approach, inventing the "strange situation" as a measure of attachment status in one-year-olds (Ainsworth, 1982; Ainsworth et al., 1978). The strange situation is a 24-minute laboratory procedure that involves observing the infant in a comfortable but unfamiliar room with mother, with mother and a stranger, with the stranger, and alone across multiple 3-minute episodes. She and her students observed and classified infants' response to the mild stress of separation. Children are classified as *secure* when they show distress, or protest, on separation and then actively seek the parent on reunion, are successfully soothed quickly if distressed, and return to exploratory play. They express negative emotion openly, and balance their orientation between caregiver and environment.

Ainsworth designated two categories of insecure attachment at opposite ends on a continuum: avoidant and resistant. Secure attachment falls at the midpoint between these two extremes on the continuum (Slade,

1999). *Insecure-avoidant* children protest little on separation, treat a stranger similarly to the parent, and display little or no attachment behavior during reunion, i.e., they snub the mother by turning away as she reenters the room and/or ignore her when she tries to engage her child in social interaction, or may hover nervously nearby. The child's exploration in any event is suppressed, not returning to pre-separation levels. They downplay overt manifestations of negative emotion, and orient towards the environment, rather than their caregiver. Anxious/ avoidantly attached children are presumed to have had experiences where their emotional arousal was not re-stabilized by the caregiver, or where they were over-aroused through intrusive parenting; therefore they *over-regulate* their affect (Sroufe, 1996) and avoid situations that are likely to be distressing.

Insecure-resistant (angry-ambivalent or ambivalent-resistant) children show separation distress and proximity-seeking on reunion, but instead of being soothed while being held, they squirm and sometimes kick, cling anxiously to the mother or furiously bury themselves in her lap. One subgroup seems very angry, while another is more passive. Generally, these infants do not return to play. They orient toward the caregiver rather than the environment, albeit without finding comfort. Ambivalent/resistantly attached children have hyperactivated emotional display, i.e., *under-regulate* their affect (Sroufe, 1996), impulsively heightening their expression of distress possibly in an effort to elicit the wished-for response of the caregiver. There is a low threshold for threat, and the child becomes preoccupied with having contact with the caregiver, but is frustrated even when it is available.

Both the avoidant and the resistant patterns of insecure infants suppress exploratory play; their behavior represents a paradoxically unfortunate compromise, since the exploration required for development is sacrificed for the sake of security. Both reflect distress at separation, and yet when mother returns and the solution to their problem is at hand, they don't accept the solution of being comforted. From the point of view of the secure base phenomenon, these infants exhibit self-defeating behavior. It may represent the best available solution, however, within the limited options and given the child's level of logical thinking capability.

Some infants do not seem to have a consistent pattern, utilizing both avoidant and resistant behaviors upon reunion, or alternating between avoidance and resistance. On reunion, they at times show extreme ambivalence in approaching and avoiding mother: they may stiffen and freeze, or collapse to the ground, or lean vacantly against a wall. More

puzzling behaviors (such as disoriented movements, dazed expressions, brief gestures of fearfulness, or prolonged stilling) may repeatedly and unaccountably intrude into the reunion patterns. These children were later designated as *insecure/disorganized* or *disorganized/disoriented* by Main and Solomon (1986).

Main and Hesse (1990) suggest that central to the disorganized attachment pattern is the infant's initiation of an attachment behavior sequence, which is then inhibited by fear (a response to frightened and/or frightening maternal behavior) or confusion due to inconsistent signals from the caregiver. An infant or young child might find frightening the display of his/her parent's anxiety, unusual vocal patterns and speech content, unusual movements, and lapses of cognitive monitoring that would accompany life stresses or fears or unresolved grief in the parent's experience. Disorganization is not a classification per se, but a dimension that may accompany any of the other classifications, and is considered a potentially pathological form of attachment.

In their analysis, Main and Hesse (1990) emphasize that, for the disorganized infant, the mother herself, not the situation, is the source of distress. That is, the mother has served as a source of both fear and reassurance, thus arousal of the attachment behavioral system produces strong conflicting motivations: attraction and avoidance. The frustration inherent in interruption of such a primal process as attachment behavior leads to high levels of stress, and to what we have elsewhere (Zimberoff & Hartman, 2001) referred to as "resistance to life." We hypothesize, and discuss later in this paper, that an original source of this interruption frustration may occur with the denial of the opportunity for self-attachment behaviors immediately after birth.

In average populations, about one in five children are avoidant, one in six are ambivalent, and one in twenty are disorganized (Crittenden, 1988). Distributions of secure, avoidant, resistant, and disorganized attachments to the mother appear to be comparable among working-class, lower-middle-class, and upper-middle-class families, among firstborns and later-borns, and among boys and girls (Colin, 1996).

Ainsworth also documented two related key determinants of secure attachment: the first is parental attunement and responsiveness to infant affect, the second is parental acceptance without intrusion of infant protest or withdrawal.

Parental attunement and responsiveness has been documented on a physiological level. The heart rates of securely attached infants and their

mothers in the Strange Situation parallel each other, whereas they do not with insecurely attached infants and their mothers (Donovan & Leavitt, 1985). The concordance of heart rates indicates the mother's sensitivity and involvement in her infant's perceived experience. Mothers of *secure* infants pick their babies up more quickly when they show signs of distress, play with them more, and generally seem more aware of them and their needs than parents of insecure infants. One such need is to be able to play "alone in the presence of the mother," and to meet this need the mother must be capable of providing an unobtrusive background, enabling the child to immerse in self-exploration (Winnicott, 1971).

Pediatrician and psychoanalyst D. W. Winnicott stressed the importance for young children of having time in unstructured states of being (Greenberg & Mitchell, 1983). The experience of formlessness and comfortable solitude is necessary in the development of a healthy self-identity. If the child is repeatedly interrupted in these experiences by a demanding caregiver, he/she becomes prematurely and compulsively attuned to the demands of others. This child loses awareness of its own spontaneous needs and develops a false sense of self based on compliance and performance. Therefore, Winnicott defined two essential elements of parenting in early childhood: sustained emotional bonding, and space to be and rest in unstructured being, which he called "going-on-being."

Ainsworth (1972) described four phases in the development of attachment in early childhood, based on observations of babies in Uganda and in Baltimore. The first phase, in the first few weeks of life, she called the *preattachment phase*. She saw this as the baby's nondiscriminative orientation and signaling to caregivers, without a preference for one caregiver over another. The signals are reflexes geared to drawing caregivers closer: crying, grasping, rooting and sucking, and social smiling (by age 4 to 6 weeks). The second phase, *attachment-in-the-making*, continues until about age 7 months. The baby is learning to reach out, and by age 5 or 6 months is reaching more selectively for caregivers than for strangers, and is more easily soothed by familiar caregivers than by others. In the third phase which persists until about age 4 years, *clear-cut attachment*, the child now shows "goal-corrected" activity (locomotion and signaling) to get and keep a specific caregiver closer. The repertoire of attachment behaviors has grown by age 7 months to include following, approaching, and clinging to the attachment figure, as well as protesting separation from her. Finally, the child enters the fourth phase, *goal-corrected partnership* (introduced by Bowlby, 1969/1982), around age 4

years. The preschooler has advanced cognitively enough to understand that the caregiver has feelings and plans that may differ from his/her own, and the child is now becoming a partner with the caregiver in planning how they will together handle attachment and separation.

Secure attachment is associated with an internalized sense of lovability, of being worthy of care, of being effective in eliciting care when required, and a sense of personal efficacy in dealing with most stressors independently. Secure preschoolers develop an understanding of other people's thoughts and emotions, leading to empathy (Harris, 1994). They are capable of inferring and predicting another person's plans, intentions and motives, hence the name of "goal-corrected partnership." This "reflective capacity" to cognitively and emotionally embrace one's own and others' feelings, wishes, beliefs, regrets, values or purposes develops directly from the affective attunement of the earliest experience. Conversely, a child will not develop that capacity if his/her parents did not provide the appropriate attunement. Such a child or adult shows "an extraordinarily diminished capacity to reflect upon feelings they are so obviously experiencing" (Fonagy et al., 1991, pp. 202-203). Securely attached children use their social skills and knowledge for the benefit of their relationships, e.g., by cooperating, and competently managing conflict (Suess et al., 1992). Insecurely attached children use their social skills to the detriment of their relationships, e.g., by exploiting their peers (Troy & Sroufe, 1987). Thus, secure individuals are described as adaptable, capable, trusting, and understanding.

Parents of infants presenting the *avoidant* pattern are more brusque and functional in their handling, unresponsive to their child's needs or intolerant of a child's distress. Grossmann and Grossmann (1991) studied parental interaction with babies identified as avoidant at 12 and 18 months. Parents of avoidant babies interfered when their babies were already engrossed in play, and withdrew when their babies expressed negative feelings. The infants showed many expressions of uncertainty. By contrast, parents of securely attached infants engaged in mutual play when the baby appeared to be at a loss for what to do next, but watched quietly, with interest when the infants did not need them. The avoidant child learns that seeking proximity through crying and clinging is futile, that it actually results in parental withdrawal. Instead, independence is reinforced and valued. As a result, attachment behaviors are relatively deactivated, and detachment behaviors become prominent.

Avoidant infants on reunion with the parent very often approach her only until reaching a certain proximity, and then veer away. That proximity is “usually a distance of about three feet, which is to say just out of the parent’s reach” and “the change from approach to avoidance is smooth, unhesitating, and hence appears almost mechanical” (Main & Weston, 1982, p. 35-36). Maintaining a degree of proximity with the caregiver is necessary for any infant’s protection and nurturing; the child’s natural tendency is to withdraw from the source of the threat and approach the attachment figure for safety and comforting. However, the avoidant child’s attachment figure (i.e., mother) *is* the threat, and punishes approach with rejection. Thus, the child has learned to avoid any communication of dependence, presenting an irresolvable conflict. The solution, we shall see, lies in defensive exclusion of some aspects of reality.

Parents of infants presenting the *ambivalent* pattern tend to be poorly attuned to their children’s needs, often ignoring them when they are distressed and intruding on them when they are playing contentedly. These parents offer interrupted or inconsistent parental care. When the parent feels calm, she responds to her child in a sensitive way; when she is angry, she expresses it openly with yelling and perhaps hitting. The parent’s responses are internally consistent, therefore, but unfortunately are unpredictable to anyone else, often including the trained psychologist who may be observing the interaction. The infant feels powerless to control or predict his/her experience because the response will be capriciously either supportive or hostile. Because proximity, once obtained, is often not soothing and may be punishing, the infant remains persistently anxious and angry. Because of the intermittent reinforcement for turning to the attachment figure for security, the need to be vigilant for the presence and loss of the other is strongly reinforced. The infant’s confidence in itself to respond appropriately to threats does not develop adequately.

Mothers of infants presenting the *disorganized* reactions tend to be generally stressed and to have a high incidence of abuse in their own childhood. These parents frequently use their children to meet their own needs, and the child is reinforced for being vigilant regarding the parents’ needs, and for meeting them.

Clearly, a strong correlation exists between the parent’s attachment style and the attachment that develops in their infant. Extensive research has compared assessments of mothers’ attachment category, using the Adult Attachment Interview (AAI), with their infant’s Strange Situation classification. The AAI (George et al., 1985; Main & Goldwyn, 1985) is a

structured, 15-question semiclinical interview that focuses mainly on the subject's early attachment experiences and current thoughts about them. Categories of adult attachment identified by the AAI are secure, dismissing, preoccupied, or unresolved. A meta-analysis of such studies by van IJzendoorn (1995) showed that a mother's classification on the AAI is predictive of her sensitive care for her infant, and of her infant's attachment classification in the Strange Situation. Eichberg's (1987) results, cited by Mary Main (1990), show an 82 percent correlation between mother's and baby's attachment category (secure/secure, dismissing/avoidant, preoccupied/resistant, or unresolved/ disorganized). Another study (Levine et al., 1991), conducted with high-risk pregnancies of predominantly African-American 16-year-olds, assessed the mother's AAI classification during pregnancy and compared it with her infant's Strange Situation assessment at age 15 months. There was an 83% match of insecure mothers and insecure babies. All of the mothers assessed as secure had babies who developed secure attachments.

Stern (1985), Trevarthen (1984) and Schore (1994, 1999) have shown how secure attachment, the capacity for intimacy, and a healthy sense of self identity develop out of parental attunement. Indeed, "parental attunement is crucial for the emergence and consolidation of personality structure and for the child's experiences of feeling alive" (LaMothe, 2000, p. 362). Conversely, with parental impingement, i.e., deprivation or the absence of parental attunement, the infant experiences his/her parents (and thus the world) as dangerous and frightening, or as overpowering. Thus, the child's vigilance to the subjective experience of others may lead to neglect or invalidation of her own subjective experience and the tendency to rely on external confirmation to maintain self-esteem and the sense of identity (de Groot & Rodin, 1994).

As mentioned, a second major determinant of secure attachment is the parent's ability to accept protest without retaliation or excessive anxiety (Winnicott, 1971). To develop secure attachment, children must know that their parents can and will survive their attempts at withdrawal or expression of negative feelings, and welcome them back with unconditional loving intimacy. The child can protest or separate without fear of abandonment, and return to intimacy without fear of engulfment. "The capacity of the caregiver to recognize and accept protest is as much a foundation of psychological health as the absence of major separation. The denial of trauma and suppression of protest were seen by Bowlby as crucial determinants of neurosis" (Holmes, 1997, p. 233).

What comprises an attachment relationship? Weiss (1991) defined attachment relationships as those that display these eight properties:

Proximity Seeking	Attempting to remain within protective range. Range is reduced in threatening situations.
Secure Base	Presence of attachment figure fosters security and leads to exploration.
Separation Protest	Threat to accessibility of attachment figure leads to protest and attempts to avoid separation.
Elicitation by Threat	When anxious, individuals display attachment feelings and direct themselves towards attachment figures.
Specificity	Attempts to substitute other figures do not succeed, even where the quality of care and attention is equivalent.
Inaccessibility to Conscious Control	Attachment feelings and separation protest persist even after permanent separation (e.g. death).
Persistence	Attachment does not wane through habituation. Separation produces pining which only slowly abates and does not desist but is incorporated into a despairing outlook.
Insensitivity to Attachment Figure's Behavior	Attachment persists even where the attachment figure's behavior is abusive. This can result in the association of feelings of anger or mistrust with attachment feelings which may give rise to conflict.

Table 1. Eight Properties of Attachment Relationships

Bowlby (1973) provided evidence for the continued importance of child-parent attachment during the period from preadolescence to early adulthood, claiming that “an unthinking confidence in the unfailing accessibility and support of attachment figures is the bedrock on which stable and self-reliant personalities are built” (p. 322).

The influence of father-child attachment may be different from that of mother-child attachment (Belsky et al., 1984; Easterbrooks & Goldberg, 1984). Toddlers securely attached to their fathers demonstrate more optimal behavior patterns in problem-solving tasks and are more consistent in their task orientation, compared with toddlers who are insecurely attached to their fathers. Fathers' attributes which increase attachment with their children are emotional supportiveness, encouragement, meshing, attentiveness, positive affect, praise, and non-intrusiveness during exploration. Infant attachment to father and a father's sensitivity during play with his toddler are related to more active and less avoiding coping

styles in adolescence (Zimmermann & Grossmann, 1997). According to Grossmann et al. (1999), “these findings are another indication of the long-lasting influence of secure exploration, facilitated mainly by fathers, on adaptation to challenging situations” (p. 780).

When infants experience warm, responsive and sensitive caregiving, they develop positive expectations of others for the future, and a view of themselves as capable and worthy. When infants experience rejection or emotional unresponsiveness, they come to expect that others will not be available or responsive. These deeply embedded expectations, referred to as *internal working models* in attachment theory, form the basis for future interactions. Research shows that the working models developed early in life continue to be displayed in adult partner relationships (Hazan & Shaver, 1987).

Adults exhibiting a secure attachment style agree that they find it relatively easy to get close to others, are comfortable with depending on others and having others depend on them, and are not often worried about being abandoned. Adults identified with the avoidant style are somewhat uncomfortable with closeness to others, find it difficult to trust others completely or to allow themselves to depend on them, and get nervous when love partners want to get too close. Individuals who exhibit the ambivalent style feel that others are reluctant to get as close to them as they would like; worry that their partners do not really love them or do not want to stay with them; and want to get very close to their partners, although they know that this sometimes scares people away.

Beyond these two aspects of parental behavior, i.e., attunement to infant affect and acceptance of withdrawal without intrusion, “factors beyond the specific interactions that transpire between mother and infant also serve to influence the development of attachment security, if only because they are likely to affect the very behavioral exchanges that take place between mother and infant” (Belsky & Isabella, 1988, p. 45). In an ambitious meta-analysis, Atkinson et al. (2000) determined that maternal social/ marital support, stress, and depression each proved significantly related to the infant’s development of attachment security. Social support/ marital satisfaction influences the mother’s experience of child rearing and thereby affects her interaction with the child and its development of secure attachment (Crockenberg, 1981; Jacobson & Frye, 1991). Social support may be defined as involving close relations with a variety of intimates, including spouse, extended family members, and good friends; as the perception that one is loved, respected, and part of a network of mutual

obligations; and as access to the exchange of material goods, information, and problem-solving strategies.

Regarding maternal stress, *life events stress* has not been shown to be a significant influence on secure attachment (Vaughn et al., 1979), but *parenting stress* has been (Manassis et al., 1994; Teti et al., 1991). Regarding maternal depression, a parent's depression impedes caregiving by reducing psychological and, possibly, physical accessibility and responsiveness to the infant, and puts at risk his/her secure attachment (Cummings & Cicchetti, 1990; Cummings & Davies, 1994). Maternal depression is strongly linked to infant disorganized attachment; about half of babies whose mother suffers from unipolar depression are anxiously attached, and 80% of babies whose mother suffers from bipolar disorder develop anxious attachment (Radke-Yarrow et al., 1985). Care from depressed mothers is often detached and unresponsive, and it is also often hostile and intrusive (Gelfand & Teti, 1990).

Follow the development of an infant assessed to be *avoidant* and defended, and one first observes a baby who has learned to deny its anger and its need for nurturance. Then in time the child has learned to devalue or minimize the importance of attachment in relationships, and by age 4 has developed complex strategies for non-dependent survival. Crittenden (1992, 1993) has identified such approaches; one is *compulsive caregiving*, in which the child reassures the withdrawn and depressed parent that everything is all right. This child has exchanged roles with the parent, so that he/she is responsible for the parent's security, and develops an artificial affect, often with a pasted-on smile and the determined bravado of competence. Children are capable of pretending to have a feeling before age 2, and this child has learned to use the ability for survival. An alternative approach is *compulsive compliance*, in which the child becomes highly vigilant to the hostile and unpredictable parent's desires and complies promptly with them or may be able to anticipate and comply with them before they are communicated or even formulated. Ultimately one finds an adolescent and adult who is counter-dependent, emotionally insulated, intimacy-phobic and "compulsively self-reliant" (Bowlby, 1973). In the extreme, this adult becomes obsessive, schizoid, or narcissistic.

Follow the development of an infant assessed to be *resistant* and demanding and angry, and one first observes a baby who has learned to maximize the attention he/she gets from the parent, regardless of whether it is positive or negative (i.e., "I'd rather be wanted for murder than not

wanted at all”). Then in time, certainly by preschool age, the child has learned to manipulate the parent by alternating dramatic angry demands with needy dependence. This child has discovered an effective way to keep the inattentive inconsistent parent involved: do the opposite of what mother is doing. When mother is preoccupied and not paying attention, the child explodes in angry demands and behaviors that cannot be ignored. The mother either reacts with hostility, punishing the child, or with sympathy, rewarding the child’s manipulation. This preschooler knows what to do in either case: respond to hostility with a coy sweetness and dependency, and respond to sympathy with anger and new demands. The two are enmeshed together in a never-ending cycle of dissatisfaction. This individual grows into an emotionally volatile adolescent and adult who seeks care, but finds only partial and transient soothing from the contact. Preoccupied/ resistant individuals are anxious, dependent, impulsive, and approval-seeking (Klohnen & John, 1998). In the extreme, this person becomes a hysterical or borderline personality.

Attachment theory can be viewed as an evaluation of the balance (security) or imbalance (anxious insecurity) of exploration and attachment. Grossmann et al. (1999) define security as an optimal balance between attachment and exploration, resulting in open-mindedness, open communication, and a careful but curious orientation to reality. For the less secure child the attachment-exploration balance is more limited, or unbalanced. Exploratory activity of infants with an avoidant attachment to their mothers is restricted by too much anxiety, observed in excessive attention to objects as a defensive maneuver to deflect the pain of not getting sufficient or appropriate attention from mother. Exploratory activity of infants with an ambivalent attachment to their mothers is restricted by preoccupation with maintaining proximity to the attachment figure. The “freedom to explore” and its mental companion, “freedom to evaluate experience” are the adult states of mind to be balanced with attachment. “Thus freedom to explore the external and internal worlds is an important attachment-related issue throughout the lifespan” (Grossmann et al., 1999, p. 762).

Secure children exhibit more delight and become more deeply engrossed in play, and show greater versatility in their exploration than insecurely attached children. Secure children are more skilled in responding to stressful situations, flexibly exploring possible solutions, and willing to call for and accept help when needed. Discussing secure 3½ year olds, Grossmann et al. (1999) relate that they may *redefine challenges in a*

creative way, for example, building a tower or a robot instead of performing a block design that is too difficult as requested by an experimenter. Or they may *redefine the goals*, for example, declaring that the task of dressing a doll is completed even though no shoes have been put on it, “because it is summer and the doll can go barefoot.” Compare these strategies with those of children with disturbed attachment (Lieberman & Pawl, 1988): *recklessness and accident proneness, inhibition of exploration, or precocious competence*, to be discussed later.

Attachment develops first as infant and childhood attachment to parents and caregivers, and continues through adolescence into adulthood.

Whereas for 1-year-olds the main developmental steps are attachment and first explorations from a secure base, the important features for 2-year-olds are self-assertion and the beginnings of autonomy. Three-year-olds show positive self-evaluation, pride, shame, the beginnings of tolerance for a sibling, and enormous growth in linguistic competence. A rudimentary understanding of words that describe time periods helps them tolerate separation much longer. For 4-year-olds, gender identification and peer relationships are important; 5-year-olds are concerned with moral issues and adult rules; and 6-year-olds have to adapt to school-related activities, among (of course) many other things (Grossmann et al., 1999, p. 768).

Needless to say, the areas of challenge and potential mastery continue to expand with each year as children grow into adulthood. One loosens or breaks the early attachments during adolescence and supplements or replaces them with attachments in romantic relationships and friendships. Nearly all adults select an adult attachment figure that fulfills (or doesn't) the same attachment needs as they had in childhood. Finally, in old age, one reverts to one's adult children, if available, as the attachment figure.

A four-category model of adult attachment style

Bartholomew and Horowitz (1991) proposed a method of defining adult attachment style based on two dimensions: the internal working model, or image, of self and of others. Each of these dimensions has a positive and negative pole: image of self as worthy of love and support or not, image of others as trustworthy and available or unreliable and rejecting. The four combinations are summarized in Table 2.

The combination of a positive self-image and positive image of others yields the secure category, indicating a sense of worthiness and an expectation that others are accepting and responsive. This individual is comfortable with intimacy and autonomy. Cell II represents the combination of a negative self-image (unworthy) and a positive image of

others (trustworthy and available). This individual, labeled preoccupied, seeks the validation and acceptance of others, resulting in dependency. Cell III represents the combination of negative self-image (unlovable) and negative image of others (unreliable and rejecting). This individual, labeled fearful, protects himself against the anticipated rejection by others through avoidance of close involvement. Cell IV represents the combination of positive self-image and negative image of others. This individual protects herself against disappointment by avoiding close relationships and maintaining a sense of independence and invulnerability (counter-dependence), and corresponds to the dismissing-avoidant attachment style.

		Model of Self (Dependence)	
		Positive (Low)	Negative (High)
Model of Others (Avoidance)	Positive (Low)	Cell I SECURE Comfortable with intimacy and autonomy	Cell II PREOCCUPIED Preoccupied with relationships
	Negative (High)	Cell IV DISMISSING Dismissing of intimacy Counter-dependent	Cell III FEARFUL Fearful of intimacy Socially avoidant

Table 2. Four Category Model of Adult Attachment

Bartholomew and Horowitz' dimensions of models of self and others can also be conceptualized as dependency and avoidance of intimacy (as labeled in parentheses). Dependency varies from low (a positive self-regard is established internally and does not require external validation) to high (positive self-regard can only be maintained by others' approval). Avoidance of intimacy reflects the degree to which people avoid close contact with others as a result of their expectations of aversive consequences. The *dismissing* and *fearful* styles are alike in reflecting the avoidance of intimacy, but differ in the individual's need for others' approval to maintain positive self-regard. The *preoccupied* and *fearful* styles are alike in incorporating strong dependency on others' approval, but

differ in their readiness to become involved in close relationships. The *preoccupied* style implies a reaching out to others in the attempt to fulfill dependency needs; the *fearful* style implies an avoidance of closeness to minimize eventual disappointment.

Maunder and Hunter (2001, pp. 558-559) summarize the four categories as follows:

Insecure attachment can be categorized as preoccupied, dismissing, and fearful. A person who expects to cope with stress inadequately but whose expectations of others are more positive is *preoccupied*. Preoccupied attachment, the adult correlate of infant angry-ambivalent attachment, is associated with excessive care-seeking, separation protest, and fear of loss (West & Sheldon-Kellor, 1994). Although the preoccupied individual seeks care, the soothing that results from contact is partial and transient. Preoccupied individuals are described as anxious, dependent, emotional, impulsive, and approval-seeking (Klohnen & John, 1998).

People who distrust the effectiveness of social supports but have a positive view of themselves emphasize independence and are classified as *dismissing*. A self-sufficient and undemanding attitude is often highly valued, but the associated distrust and avoidance of intimacy communicates the underlying insecurity. Situations that demand relinquishing control and depending on others, such as hospitalization for acute illness, may result in crisis. Dismissing attachment is characterized by coldness to others and competitiveness (Bartholomew & Horowitz, 1991).

Finally, a person whose expectations of both self and other are negative is *fearful*. Fearful attachment is the least-studied category, having been introduced by Bartholomew in 1991 (Bartholomew & Horowitz, 1991). Fearful individuals are described as cautious, doubting, self-conscious, shy, and suspicious (Klohnen & John, 1998).

Dismissing and fearful attachment taken together are the adult correlate of infant avoidant attachment.

People with the *preoccupied* style blame themselves for perceived rejections by others, thereby maintaining a positive view of others and reinforcing the negative view of themselves. People with the *dismissing* style downplay the importance of others whom they have experienced as rejecting, thereby maintaining high self-esteem and reinforcing the view of others as unreliable and rejecting. People are able to go beyond simply interpreting experiences to correspond to their internal models, but actually structure their experience selectively to maintain and reinforce those models. How? People seek or avoid social contacts, and select social partners who are likely to confirm the internal models; this is referred to as “selective affiliation” (Collins & Read, 1990; Davis & Kirkpatrick, 1991). People also structure social interactions so as to induce social partners to engage in self-confirming interaction patterns; this is referred to as “interactional continuity” (Caspi & Elder, 1988). “Internal models are expected to direct attention, organize and filter new information, and

determine the accessibility of past experiences. Thereby, ambiguous stimuli (which may form the bulk of all social stimuli) tend to be assimilated to existing models” (Bartholomew & Horowitz, 1991, p. 241).

Openness to experience

Here we will briefly examine the concept of openness to experience, and its association to that of “freedom to explore the external and internal worlds.”

The construct of openness to experience has its roots in the psychoanalytic and humanistic approaches to personality, and represents tolerance for the unfamiliar, interest in ideas and problems, and appreciation of experiences involving actions, fantasy, values, feelings and aesthetics (Tesch & Cameron, 1987). Schachtel (1959) proposed the concept of openness to experience, derived from the concept of regression in service of the ego, to mean a loosening of fixed anticipations so that one approaches the objects of his/her experience in different ways, from different angles.

Openness to experience was first empirically applied by Fitzgerald (1966), who found that college students scoring high in openness were low in repression on the MMPI. He depicted the following aspects as components of openness to experience (derived from the concept of regression in service of the ego):

- Tolerance for regressive experiences (affects, childishness, fantasy, daydreaming, etc.)
- Tolerance for logical inconsistencies (seeming impossibilities or bizarre implications)
- Constructive use of regression (uses fantasies in a creative way)
- Altered states (inspirational experiences with relative breakdowns of reality orientation)
- Peak experiences (seeks experiences which are overwhelming, enrapturing, and thrilling)
- Capacity for regressive experiences (inquisitive into the unusual, with rich imagination, and not bound by conventional categories of thought)
- Tolerance for the irrational (acceptance of things which violate common sense or science)

Fitzgerald, based on his research, concluded that openness to experience has a somewhat different meaning for males and females. Males who are open to experience are open to *inner* (controlled)

experience; females who are open to experience are open to *outer* (expressive) experience.

Coan (1972) observed that people vary considerably in the range and types of experience to which they are open, and also that a given individual can be very open in one area of experience while being very closed in another area. He also noted that women tend to be more open in the realm of feeling and thought, while men tend to be more open in the realm of action. Openness to experience is a basic and stable aspect of personality that can be detected and quantified (McCrae & Costa, 1982; Tesch & Cameron, 1987). They operationalized openness to experience as non-defensiveness, willingness to share experiences, openness to the unknown and unknowable, to emotions, ideas and spirituality, and to seeming incompatibilities.

Psychological openness may determine the degree, frequency and duration of identity exploration entered into by an individual. Openness is a central personality “constant” that affects ego development and identity formation (Tesch & Cameron, 1987):

The relationship between openness to experience and identity formation observed in the present study supports Rogers’s (1961) theory regarding the importance of openness for positive personality growth. . . . That is, openness to experience may lead to both exploration of alternative identities and to introspective and expressive behaviors, thus creating indirect associations between identity formation and various behavioral manifestations of openness to experience.

. . . a tendency toward psychological openness may facilitate exploration of identity which in turn leads to greater self-awareness and openness to experience. Conversely, a person who is less open to experience may not become aware of identity alternatives, and the premature foreclosure of identity might further depress the level of openness (pp. 627-628).

Research (Griffin & Bartholomew, 1994; Shaver & Brennan, 1992) has shown that of the “Big Five” dimensions of personality (extraversion, agreeableness, neuroticism, openness to experience, and conscientiousness), openness and conscientiousness are least closely related to adult attachment. That conclusion may, indeed, reflect the dichotomy between attachment and exploration. Openness may well prove to be correlated with adult exploration. Secure attachment is related to higher cognitive openness (Mikulincer & Arad, 1999). For example, secure people tolerate ambiguities and contradictions well, and, showing no inherent preference for consistency, are relatively free from prior expectations in integrating new information. On the contrary, ambivalent-resistant people are preoccupied with the threatening aspects of new

Holmes explains his “Triangle of Attachment” (Figure 1) in this way:

The base of the triangle forms the attachment axis, each corner of which has, in an Eriksonian dichotomy (Erikson, 1968) a defensive, insecurity-avoiding, and a positive exploratory-creative, facet. At the corner of detachment is autonomy, which carries within it the seeds of avoidance and isolation, and fear of engulfment. At the corner of attachment is intimacy which is shadowed by the possibility of ambivalence and clinging as an avoidance of irreparable loss. At the apex, the corner of non-attachment, lies severe disruption of attachment, in the sense of lacking a caregiver who is able to see one as a separate sentient being. This links with severe psychopathology such as borderline personality disorder, but, more positively, with ‘dis-identification’ from psychic pain, and the synthesis of attachment and detachment into an acceptance that transience and suffering are inherent aspects of living (1997, p. 235).

Facets of attachment

The positive aspect of attachment, the exploratory-creative aspect, is primarily its contribution to development of the capacity for intimacy. The principal role of the attachment bond is to provide the individual with security by reducing anxiety, and thus make possible creative or playful exploration.

The (maladaptive) defensive aspect of attachment, the insecurity-avoiding aspect, can be expressed in ambivalence, clinging, and fear of autonomy. Attachment expressed through ambivalence (preoccupation) is the imbalance created when a child must sacrifice exploration of herself and her world to be preoccupied with the inconsistent presence of her primary caregiver. This child has learned not to trust the caregiver for security, and may develop a number of solutions, as we have seen. For example, this child may become impulsive, emotionally volatile, or dependent and approval-seeking, unable to experience comforting when it is available due to waiting for the “other shoe to drop.”

Attachment expressed through clinging is a defensive behavior. “Infant clinging” serves a healthy purpose; the infant’s instinct to cling is based upon the protection and gratification that the child’s mother provides (Murphy, 1964). This natural and healthy instinctual behavior can be perverted by inconsistent parenting into “maternal clinging,” where the infant’s motive is to protect the mother against feelings of abandonment. Such a dysfunctional application of clinging is highly destructive to the child’s efforts to separate and individuate (Masterson, 1973), interfering with the normal process of identity formation and willingness to acknowledge one’s own needs and ask for help when appropriate.

Fear of autonomy comes about through the infant’s consistent defensive choice to avoid the anxiety inherent in any attempt at autonomy.

This child's separation/ individuation attempts have all been undermined, either by the parent's lack of attention or by the punishment of rejection. The fear of autonomy can eventually manifest as success phobia, fear of wealth, or fear of risk (Krueger, 1991). Indeed, this individual exhibits the strongest fear of death, including the loss of his/her social identity in death.

Facets of detachment

The positive aspect of detachment, the exploratory-creative aspect, is primarily its contribution to the development of the capacity for autonomy. We have seen the immense importance for child development of the "freedom to explore," to detach from the caregiver temporarily in order to attend to its environment. We will discuss later the same process for newborns, the detachment phase within the process of 'affect synchrony.' Mothers who are most responsive and synchronized with their infant tune their activity level to the infant *both* during periods of social engagement *and* during the quiet recovery periods of disengagement. They are also attentive to the child's reinitiating cues for reengagement (Schore, 1999). Buchholz and Chinlund (1994) have proposed that aloneness, or detachment, is a basic-level human need in the process of development over the life span, parallel to and of the same valence as attachment. They suggest that focus on attachment and object relations has kept the regulatory function of detachment in partial eclipse.

The (maladaptive) defensive aspect of detachment, the insecurity-avoiding aspect, can be expressed in avoidance, isolation, and fear of intimacy. That is, the child who is repeatedly interrupted by a demanding caregiver, who is not allowed recovery periods of disengagement, becomes compulsively attuned to the demands of others, losing awareness of its own spontaneous needs and developing a false sense of self based on compliance and performance. The avoidance here is an obsessive behavior used as a defensive effort to displace the focus of those thoughts, desires, or intentions that individuals feel will threaten their security, namely the intrusive attachment figure. They experience extreme anxiety about losing control and attempt to forestall this loss through many tactics: intellectualization, perfectionistic efforts at absolute control, avoidance of feelings that cannot be completely controlled, procrastination and indecisiveness that avoid closure, and obsessive or compulsive rituals that are maneuvers to give them the illusion of control (Salzman, 1979).

It is clear that defenses formed in childhood act as a barrier to closeness in adulthood (Firestone & Catlett, 1999), and that fear of

intimacy goes hand-in-hand with loneliness (Descutner & Thelen, 1991). Other traits or states related to fear of intimacy are high resistance to risk taking, strong need for safety and security, strong need to appear and behave as if emotionally independent, strong fear of getting hurt in an emotional relationship, general belief that marriage is a trap, inability to deal with intense feelings, feeling unlovable, and strong need to defend against financial dependence (Lutwak, 1985). Lutwak quotes Greenson (1962) in discussing “counterfeit emotional involvement” where individuals can be together physically yet never take the risk of allowing themselves to be emotionally touched for fear of getting hurt. Two people, both of whom are fearful of intimacy, may attract each other and form an unspoken, perhaps unconscious, agreement to have a counterfeit emotional involvement. One or both of them may even lament that intimacy is missing in the relationship, perhaps blaming the other as emotionally unavailable.

Let’s look at precisely how this detachment, the defensive avoidance of intimacy, occurs. Fraley et al. (1999) have carefully documented the architecture of defense in the child and in the adult. Infants who exhibit lack of attention to the parent in the reunion after separation and instead distract themselves with a toy are attempting to conceal the troubling thoughts and feelings, the dependency on an unreliable caregiver. Physiologically, we know that the child remains anxious regardless of the avoidance behaviors. That is, the child is *pretending* not to be anxious, rather than actually being disengaged. For example, the infant’s absence of transitory blinking when averting eye contact with the parent belies that it is not the same as engaged exploration, within which blinking occurs (Waters et al., 1975). Also, avoidant infants continue to have high heart rate levels following separation and are not able to engage their attention completely with distracting toys (Sroufe and Waters, 1977). The child’s diversionary play is half-hearted or mechanically repetitive (Main & Weston, 1982). Therefore, we can infer that they are not actually *blocking* the anxious feelings, but only the expression of the feelings, because the distraction is superficial.

Over time, habitually shutting off the *expression* of distress leads to shutting off the *experience* of distress through changing the way cognition and memory become organized. Avoidant adults have actually managed to block anxious feelings and thoughts by using defensive strategies to successfully disengage awareness of the need that is not being met (Fraley et al., 1999). In short, dismissing adults are able to remain detached by

maintaining a dissociative memory system. However, the underlying anxiety is revealed by substantial arousal when a dismissing person is made to focus on thoughts of attachment-related experiences that he/she prefers to avoid (Dozier & Kobak, 1992).

The mechanism of suppression of anxious thoughts or feelings has been amply studied, and provides information germane to detachment and useful in tailoring treatment for avoidant clients. When an individual attempts to suppress a thought, one outcome may be a *rebound effect*, that is the act of suppression paradoxically elicits the very thought one is trying to suppress, making it more accessible to consciousness at a later time (Wegner, 1989, 1994; Wegner et al., 1987). The more specifically an individual is able to replace the thought to be suppressed with another distracting thought, and the less connected to the original thought the distracter thought is, the more the rebound effect reverses and the more successful the suppression. Dismissing-avoidant individuals, with chronic experience of suppressing distressing thoughts, have developed specific distractions that they know will work (Kelly & Kahn, 1994). Conversely, when the mind is allowed to wander, it is likely to return to thoughts that have been prohibited.

Hansen and Hansen (1988) suggest that repressive individuals' memories are relatively inaccessible to them, because of the limited associative connections between emotional memories and memories for other life experiences. Generally, memories for emotionally significant events incorporate a complex mixture of *dominant* and *nondominant* emotional states. For example, the recall of a sad memory elicits the dominant emotion of sadness plus nondominant emotions such as anger, shame, or fear. Repressive individuals do not experience nondominant emotions as strongly as nonrepressive individuals do, suggesting that repressors' memories of emotional events are not tightly connected but are rather dissociated from each other. Repressors tend not to focus on nondominant emotions when initially experiencing an event.

Davis (1987, 1990; Davis & Schwartz, 1987) found that repressive individuals recall fewer early childhood memories, and take longer to retrieve the memories they do recall, and that the memories are available but not easily accessible because of the lack of associative interconnections. Once emotional memories are recalled by the repressive person, however, they can be retrieved later as easily as by the nonrepressive person. Mikulincer and Orbach (1995) found that avoidant adults took longer to retrieve early childhood memories of negative

experiences, and that the memories recalled do not contain a diffuse array of nondominant emotions. They have a relatively dissociated memory system for experiences related to emotions, attachment, or relationships, indicating that they have structured their experience to minimize vulnerability to emotions that might trigger an emotional response.

To minimize vulnerability to emotional response, avoidant individuals have learned not to allow themselves intimate behavior. For example, dismissing individuals are generally overly controlling and critical when helping their romantic partners, and pull away when their partners need support or comfort (Fraley et al., 1999). Additionally, they tend to avoid intimate behaviors such as holding hands, mutual gazing, cuddling, and kissing, and to express less affection during sexual activities.

In reality, the act of detaching emotionally from relationships as protection is an empty gesture. Research (Reed, 1993) with surviving family members of victims of suicide or accidental death indicate that the most grief-stricken survivors were more detached from family than those who were least grief stricken. The detached survivors actually had more unresolved in their relationships, which created greater grief when the opportunity for resolution was suddenly and permanently denied. Remorse compounds the loss.

These are the individuals who may employ the compensating strategies of *compulsive caregiving*, in which the child reassures the withdrawn and depressed parent that everything is all right, or *compulsive compliance*, in which the child becomes highly vigilant to the hostile and unpredictable parent's desires and complies promptly with them or may be able to anticipate and comply with them before they are even formulated (Crittenden, 1992, 1993). Ultimately they become adolescents and adults who are counter-dependent, emotionally insulated, intimacy-phobic and "compulsively self-reliant" (Bowlby, 1973). A consequence of this insulation of detachment is isolation. The underlying incentive of the insecurity-avoiding aspect of detachment is fear of intimacy.

Facets of nonattachment

The positive aspect of nonattachment, the exploratory-creative aspect, is primarily its contribution to the development of integration and meaning in life. It is the freedom to "live with abandon" without fear of abandonment. It is living with an attitude of commitment to the path without attachment to the outcome. With the clarity of nonattachment, an individual can see that the object of desire (e.g., a person, job, goal, or

approval) can never be possessed, and that the attempt to do so only enslaves him/her in an unfulfilling and futile search. "A healthy nonattached individual is fully involved with the relationship and is not distant and withdrawn. This full involvement is possible because the suffering created by attachment, a form of thirst and greed, is observed and abandoned. Thus the object of attachment can be itself and the individual does not have to defensively control or possess the object of attachment" (Twemlow, 2001b, p. 31).

In eastern philosophy, it is called *dharma*, and recognizes an experience of emptiness as freedom. The experience of emptiness may be, in fact, a necessary stage in the process of self-transformation. By confronting and working with experiences of emptiness, a person undergoes a fundamental change in the direction of becoming more real, more truly oneself, including a heightened sense of what one has uniquely to offer to the human community (Gunn, 1997). Erikson (Erikson et al., 1986) defines wisdom as a "detached concern with life itself, in the face of death itself" (p. 37) or as "involved disinvolvement" (p. 51).

One example of the positive aspect of nonattachment is disidentification from role, image, or identity. The adolescent developmental stage from age 12 to 18 is focused on clarifying the distinction between one's roles and identity. However, that process is an ongoing one for most people. When an individual identifies with an image or an identity, he/she "takes on" the accoutrements associated with it. For example, identification with an addiction may lead to increased involvement in the addictive activity, whereas identification with behaviors incompatible with an addiction may lead to reduced involvement in the addictive activity (Walters, 1996). In psychosynthesis, the part of oneself fixated at an incomplete developmental stage is a subpersonality, functioning mechanically, unconsciously. If an individual becomes totally identified with a subpersonality, he/she places its needs and perspectives above all else, "repetition compulsion" in psychoanalytic terms. By recognizing and naming subpersonalities, disidentifying from them and dialoguing with them, their underlying (unresolved) needs and as yet unclaimed higher qualities become apparent. Their distorted behaviors can be transformed and energies released for the benefit of the total person.

We view another perspective on disidentification in Jungian terms. The part of oneself fixated at an incomplete developmental stage is an autonomous complex, and the aim of Jungian analysis is to transform autonomous complexes into consciousness (Nitis, 1989). One of the

complexes is the ego-complex, the center of the field of consciousness, the adaptive, conscious executive of the personality, the observing aspect. The personal unconscious is related specifically to this ego-complex. Other complexes are collections of ideas and images organized around one or more archetypes at the core of the complex and having a certain feeling tone and energy charge. Examples might include a father complex, mother complex, hero complex, child complex, the anima, the animus, etc. All the complexes together Jung called the collective unconscious, or objective psyche. In the altered state, the normally unconscious complexes begin to come into conscious awareness.

Competing identities can often be incompatible. One may be determined to “be good” and stay away from sweets, while another pops up and devours all the candy in the jar. Each is successively in control, and the secondary gain of the latter defeats the intentions of the former. Carl Jung saw most people as identified almost entirely with certain acceptable aspects of themselves (the *persona*), having denied and repressed the unacceptable aspects (the *shadow*). The process of disidentifying from the former as “I”, and from the latter as “not I” allows a new fluidity into one’s identity, a loosening of the rigidly held and defensively guarded self-image.

The ego in midlife ideally has become secure enough to reverse the focus on autonomy, to initiate a return (Jung’s *enantiodromia*) to its underlying source in the collective unconscious. The undoing of the ego’s grip on independence and control requires undoing the primal repression and embracing that which has been repressed (the shadow side). The ego must surrender to enter the final stage of development, but of course the ego fights tooth and nail to maintain its sense of independence and control. Surrender is actually accomplished through the release of shame and fear, the ‘glue’ of repression, allowing for a redemptive return to innocence, wonderment, awe, mystical and spiritual experience, and sensuality.

The aim, then, is not so much the dissolution of the ego as the dissolution of the false view of the ego; and what is to be achieved is an openness to all possibilities that present themselves, and above all, a realization that we are infinitely more than we believe we are when *identified* with our concrete little ego. We have limitless potentials, once we are free from the bondage of our egocentric world (Moacanin, 1986, p. 83) (*italics added*).

The way back to authenticity and real *free will* is through recognition of the unconscious nature of most of our choices and experiences. When we “snap out of” the state of absorption, we expand our consciousness of

who we are to include a wider spectrum, allowing for new possibilities. Liberation from unconsciousness, waking up from the trance, arousing from the dissociation comes with disidentification from the limited 'I'. First we must become aware of, incorporate and even embrace our dark side, our shadow, those parts of us that we shudder to conceive could be within us or the parts we are afraid to grow into. Part of us may be "the compulsive smoker", and another part is the great mystic, and both parts are intimidating to own up to. Experiencing our shadow is the "doorway to the real," ripping apart the ego's imaginary identifications (Humbert, 1988, p. 50) and seeing clearly into the blind spots.

The defensive aspect of nonattachment, the insecurity-avoiding aspect, can be expressed in chaos or a pervading sense of meaninglessness. This aspect of nonattachment, when used in the context of an attitude of noncommitment or lack of engagement, reflects the inability to connect. This individual abandons and neglects his relationships and duties, or performs mechanically, without enthusiasm, passion, or ideals. He/she experiences an inner emptiness, an inner sense of hunger and yearning and a generalized sense of emotional numbness. Childhood emotional abuse seems to be the best predictor for the experience of emptiness (Buggs, 1997). This defensive aspect of emptiness can be explained as (1) a deficiency, (2) a defense, (3) a defect in self/object integration, or (4) the result of inner conflict over idealized aspirations of the self (Epstein, 1989), each in contrast to the Buddhist view of emptiness as wholesome, fulfilling and liberating.

Living in chaos or a pervading sense of meaninglessness and emptiness, absorbed in nonattachment as a means of avoiding insecurity, may be looked at as a spiritual crisis. Jung said his task was the "cure of souls" (1961, p. 124). Jung refers to the diminution of the personality known in primitive psychology as 'loss of soul' (1959, p. 119). He states that we label the similar experience in our civilized culture as an "abaissement du niveau mental," and describes it as "a slackening of the tensivity of consciousness, which might be compared to a low barometric reading, presaging bad weather. The tonus has given way, and this is felt subjectively as listlessness, moroseness, and depression" (p. 119). The condition can go so far that the individual parts of the personality become independent and thus escape from the control of the conscious mind, a phenomena known as hysterical loss of function. The condition results from physical and mental fatigue, bodily illness, violent emotions,

traumatic shock (p. 120), and dissociation and suppression of consciousness (p. 281).

Section 3: Synthesis of polar opposites

If we view attachment theory as an evaluation of the balance (security) or imbalance (anxious insecurity) of exploration and attachment, then we are observing a process of synthesis. Let us define security as an optimal balance between attachment and exploration, the freedom to explore, liberation from slavery to the old and unconscious internal working models.

First, we will refine the concept of balance and synthesis, then explore a few examples of it throughout the lifespan.

Roberto Assagioli (1974) wrote a paper on the subject of the balancing and synthesis of opposites which is helpful to establish an underlying understanding of the principle, which we may then apply to how secure attachment liberates. He said, “psychological life can be regarded as a continual polarization and tension between differing tendencies and functions, and as a continual effort, conscious or not, to establish equilibrium.” He analyzed how one might balance opposite poles of any polarity, with the object of resolving polar tensions, of transcending the polarity. He describes four methods of achieving balance:

1. *Fusion of the two poles*, involving the neutralization of their charges of energy.
2. *Creation of a new being, of a new reality*.
3. *Adjustment of the opposite poles*, by means of an “intermediary center” or of a principle higher than both. A regulating action of this kind can be brought about in two ways:
 1. By diminishing the amplitude of the oscillations between the two extremes, at times even to vanishing point, thus inducing a more or less complete neutralization (“the happy medium”). An instance of this, of great actual interest, is the oscillation between excessive authority and uncontrolled freedom in education and the search for a balanced attitude.
 2. By consciously and wisely directing the alternations so that the result is harmonious and constructive, and in accord with the cyclic alternations of both individual and general, human and cosmic, conditions. (This is the method taught by Chinese philosophy and particularly by the *I Ching*.)

4. *Synthesis*, brought about by a higher element or principle which transforms, sublimates and reabsorbs the two poles into a higher reality.

The process of synthesis achieves balance most economically at the highest new level. Synthesis includes and absorbs the two elements into a higher unity endowed with qualities differing from those of either of them. An example given by Assagioli is the polar opposites of self-deprecation (inferiority complex) and arrogance (superiority complex). The “middle way of compromise,” modesty, is achieved on the same level through blending the two poles. Synthesis of the poles, spiritual dignity, is achieved at a higher level than any of the other three qualities (i.e., self-deprecation, modesty, or arrogance).

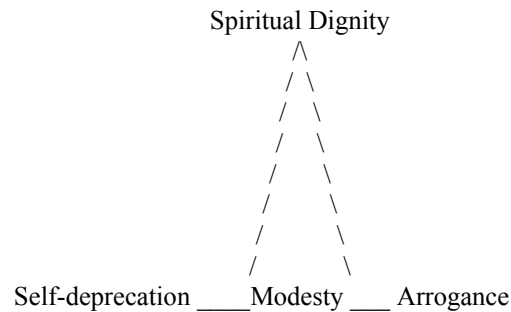


Figure 2. (from Assagioli, 1974)

Synthesis requires one to avoid *identifying* oneself with either of the two opposite poles, to learn how to *disidentify* from one aspect or another in order to be able to observe and evaluate them, and to wisely select from among them at a given moment. The energy applied to avoidance will itself feed the insecurity ostensibly being avoided. Ajaya (1983, p. 175) cites Carl Jung’s observation in *Memories, Dreams, Reflections* that “whenever we are still attached, we are still possessed; and when we are possessed, there is one stronger than us who possesses us.” Indeed, Jung refers to the identification with the persona complex as an instance of *possession*, i.e., “identity of the ego-personality with a complex” (1959, p. 122). We become consumed by the addiction or obsession of attachment. Put another way:

Paradoxically, struggling against an unwanted situation may keep it from changing; arriving at a more encompassing purview, however, frees the external situation to change. For when one is caught up in a polarity, his very resistance to the unwanted pole maintains it; but when one lets go of his polarized attitude through attaining a metaperspective, the circumstances evolve into a new form (Ajaya, 1983, p. 164).

Disidentifying from either pole of the spectrum, i.e., entering into a synthesis process, requires *cognitive flexibility*, the capacity for *diffuse attention*, and a conscious *inner witness*. Stepping outside of a symptom, reaction, problem or attitude to *observe* it helps one to establish a larger perspective, to create the maneuvering room necessary for real change to occur. This observer is the inner knower, the witness, that part within which holds or contains all of one's experience, the broad spectrum of context for one's life. Secure attachments in infancy and through adolescence foster a self-reflective capacity, which enhances an individual's ability to take another person's perspective and to process interpersonal feedback (e.g., Fonagy et al., 1993; Kobak & Sceery, 1988; Main, 1995). The capacity for self-reflection, as we have seen, is significant to the positive expression of nonattachment. Incidentally, the quality of reflectiveness correlates only negligibly with I.Q. and educational background. It is an interpersonal skill available to anyone who is him/herself provided enough security to develop it.

Disidentifying relies on dialectic reasoning, also called *cognitive flexibility*, and on the capacity for *diffuse attention*. Dialectic reasoning permits expanded awareness through simultaneous consideration of opposite poles of bipolar meaning structures (e.g., life – death, intimacy – isolation, purpose – meaninglessness, abdication – responsibility) (Slife & Barnard, 1988). In other words, cognitive flexibility permits one to accommodate multiple solutions, even mutually exclusive ones. It carries the ability to shift cognitive strategies and states of awareness, shifting from details (attending to selected content and disattending to other content and to the context) to holistic view (attending to both content and context) and back again. Complex, novel or unpredictable events are appraised as opportunities for growth rather than as personal threats requiring reflexive response. Contrast this with demonstrative reasoning, which is constrained by a mechanical logic. Welwood (2000) refers to these two types of reasoning as *focal* attention and *diffuse* attention.

Focal attention screens out wholes in favor of differentiated parts, becoming preoccupied with the foreground content, e.g., with the waitress' inattention or the performance anxiety preceding a lecture or the

discomfort of being in a crowded elevator. *Focal* attention is a telephoto lens through which to concentrate on selective details. It is very useful, but over-reliance on it leads to obsessive mentation, narrow-mindedness, and disconnection from purpose and meaning in life. *Diffuse* attention is receptive, alive, a wide angle lens through which to experience the whole context all at once. The two forms of attention represent thought (focal, the contents of consciousness) and awareness (diffuse, consciousness itself).

Current brain research (Crawford, 1994) sheds light on the topic as well. The literature suggests four main attentional dimensions: (a) focused and sustained attention (the ability to focus and sustain attention over time without distraction); (b) selective attention (the ability to select and discriminate between stimuli); (c) divided or dual attention (the ability to divide attention between two tasks, often one primary and the other secondary); and (d) ambient attention (the ability to attend to one task but also to have diffuse attention in preparation to respond to other stimuli). Ambient attention is that state which, while taking care of the business at hand, keeps open to other interpretations, including those which may be mutually exclusive. It combines *focal* and *diffuse* attention, and is also related to *cognitive flexibility*, a primary ingredient of the trait “openness to experience.”

From this perspective, anxious insecure attachment is the identification with one polar extreme (the attachment behavior aspect, or preoccupied) or with the other (the detachment aspect, or resistant) and the rejection of the other. It is based on selective focal attention. Secure attachment is the balancing or synthesis of both through diffuse attention. We will apply this perspective to several examples of attachment synthesis throughout the lifespan.

One example is Ainsworth's key determinants of secure attachment: parental responsiveness to the infant and parental acceptance of withdrawal without intrusion. The synthesis of the two, ‘rhythmic reciprocity,’ or ‘affect synchrony’ or ‘contingent responsivity,’ is a transcendence of the two as opposites. In this process of rhythmic reciprocity, the more the mother tunes her activity level to the infant during periods of engagement, the more accepting she becomes of disengagement, and the more she attends to the child's reinitiating cues for reengagement (Schor, 1999). We will be discussing this phenomenon later in the paper. Figure 3 represents this synthesis.

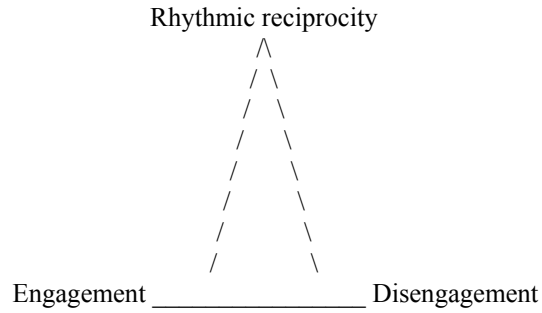


Figure 3.

Another view of the same phenomena is the balance (security) or imbalance (anxious insecurity) of exploration and attachment. Achieving security, i.e., an optimal balance between attachment and exploration, the freedom to explore, is more than a happy medium between the two. It is the transcendence of the two as opposites. Take, for example, Lifton’s (1979) proposal that a secure attachment to the world is a basic prerequisite for the capacity to “let go” of the world gracefully in approaching one’s death (Figure 4). We will discuss this phenomenon later in the paper.

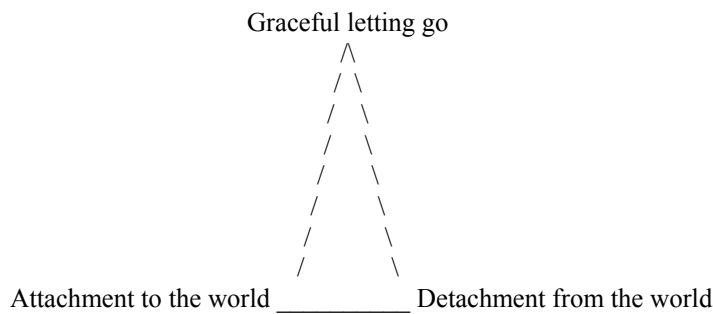


Figure 4.

To develop personal power, adolescents must have their thoughts and words validated, and be free to participate in intellectual curiosity and questioning. Developing personal power requires secure connection and attachment with parents *coupled with* healthy separation-individuation (Josselson, 1988; Ryan & Lynch, 1989). Achieving identity is facilitated by the same balanced expressions of parental connectedness and

individuality (Grotevant & Cooper, 1985). Optimal development depends, then, on synthesizing the polar opposites of attachment and detachment, connection and separation (Figure 5).

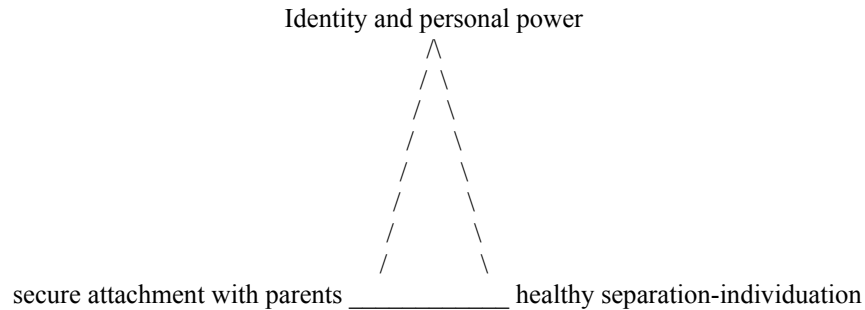


Figure 5.

Another example is the balancing of engagement and detachment in healthy caregiving. “Caregivers who balance engagement and detachment can affect outcomes without needing to control outcomes (Carmack, 1997, p. 139). Achieving this balance helps caregivers to cope with cumulative demands and losses by setting and maintaining limits and boundaries while recognizing the importance of practicing self-care (Figure 6). “The idea of nonattachment does not dispense with the idea of effort, but embodies the idea of intelligent, nonclinging effort” (Twemlow, 2001b, p. 23).

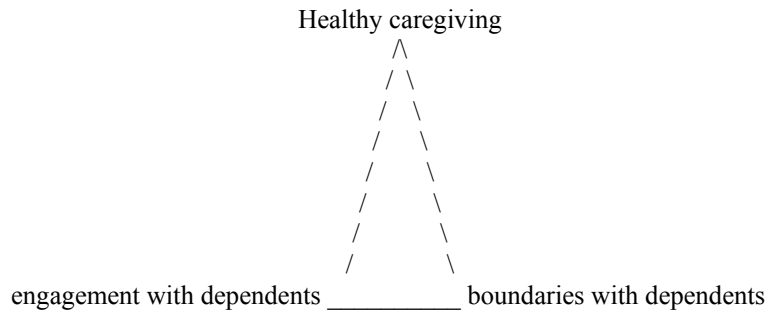


Figure 6.

Section 4: Breadth of influence and continuity of attachment style

Stan Grof (1985) identified levels or dimensions of the human psyche beyond the strictly personal, biographical and interpersonal: (1) the sensory barrier; (2) the individual unconscious; (3) the level of birth and death; and (4) the transpersonal domain. The attachment and secure base model was developed through observation of interpersonal interaction between mothers and their infants. It has been researched and applied almost exclusively to the personal and biographical realm of human psychic existence. We will briefly explore applications of the model to the dimensions beyond the interpersonal.

Of course, there is not a clear delineation between these dimensions of the psyche, and they overlap each other frequently. Let's take, for example, the overlap of a child's early experience and the residual memory of it once he/she has aged enough years for the cognitive recall to disappear. The experience occurred in the biographical, interpersonal realm, while the remnant of the experience, now inaccessible to conscious recall, occurs in the individual unconscious realm. Newcombe and Fox (1994) presented children aged 8 to 10 with pictures of 3-year-olds, some of whom had attended preschool with the subjects 5 to 7 years earlier. Although children could not consciously identify the children in the pictures that had been classmates, physiological measurement (skin conductance responses) reliably indicated the child's recognition, albeit unconscious. Fox and Card (1999, p. 241) interpret these results to mean that "early childhood memories may remain with an individual even after conscious recall has disappeared. In addition, these memories may hold an affective charge that can influence subsequent behavior (e.g., Zajonc, 1980)." Furthermore, some experiences occurred so early that, while biographical, they were not recorded as discreet events and therefore again are unavailable to conscious recall. These memories, too, remain present to influence behavior over the lifespan, and will be discussed in greater detail later in this paper.

First, we will explore the breadth of influence and continuity of attachment style within the context of the interpersonal, biographical realm, including the concept which bridges to the other dimensions, namely the *internal working model*. Then we will explore the other domains, the intrapsychic (ego states, shadows, the individual unconscious), the prenatal and perinatal and death dimensions, and the

transpersonal domain of spiritual development, ego surrender, and nonattachment.

An observation regarding the most effective regressions is that “the earlier the trauma, the more global the insights” (Janov, 1996, p. 231). The further into the past one regresses (to childhood, more so to infancy, even more so to birth or in utero, perhaps even more so to pre-conception or past lives), the more transpersonal is the re-experience and the more far-reaching is the life pattern exposed. Regression to childhood draws attention to patterns of behavior learned in that state related to personality traits and interpersonal styles, with generalizations of people and places and self. Regression to pre- and perinatal experiences reveals deeper, more encompassing patterns related to underlying existential and safety issues, with generalizations of life on earth and God. Regression to pre-conception or past lives adds a cosmic element to the patterns revealed, with generalizations regarding purpose. With each deeper level of transpersonal experience, the same generalization or ‘core issue’ or internal model (such as shame, abandonment, engulfment, identity, worthiness) is revisited with higher level implications.

1. Attachment and the interpersonal realm

Attachment style tends to be consistent through the lifespan (Collins & Read, 1994). It holds predominantly that the securely based child at thirteen months is securely attached at six years, and the avoidant child at thirteen months is avoidant at six years (Sroufe, et al., 1983). Three major longitudinal studies (Hamilton, 1994, 2000; Main, 1997; Waters et al., 1995, 2000a) have shown a 68-75% correspondence between attachment classifications in infancy and attachment classifications in adulthood. This is observed in many areas of life, including (1) depth of intimate relationships (Sroufe, 1983; Sroufe et al., 1990); (2) work activity (Hazan & Shaver, 1990); (3) sexual, dating and marriage relationships (Levy & Davis, 1988); and (4) psychopathology. A detailed discussion follows.

Attachment is a stable, yet dynamic process that is amenable to change as a result of major life experiences (Hamilton, 2000; Waters et al., 2000a; Waters et al., 2000b). The primary factor affecting a change in attachment classification over the lifespan is negative life events. Higher levels of stressful life events are significantly related to secure infants becoming insecure children or adults. Negative life events are associated with insecurely attached infants maintaining an insecure style as adults.

Depth of intimate relationships

The attachment figure in adulthood may be described as “a peer who is not a member of the family of origin, with whom there is usually a sexual relationship, and with whom there has been a special relationship for at least 6 months” and “the person you would be most likely to turn to for comfort, help, advice, love or understanding; the person you’d be most likely to depend on, and who may depend on you for some things; the person you feel closest to right now” (West et al., 1993). The degree of experienced intimacy with an attachment figure is greater in adults with secure attachment (Sroufe, 1983; Sroufe et al., 1990).

The adult exhibits attachment behaviors related to the same components of attachment as the infant: feared loss of the attachment figure, proximity seeking for reassurance, and protest at separation. Of course, the secure adult maintains security in an interpersonal relationship differently than does an infant. Only when an adult feels severe distress, such as illness, injury, or emotional upheaval, are the external attachment behaviors, i.e., fear of loss and separation, and proximity seeking, expressed with the same intensity as by infants or children. The preoccupied anxiously attached adult, by contrast, has an overwhelmingly urgent need to seek proximity in order to feel secure, and a dramatic protest when threatened with separation or loss. The resistant anxiously attached adult has an overwhelming need to avoid proximity in order to feel secure, and a decided lack of protest when threatened with separation or loss.

Work activity

Adult work activity can be viewed as functionally parallel to the child’s exploration, i.e., a source of actual and perceived competence, just as adult romantic relationships provide the secure base and safe haven aspects of infant attachment. An individual’s working characteristics tend to correlate with his/her interpersonal attachment style (Hazan & Shaver, 1990). Avoidant adults tend to approach their work somewhat compulsively, using it to avoid the difficulties and deficiencies they experience in interpersonal relationships. They often report that they would choose success at work over success in love. They give themselves low ratings on job performance and expect similarly low ratings from others. Resistant adults, preoccupied with getting unresolved attachment needs met, often tend to allow interpersonal involvements to interfere with their work. They often report feeling unappreciated by others at work, and are

motivated by approval. Securely attached workers report relatively high levels of satisfaction at work and job performance. They are least likely to procrastinate. They place a higher value on relationships than on work, and do not allow work to jeopardize their relationships or their health.

Sexual, dating and marriage relationships

Attachment style extends relatively stable throughout childhood, adolescence and adulthood. Ample research has documented how the organization of attachment theory can be applied to adult behaviors in intimate relationships. Adults' skill at serving and using the partner as a secure base can be viewed in terms of criteria derived from Ainsworth et al.'s (1978) conceptualization of maternal sensitivity. Secure base behavior in an adult relationship entails detecting the partner's implied or explicit requests for secure base support, correctly interpreting the request, and responding appropriately and in a timely manner. Key features of assessment include clearly signaling the need for secure base support, maintaining signals until they are detected, openness to the partner's response, and finding comfort in an appropriate response (Crowell et al., 1997).

Adult romantic love is itself a process of attachment, fitting the secure, avoidant and anxious/ambivalent categories of attachment classification. Hazan and Shaver (1987) found that people's prevalent attachment style of childhood experience is the same as their most significant adult, loving relationship. Avoidant and anxious individuals are less likely to be in a relationship than secure individuals (Kobak & Hazan, 1991). And three quarters of adults experience no change in their style of romantic attachment during adulthood. The majority of those who do, grow from insecure styles to secure, due to being in a relationship which provides a new, healthier image of self or other than that which underlay the pattern of insecurity (Hazan & Hutt, 1990).

An individual's attachment type denotes a disposition toward certain perceptions of others, of oneself, and certain preferred strategies that will be triggered by the presence of a perceived threat. The specific choice of attachment behavior is highly context dependent, a *state* phenomenon, but the internal working model that provides consistency to the pattern of behavior that emerges is a *trait* (Maunder & Hunter, 2001). They discuss Bartholomew and Horowitz' (1991) three insecure adult attachment types: preoccupied, dismissing, and fearful. Those in the fearful group want close relationships, but feel uncomfortable with closeness, fearing rejection.

They find it difficult to trust others completely, or to let themselves depend on others. Those in the dismissing group are comfortable without close relationships. They need to feel independent and self-sufficient, and prefer neither to depend on others nor to have others depend on them. Significantly more females identify themselves as fearful, whereas significantly more males identify as dismissing (Bartholomew & Horowitz, 1991). Even though a majority of individuals describe themselves with one of the insecure styles, they do not necessarily regard these styles as preferable or optimal. When individuals are asked with which kind of partner they would feel best, most select the secure style for the ideal partner (Carnelley & Pietromonaco, 1991).

Psychopathology

“The denial of trauma and suppression of protest were seen by Bowlby as crucial determinants of neurosis” (Holmes, 1997, p. 233). Significant research efforts have been directed to seeking correlations between early attachment styles and subsequent psychopathology. There has been an explosion of interest in attachment and its relationship to attachment disorder in infancy, trauma, depression, borderline personality disorder, and dissociation.

Lieberman and Pawl (1988) identified three major categories of attachment disorder in infancy: *nonattachment*, *disrupted attachment*, and *anxious attachment*. The most devastating disorder, nonattachment, occurs when the infant fails to form an enduring bond with any specific attachment figure (caregiver). Because infants will attach to even the most deficient caregiver, regardless of how emotionally unavailable or abusive, nonattachment is virtually never seen outside of institutionalized settings where caregivers are many and transient. The nonattached child may never be able to form intimate relationships. Disrupted attachment results from the child's premature and prolonged, or permanent, separation and loss of the attachment figure. The loss is most devastating if it occurs after clear-cut attachment emerges (age 7 months) and before the attachment partnership develops (age 4 to 5 years). Loss or repeated separations may cause long-lasting impairment of the child's capacity to form enduring, trusting bonds. Anxious attachments are, of course very common, 35% to 40% of an ordinary low-risk population (Colin, 1996; Mickelson et al., 1997) and must reach serious depths of disturbance before being considered an attachment disorder.

Boris et al. (1997) delineated specific behaviors to use in assessing the degree of clinical significance in disturbance of attachment pattern in infants:

- a lack of affectionate interchange between child and caregiver, and/or indiscriminant affection with strangers
- excessive dependence on the caregiver or an inability to seek comfort from her
- failure to check back with the caregiver or to use her as a secure base

Lieberman and Pawl (1988) observed three major patterns of distortion in secure-base behavior in seriously disturbed anxiously attached infants. Each is an adaptive solution to the double-bind predicament faced by the severely disturbed infant, i.e., the parent's simultaneous indispensability and unavailability. The first is *recklessness and accident proneness*. The child frequently wanders away from his mother for prolonged periods, showing no distress, and makes no effort to restore proximity to connect with her again. Other examples of this behavior pattern would be to play with sharp objects, fall while climbing, or crash into things while running. The child's exploration is unbounded by appropriately attentive caregiving, and therefore unsafe.

The second pattern observed was the opposite, namely, *inhibition of exploration*. These children hesitate to approach, touch or manipulate objects in their environment; withdraw from unfamiliar people; are often immobile in unfamiliar situations, regardless of the presence of the mother; and show decided constriction of affect. Some of these children cling to the mother for long periods. Their mothers encourage the dependency, and withdraw or become punitive when the child moves toward exploration (and by extension, autonomy). Other children avoid both the mother and the environment, keeping their distance to avoid the danger that threatens them whether they choose attachment or exploration. Their mothers unpredictably punish the child whenever they become displeased with the child's behavior.

The third group of seriously disturbed children show *precocious competence*, reversing normal child-parent roles in order to give care to the parent. These "parentified" children cannot rely on the attachment figure as primary protector and caregiver, so they learn to mimic the parental role. Because this option is survival-based, the pattern of role reversal becomes compulsive as a means of reducing anxiety.

Fraiberg (1982) observed several other adaptive pathological defenses in seriously disturbed infants. *Freezing* occurs in infants as young as 5 months, in which the infant remains immobile and glassy-eyed for as long as 20 minutes. Older babies (12 to 18 months) fight to reduce anxiety, and others show giddy, almost manic behavior in response to frightening situations. Others cause self-injury without any signs of pain. Some of these pathological defenses are in use as early as 3 months of age, long before most psychologists believed that the ego and ego defense mechanisms could emerge.

The *over-regulation* of affect by insecure-avoidant children through deactivating strategies, and the *under-regulation* of affect by insecure-resistant children through hyperactivating strategies (Sroufe, 1996), if allowed to continue unmodified into adulthood, may well manifest as affective disorders or other pathology. Research findings are relatively consistent in suggesting that hyperactivating defenses, utilized by resistant/preoccupied individuals, are associated with the felt experience of distress, such as depression (Cole-Detke & Kobak, 1996), anxiety disorders (Warren et al., 1997), affective disorders (Rosenstein & Horowitz, 1996), or borderline personality disorder (Patrick et al., 1994). Deactivating strategies, employed by avoidant individuals, are associated with more externalized indices of distress, such as eating disorders (Cole-Detke & Kobak, 1996), conduct disorders (Rosenstein & Horowitz, 1996), and hard-drug use (Allen et al., 1996).

The child who is repeatedly interrupted by a demanding caregiver, i.e., through the parental impingement phenomenon, becomes compulsively attuned to the demands of others, losing awareness of its own spontaneous needs and developing a false sense of self based on compliance and performance. This infant experiences his/her parents (and thus the world) as dangerous and frightening. This can be the genesis of codependency in adulthood.

Main and Morgan (1996) describe the resemblance between infant behavior in separation situations and dissociative reactions in adults. A recent study by Ogawa et al. (1997) documents an increase in dissociative symptomatology among adolescents with early attachment patterns characterized as disorganized or avoidant, and with a history of infantile neglect. Dissociation is an anxiety defense strategy, a way of avoiding stress by avoiding conscious awareness, a process whereby specific mental contents (memories, ideas, feelings, perceptions) are lost to conscious awareness and become unavailable to voluntary recall. Seriously insecure

attachment creates a dissociated core of the self, an absence of self. It reflects a breach in the boundaries of the self, creating in Peter Fonagy's words "an openness to colonization" by the mental states of other important attachment figures.

Dissociation is a stress defense, an example of the imprinting process. Nijenhuis and colleagues (Nijenhuis et al., 1998a; Nijenhuis et al., 1998b) have proposed that understanding animal defensive reactions to predators, i.e., the discrete biological changes of narrowing of perceptual field and numbing and bodily analgesia, may serve as a useful model for organizing our observations about human dissociative symptoms. An individual's dissociation may thus be viewed as an animal defense strategy to cope with severe danger, rooted in our biological heritage. Typical of dissociation is the classically conditioned fear response and learned escape response of the abuse victim. This model explains the intractability of the dissociator's behavioral pattern, given the biologically-based resistance to extinction of fear-based responding (LeDoux, 1996; Nijenhuis et al., 1998b).

Borderline personality disorder (BPD) is perhaps best understood as an attachment disorder. People with tendencies to BPD often have highly unstable patterns of social relationships based on intense but stormy attachments and marked impulsivity. Their attitudes toward family, friends, and loved ones may suddenly shift from idealization (great admiration and love) to devaluation (intense anger and dislike). They may form an immediate attachment and idealize the other person, but when a slight separation or conflict occurs, they switch unexpectedly to the other extreme and angrily accuse the other person of not caring for them at all. Even with family members, individuals with BPD are highly sensitive to rejection, reacting with anger and distress to such mild separations as a vacation, a business trip, or a sudden change in plans (NIH Publication No. 01-4928). The attachment figure is not another person, but rather their *internal representation* of that person. BPD is indicated by five or more of the following (adapted from the American Psychiatric Association *DSM-IV*, pp. 650-654):

- frantic efforts to avoid real or imagined abandonment
- a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- identity disturbance: markedly and persistently unstable self- image or sense of self
- impulsivity in at least two areas that are potentially self-damaging
- recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

- affective instability due to a marked reactivity of mood
- chronic feelings of emptiness
- inappropriate, intense anger or difficulty controlling anger
- transient, stress-related paranoid ideation or severe dissociative symptoms.

In BPD there is a likelihood of a trauma history: physical or sexual abuse, neglect, or early parental loss or separation.

A concomitant of secure attachment is the early acquisition and acceptance of a self bounded from the world, a state of awareness that Winnicott (1965) refers to as “personalization,” based on his theory of ego distortion in terms of true and false self. People who made early adaptations to pathological parental needs that interfered with psychosocial development and identity formation lead lives that are constricted with relationships characterized by adaptations to the needs of others (Kahn, 1986). In the extreme this becomes the defense *depersonalization* – the uncanny sense of estrangement from or feeling of unreality about the bodily or mental self. We might think of the awareness of “personalization” as a comfortable lucidity. If one’s identity formation is unresolved, the individual acts *as-if* she knew her identity, Winnicott’s “false self.” This individual’s Soul feels incomplete, disconnected, and self-conscious. The criteria for depersonalization disorder include (American Psychiatric Association, *DSM-IV*, p. 490):

- Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one’s mental processes or body
- During the depersonalization experience, reality testing remains intact
- The depersonalization causes clinically significant distress or impairment in functioning
- The depersonalization experience is not attributable to another mental disorder, the effects of a substance, or a general medical condition.

Internal working models

The construct to explain how the early attachment experiences become long-term, lifelong traits is that of internal working models. With repetition over time, the infant is conditioned into generalizing his/her experiences into expectations for future experience, a belief system that Bowlby called internal working models. They serve to regulate, interpret, and predict both the attachment figure’s *and* the self’s attachment-related behavior, thoughts, and feelings when attachment-related choices are presented, e.g., loss, threat, isolation and dependency. A child constructs a working model

of itself as valued and competent in the context of a working model of parents as emotionally available and supportive of exploratory activities. Conversely, a working model of self as devalued and incompetent develops from a working model of parents as rejecting or ignoring attachment behavior and/or interfering with exploration. The models of self and parents develop together, as complements of each other, and represent both sides of the relationship (Sroufe & Fleeson, 1986).

In Heart-Centered Therapies we have used the term “early conclusions” in an interchangeable way with “internal working models,” to denote the basic deeply embedded beliefs about self and the world from the earliest experiences, which then are carried forward in time as templates for how one sees the world and functions in it.

Starting, we may suppose, towards the end of his first year, and probably especially actively during his second and third when he acquires the powerful and extraordinary gift of language, a child is busy constructing working models of how the physical world may be expected to behave, how his mother and other significant persons may be expected to behave, how he himself may be expected to behave, and how each interacts with the other. Within the framework of these working models he evaluates his situation and makes his plans. And within the framework of the working models of his mother and himself he evaluates special aspects of his situation and makes his attachment plans (Bowlby, 1969/1982, p. 354).

Bowlby and Ainsworth asserted that the average baby shows unmistakable signs of proximity-seeking behavior towards a distinct, preferred figure not before he/she is 6 months old, establishing that as the onset of attachment behavior. We argue an important modification to this formulation, based on current research into the nature of prenatal and perinatal cognition and memory (to be reviewed later in this paper). While the infant may not engage in attachment behavior toward “a distinct and preferred” figure before about six months, we suggest that he/she begins constructing the working models much sooner, i.e., during the preattachment and attachment-in-the-making phases. Indeed, our clinical experience reveals through hypnotherapeutic age regressions that the unborn fetus has already begun the process of generalizing experience into expectations through stress response.

Healthy development requires a child to adaptively update internal working models over time. In fact, “Bowlby repeatedly warned of the pathogenic potential of working models that are not updated” (Bretherton & Munholland, 1999, p. 91). The expectations of one’s parents and oneself at age one certainly adjust and expand by age three, or ten, or eighteen. As

well, a parent may “reform,” becoming more able to respond to his/her child’s needs when life circumstances improve, leading the child to construct revised working models of self as valued and of parents as caring. However, there is built-in resistance to change in the models once they have become habitual and automatic. Expectations become self-fulfilling through biased perceptions of upcoming experiences with attachment figures, through the process of *interactional continuity* (Caspi & Elder, 1988), to be explored later in this paper. Thus an attachment figure’s occasional failures to attend are not likely to undermine a child’s confidence in the figure’s emotional availability, nor is her occasional healthy caregiving likely to overcome a child’s learned insecurity. Eventually, the internal working models that underlie our ways of acting and thinking tend to become unconscious, inaccessible to consciousness, and thus inflexible and reactive.

Internal working models can be changed over time, as documented by changes in attachment classification. However, change in working models requires that the individual reassess some deeply embedded beliefs. That in turn requires enough security to risk the “freedom to explore” one’s fundamental foundations. The more deeply embedded the working model, the more profound any change becomes. Changing a working model based on early traumatic events requires revisions and reinterpretations of many related assumptions and beliefs. Thus, changing one’s working model of hypervigilance (e.g., “I expect my mother to explode in rage unpredictably any moment”), based on innumerable occasions of parental inconsistency in childhood, requires going to the source experiences and creating “corrective experiences” to replace the originally embedded fearful ones. The child may have used denial and suppression, i.e., *defensive exclusion* of noncorroborating evidence, as well as *defensive misattribution*, i.e., reinterpreting an abusive event defensively (e.g., “My father hits me because he loves me”) (Bretherton & Munholland, 1999).

Further complicating the updating process, if a child’s experience is divergent from what his/her caregiver communicates to be reality, the child may come to operate with two incompatible sets of working models of self and of attachment figure. One will be a consciously accessible set, based on the false information either overtly or covertly provided by the parent. The other will be a consciously inaccessible or only intermittently accessible set, reflecting the child’s own experience and interpretation of the situation at the time.

Thus the family experience of those who grow up anxious and fearful is found to be characterized not only by uncertainty about parental support but often also by covert yet strongly distorting parental pressures: pressure on the child, for example, to act as caregiver for a parent; or to adopt, and thereby to confirm, a parent's false models - of self, of child and of their relationship. Similarly the family experience of those who grow up to become relatively stable and self-reliant is characterized not only by unfailing parental support when called upon but also by a steady yet timely encouragement toward increasing autonomy, and by the frank communication by parents of working models - of themselves, of child and of others - that are not only tolerably valid but are open to be questioned and revised (Bowlby, 1973, pp. 322-323).

One defense in the face of such parental pressure is to change the model which is incompatible with his/her own experience by changing the identity of the person (e.g., an attachment figure) involved (Bretherton & Munholland, 1999). For example, a child may divert hostile feelings toward, or unflattering assessments of the parent which are inconsistent with the parent's false models, toward another less formidable person. Some children defensively redirect toward themselves the anger they initially felt toward an attachment figure, producing defensive self-blame. Or they may compulsively attempt to offer caregiving to others (including the parent), diverting attention from their own unmet attachment needs.

The child's response to negative parental treatment can be generalized as follows: the avoidant child develops a deactivating strategy to ward off stressful experiences, and the ambivalent/ preoccupied child develops a hypervigilance strategy to detect and disarm them. These patterns, while deeply embedded in the unconscious, remain active in driving behavioral choices (Dozier & Kobak, 1992).

As we shall see, adaptively updating the (state-dependent) underlying models is challenging, and may best be accomplished by a return to the state in which they were formulated. Rossi and Cheek (1988) explain in great detail the way in which state-dependent memory is activated through clinical hypnosis and other trance states to access and heal early trauma. Following traumatic events, details of the incident that were vivid when it took place become vague and more or less forgotten. This is because the special stress-released information substances that encoded their traumatic memories have changed as their mind-body returned to normal. The memories are thus not available to normal consciousness, and the phenomenon is called traumatic amnesia. The traumatic memories are still present and active, and they may influence the trauma victim's dreams and/or be expressed as psychosomatic symptoms. The memories are *dissociated* from normal consciousness and encoded on deeply imprinted

physiological levels where they form the nuclei of psychosomatic and psychological problems. The severity of these problems depends on the age of the person, the degree to which the traumatic situation is acknowledged and reviewed within oneself or with others, and the type of emotional support received.

Statebound learning occurs in young children, including the fetus, not just in traumas but in every experience, resulting in internal working models. For example, fetuses of women with chronic stress have fast heart rates and are very active (Klaus & Klaus, 1998). The fetus may experience that its mother's constant stress level is lowered, bringing calming relief, *only* when it also experiences nicotine or sugar or alcohol in the blood supply. This lesson is learned at the deepest layer of the developing fetus' nervous system functioning, and re-enacted unconsciously later in life in the compulsive self-medicating use of nicotine, sugar or alcohol. The memory is not verbal or conceptual, it is viscerally imprinted. The only means of accessing it for possible change is to return to the state in which it was learned: re-living the original experience *as it was first experienced*, then re-living it with a "corrective experience," allowing the option of conscious change.

The repeated 'mini stress' involved in the therapeutic sensory and emotional reviewing of the traumatic event in hypnosis can partially reactivate the stress-released hormonal information substances that originally encoded that event in a statebound condition. The body actually remembers physical sensations and recreates these *body memories* during hypnosis age-regressions or other deep experiential transpersonal experiences. The statebound information is brought into consciousness, where the client's ordinary cognitive and verbal ego can process it. This allows the statebound or dissociated memories of the traumatic event, the basis of internal working models, to be accessed, processed, and therapeutically resolved.

Let us look more carefully at the memory system (see Colin, 1996) in order to appreciate the continuing presence of early experience through the lifespan. Bowlby based his theories of working models in part on Tulving's (1972) theory of memory. Tulving suggested that people have two distinct kinds of memory: *episodic* and *semantic*. Episodic memory stores recall of specific events or episodes, holding chronologically organized experiences. For example, "On my sixth birthday, my mother invited my friends and my sister to a party in our backyard. We ate watermelon and played hide-and-go-seek." Semantic memory stores generalizations or summaries of the

meanings of recurring memories. For example, “My father always ridiculed the kids in the family during mealtimes.”

The information in episodic memories can contradict the information in semantic memories, because a child builds their generalizations on selective episodes and on other significant input (such as how a parent interprets events). One might grow up with the semantic memory, “My mother always comforts me when I am scared” even though there were many specific events when she didn’t. The child does not notice that this generalization contradicts her experience, because episodic memory usually does not emerge until after the child’s second birthday. When children up to three years old are asked for episodic memories (“What did you eat for dinner last night?”), they tend to answer with semantic abstracted generalizations (“I like the dessert best”). Only extraordinary events are likely to be recalled as episodic memories.

Research by Crittenden (1990, 1992, 1993, 1994) demonstrates that there are at least three different memory systems that appear in childhood and continue to operate all through the adult years. In addition to episodic and semantic memories, there is a *procedural* memory that begins in infancy and is based on sensorimotor representations. Procedural memory is the only system available for most of the first year of life. Procedural memory consists of recall of repeatedly enacted and experienced patterns of behavior that become generalized. When the same interaction has happened over and over again, the baby comes to expect the caregiver’s familiar pattern of behavior. The expectation is behavioral, not conscious. For example, when the mother dresses her baby or toddler, the child seems to know when to lift an arm for the sleeve of the shirt or when to lean forward, etc. The little details of the sequence flow smoothly without conscious effort because they have become “procedurally memorized” through repetition. When a different caregiver dresses the child, the interaction is disrupted because the new adult doesn’t proceed in the same sequence. The baby is expecting the past to be recreated, and acts accordingly. The expectation is encoded in the unconscious as a script; it is held as an unchallenged “fact of life.” The infant may have procedural memories of abuse, neglect, dominant parental attitudes, or other treatment that become scripted.

The connection between the specific memories and the generalized procedural script has implications for psychotherapy. Colin (1996) notes that

memories of the specific experiences that led to the generalized script may be hard to recover. The same sort of information may not even be represented in any stored autobiographical episodes. In that case, the child will not be able to retrieve any episodic memories; there are no occasion-specific memories to retrieve. If the child's experiences have been benign, this is likely to be unimportant. When the experiences stored in scripts include pervasive unresponsiveness from a clinically depressed parent, routine incestuous molestation, or recurring family violence, the damage these scripts can do to the child can be painfully serious, and retrieving any occasion-specific memories for reinterpretation in psychotherapy can be painfully difficult" (p. 229).

This information on memory helps to clarify the process by which internal working models are developed and maintained through the lifespan. The semantic and procedural memories begin very early in life, based on the anticipated behavior of caregivers. "Bretherton, Crittenden, and Main have all argued that caregivers influence not only the content of the interactions the child experiences, but also the rules the child develops for deciding what information to store in generalized form, what information to keep as accurately as possible, and what information to discount altogether" (Colin, 1996, p. 239).

Relevant here is the distinction between *trauma* and *shock* (Castellino, 2000). Trauma is an injury that occurs during an event that, to some degree, propels an individual toward mental, emotional or physical overwhelm. Shock is a physiological process that occurs in response to trauma when the individual goes into overwhelm. Both levels of injury are deeply embedded in the body and unconscious, shock more pervasively so. When a current experience triggers the embedded shock memory, the body responds as if it is actually reliving the original imprinting experience, a recapitulation of the trauma. Because the response is a reaction to overwhelming terror, the recapitulation of it often is an activation of the parasympathetic nervous system, that is shutting down and withdrawal of attention, dissociated loss of conscious awareness.

When we therapeutically uncover the "defensive exclusions" and "defensive misattributions," we bring to awareness the terrible traumatic truth they were used to hide. To the degree that it was originally overwhelming, the response is to freeze like a deer caught in headlights. Changing working models based on trauma and shock requires slow and steady reconnection with the inner resources which were left behind, abandoned in the tradeoff for the illusion of control. With sufficient safety and corrective attachment experience, the working models can be changed; they are, however, "the last to change" (Dozier & Tyrrell, 1998, p. 223).

Application of attachment concepts to realms beyond the interpersonal

The attachment and secure base model was developed within the interpersonal realm of personal and biographical existence. We will explore how attachment concepts may be applied to dimensions beyond the interpersonal.

Attachment theory is based on the fundamental human need for security and exploration. The experience of security begins with the process of attachment, and that sense of security is necessary for exploration to thrive. As earlier stated, Bowlby stressed the themes of (1) a psychology based on the opposing tendencies of attachment and separation/loss; (2) the individual's need for secure attachment in order to successfully reach out and explore one's inner world and outer environment; (3) the persistence of attachment needs throughout life; (4) the negative consequences of early disruption of affectional bonds, or attachment; and (5) the vital importance on a child's mental health of the caregiver's capacity to maintain loving presence (intimacy, avoiding separation/loss) as well as to accept protest (autonomy, avoiding engulfment).

We will suggest that all of these five themes are observable in the realms of the sensory barrier, the individual unconscious, the level of birth and death, and the transpersonal. People's need for security and exploration can be traced in each realm. A predominant "attachment figure" can be identified that satisfies the defined eight properties of attachment relationships (Weiss, 1991). For example, people generally attempt to remain within a protective range (*proximity seeking*) in their experiencing of emerging unconscious material, or experiences related to birth, death or spiritual transcendence. The presence of the "attachment figure" fosters a sense of security and leads to exploration (*secure base*). For example, in relation to death, the "attachment figure" may be identified as one's life, or perhaps as one's purpose for continuing to live. In relation to one's own birth experience (which one may approach through symptoms such as claustrophobia, struggle to survive, overwhelm, or abandonment), the "attachment figure" may be identified as the sense of belonging and the "rightness" of being here in this life: birthright. In relation to spiritual transcendence, the "attachment figure" may be identified as a loving God, or spiritual acceptance.

Finding security in one's experience of his/her life (purpose, belonging, God) allows one to explore separation (death, annihilation, spiritual exile). The threat to accessibility of the attachment figure (e.g.,

life) generally leads to protest and attempts to avoid separation (*separation protest*). Individuals display attachment feelings most when anxious (*elicitation by threat*), and attempts to substitute other figures do not succeed (*specificity*). Attachment feelings and separation protest persist even when they are no longer rational (*inaccessibility to conscious control*), and do not wane through habituation (*persistence*). Attachment persists even when the attachment figure's behavior is perceived as abusive, resulting in conflicted approach/ avoidance (*insensitivity to attachment figure's behavior*). For example, most people are persistently committed to living, even if life seems chronically painful and unrewarding. Most people orient toward a spiritual connection (whether with positive or negative valence), even if the figure of that connection is perceived to be punishing or abandoning.

The attachment styles that have been classified through interpersonal observation can be applied in these additional realms. Internal working models, deeply imprinted at a highly vulnerable early stage of development, regulate the ongoing experience in each of these realms. The pattern of preoccupation with and clinging to the attachment figure, or avoidance of any sense of dependency on it, can be applied to purpose in life, or the sense of birthright, or God/ spiritual acceptance. Clearly, most people operate on habituated, unconscious working models in relation to life/ death, birth/ nonexistence, or God/ spiritual abandonment.

We assert that Bartholomew and Horowitz' (1991) four categories of adult attachment style apply to these realms as well as to the interpersonal, and we will explore them further.

2. The sensory barrier, or body-mind

Grof refers to this dimension of the psyche as a sensory barrier because, as he sees it, the senses represent a barrier that one must pass through before the journey into one's unconscious psyche can begin. Put another way, sensory experience is a vehicle through which the journey of self-exploration unfolds. Let us look at the mechanisms for storing information in the body, and for re-accessing it in the process of psychotherapy.

For many of our clients, the deep experience of emotions has been blocked or repressed. Often in experiential therapy the key to unlocking those repressed emotions is to get the individual "into their body" and the energy in their body moving. Activating the flow of physical energy activates the flow of emotional energy. It may also release "body

memories,” which bring to consciousness any repressed memories of experience contained in them, or memories so early that they were encoded in sensorimotor representations. Finally, activating physical energy *in the powerless ego state in which the trauma originally occurred* provides a corrective experience that is immensely empowering for the client.

Ego states, particularly those created in moments of trauma, may be predominantly somatic. Stated another way, symptoms may be state-specific, and physical symptoms may contain dissociated memories. The body, not only the brain, contains the unconscious mind. For example, the child physically shutting down to become totally still as a means of defense against the terror of abuse creates a “somatic ego state” of pervasive immobilization. Following the somatic bridge (body memory) of immobilization back in regression may lead to conscious access to the memory of the source trauma which created that ego state - the incident of terrifying abuse. The dissociated memories are “physically contained” within the somatic symptoms (Gainer, 1993). The body physically encodes its learned symptoms, neurotic coping mechanisms, and decisions in the limbic-hypothalamic systems. Healing occurs by accessing the encoded learned responses.

That wounded ego state can be dramatically healed by retrieving it for re-experience in age regression, abreacting the experience, and allowing a means of reintegration and transformation of the trauma experience into a *physically* corrected experience of empowerment (van der Kolk & Greenberg, 1987). A *physical* corrective experience activates psychophysiological resources in his/her body (somatic as well as emotional resources) that had been previously immobilized by fear and helplessness (Levine, 1991; Phillips, 1993, 1995). The regressed person is allowed to actually experience the originally immobilized voice yelling for help, and the originally immobilized muscles kicking and hitting for protection. These somatic and emotional corrective experiences *reassociate* the individual’s originally dissociated body and emotion in positive ways to positive outcomes.

Changing a trauma-induced behavior (such as fears, phobias, self-defeating patterns, recurrent and intrusive dissociation, numbing of general responsiveness) is best accomplished *in the ego state in which the behavior was originally established*. Here we refer to recent research in state-dependent memory and learning (Janov, 1996; Pert, 1997; Rossi, 1986). Research shows that a person who learns a task or creates a memory while under the influence of a particular emotional state will repeat the task or

recall the memory most efficiently when again under the influence of the same emotional state. We might use the hypnotic age regression to access a traumatic event for healing, assisting the person to reconnect with the state in which the state-dependent learning took place.

During the shock and stress of an automobile accident, for example, the special complex of information substances that are suddenly released by the limbic- hypothalamic- pituitary-adrenal system encodes all the external and internal sensory (visual, auditory, proprioceptive, etc.) impressions of the accident in a special state or condition of consciousness. The accident victim is often recognized as being “dazed” and in an altered state of psychophysiological shock. Hypnotherapists describe such shock states as *hypnoidal*: The memories of these traumatic events are said to be *deeply imprinted* as *physiological memory*, *tissue memory*, or *muscle memory*. We propose that all these designations are actually metaphors for the special *state-dependent encoding of memories by the stress released hormonal information substances*.

When accident victims recover from their acute trauma and return to their ‘normal’ psychophysiological states a few hours or days later, they find to their surprise that the details of the accident that were so vivid when it took place are now quite vague and more or less forgotten. This is because the special complex of stress-released information substances that encoded their traumatic memories has changed as their mind-body returned to normal; the memories are thus not available to normal consciousness. We say they are now experiencing a traumatic amnesia. That the traumatic memories are still present and active, however, is evidenced by the fact that they may influence the accident victim’s dreams, for example, and/or be expressed as psychosomatic problems. Clinicians typically hypothesize that the memories are *dissociated* from normal consciousness and encoded on ‘*deeply imprinted physiological levels*’ where they form the nuclei of psychosomatic and psychological problems.

Essentially similar psychobiological processes of stress-encoded problems can take place in many other traumatic life situations. These range from what has been called the ‘birth trauma’ to child abuse and molestation, from ‘shell shock’ under battle conditions to the extremes of social and cultural upheaval and deprivation.” (Rossi & Cheek, 1988, pp. 7-8)

There is ample evidence of the vital importance of a somatic, or physical, experience for accessing deep trauma, and for healing that trauma. This principle operates on the cellular and hormonal level of the body, where memories are encoded and can be reframed. This principle also operates on the gross motor level, wherein body memories provide a somatic bridge to follow in the retrieval of repressed emotions and memories, and in the physical reframing of now-dysfunctional imprints.

We are referring here to one’s relationship with his/her own body in all its complexity. Some individuals are secure in their relationship with their body’s functioning, comfortable in an intimacy with it, and willing to explore the further reaches of its boundaries. Others are preoccupied with it, dependent on a predetermined standard of function and form. Others are fearful about their body and its functioning, expecting disappointment and distrusting self and others. Finally, others are dismissing of their body,

tending to a counterdependent avoidance of any recognition of its needs or support that is available for it.

3. *Intrapsychic (ego states, shadows of the individual unconscious)*

Attachment/ detachment concepts may help to explain the dynamics of the individual unconscious. One way of approaching that viewpoint is the concept of *identification*, with a role or an ego state. Ego strength is achieved through attachment, or identification, with the successful functioning of the ego system (without going to the extreme of rigid identification). Ego resilience is achieved through ego detachment, or disidentification, without going to the extreme of depersonalization. Ego nonattachment is achieved with the synthesis of these two processes.

A good metaphor for the application of attachment to the transpersonal realm of ego states is a re-enactment of rapprochement at age two and at adolescence. The adolescent experiences rapprochement, the conflicting desires for intimacy and independence, on a whole new and even more intense level than during the toddler stage. Adolescence has been described as a “second individuation” phase (Blos, 1968). The prospect of an identity created wholly by the ego is at once intoxicatingly seductive and terrifying; seductive because it offers the long-sought independence, and terrifying because it highlights the anxiety of separation, alienation, and nothingness. Adolescents, after all, need an audience to their experiments with identity to validate them as independent. They are acutely conscious of how they present themselves to others, usually seeking the recognition and approval for their newly styled selves from peers.

The adolescent may even be observed to follow the same four-subphase sequence as the toddler in this effort at detachment and individuation. The fledgling adolescent, like the junior toddler, moves into a “practicing” period of unrestrained exuberance for newfound freedom (Esman, 1980). Uncertainty provokes turning back to parents or other attachment figures for security, regression to more primitive and dependent behavior. Tension grows because that return only evokes fears of engulfment and loss of freedom, leading to renewed assertions of autonomy - rapprochement. Troubled teens often regressively revisit and “act out” the unresolved rapprochement crisis of year two (Quintana & Lapsley, 1990; Schachter, 1986).

For a moment, see the ego struggling for transcendence as an adolescent. The attachment figure is the safe and familiar ego state that one feels most comfortable with, the *persona*, the “false self-concept.” The

prospect of separation and individuation from it, an identity created wholly by surrender of or transcendence of the persona (through acceptance of the whole self including shadows and higher aspects) is at once intoxicatingly seductive and terrifying; seductive because it offers the long-sought independence from the tyranny of limitation and suffering inherent in the “normal” state, and terrifying because it highlights the separation anxiety and potential nothingness of surrender. The process of alternately stretching the boundary between them and coming back to familiar security, just as the two-year-old does with his/her mother, is the process of ego-strengthening. The fledgling surrendering ego moves into a “practicing” period of unrestrained exuberance for newfound freedom. Anxious uncertainty provokes turning back to the attachment figure of the familiar ego state for security, regression to more spiritually primitive and dependent behavior. Tension grows because that return only evokes fears of engulfment and loss of freedom, being absorbed in the routine of normality again. This leads to renewed assertions of disidentification - rapprochement. As the individual discovers the ability to perform all necessary ego functions without the limiting bond to its familiar “false self-concept,” a new level of developmental potential is reached.

Experiences of the individual unconscious are derived from significant biographical events which carry a strong emotional charge. That might include unresolved conflicts; repressed traumatic memories, fantasies, or fears that have not been integrated; an incomplete developmental stage or sequence.

4. Birth and death experience

We have briefly reviewed the evidence for using the secure base concept as a lens through which to interpret and understand behavior throughout the lifespan. Moving back in biographical time to conception, gestation and birth directs that lens into “an important intersection between the individual and the collective unconscious, or between traditional psychology and mysticism or transpersonal psychology” (Grof, 1985, p. 100).

A child’s instinct to initiate and pursue attachment is universal and complex, and may be observed as a series of self-attachment sequences. It begins, we assert, at the moment of conception. It extends throughout the pregnancy. Then the baby initiates the onset of labor, moving in ways that signal the release of hypothalamic neuropeptides (HNPs). These HNPs in turn trigger the mother’s neuroendocrine system to release the hormone

oxytocin, causing her uterus to contract. Oxytocin is the same hormone released during breast-feeding and is associated with the pleasurable sensations for the mother and the baby, accelerating the bonding between them.

The birth process culminates in delivery, bringing further self-attachment sequences. Normally when the baby's head emerges from the birth canal, its head is turned in the direction of the shoulder that is closest to his/her mother's sacrum. The head then returns to a normal alignment with its body, which is now ready to be born. The baby is experiencing movement away from the mother, a process that culminates with the cutting of the umbilical cord. Following the dramatic separation, i.e., emergence from the mother's body, the baby's attachment need requires that he/she reconnect with the mother and stimulate her bonding by finding, attaching and sucking at her breast.

The "delivery self-attachment" (Righard & Alade, 1990; Righard & Franz, 1995) is every (mammal) newborn baby's instinctive and innate ability to find its mother's breast, latch on and suck. The human newborn, if placed on the mother's naked belly immediately after birth, begins the self-initiated journey to the breast within about twenty minutes, and completes it within about fifty minutes. "Delivery self-attachment is an integral part of the bonding and attachment process," and "the completion of the delivery self-attachment sequence at birth will have long lasting positive effects on the baby's neurological, somatic, and psychological development" (Castellino, 1997, p. 19).

Immediately upon birth, the baby enters a prolonged quiet but alert state of consciousness, averaging forty minutes duration. In this *quiet alert* state, babies look directly at their mother's or father's eyes and face, and can respond to voices (Emde, et al., 1975). During this special time, in the state most conducive to eliciting the mother's bonding, motor activity is suppressed, and all the baby's energy seems to be channeled into seeing, hearing, and responding (Klaus, et al., 1995). This period is a "sensitive period" for the installation of a personal relationship with the baby's mother. Bowlby (1969/1982) speculated on the issue of a "sensitive period" (i.e., a crucial, short period during which the individual learns a behavior or a string of behaviors at a very quick rate) for attachment behavior and referred to it generally as "the precursors of attachment" during the first 6 months of life. He borrowed the concept from Bateson's (1976) studies on perinatal "sensitive periods" in animal species other than human.

Robson's work (1967) clearly demonstrates how vitally important eye-to-eye contact is in the establishment and growth of a mother's relationship (bonding) with her infant. For example, Fraiberg (1974) found that mothers of blind infants, with unsatisfying eye contact, initially felt detached and distant from their babies. Juan Carlos Garelli and associates at the Buenos Aires Attachment Research Center (Montuori & Garelli) report that extensive observation shows that during this sensitive period immediately following birth, when the mother who is cuddling her baby breaks off eye or skin contact or both, the baby becomes distressed. Restoring contact comforts the baby back into calmness. Eye contact is keenly accurate with a seemingly high image resolution at the baby's focal distance of 25-30 cm. (newborns are extremely myopic). If the mother even slightly averts full eye contact, the baby bursts into tears. Mothers are usually prone to stimulate their babies by stroking their foreheads and their cheeks, and talking to them in high-pitch tones. Whispering elicits no response from the baby, but enthusiastic and high-pitch talking elicits the first newborn's smiles, full symmetrical smiles. This usually triggers a positive feedback spiral which leads the dyad to intense, frequent interchanges of mutual expression: smiles, gesturing, mimicking, vocalizing, grinning, rooting, cooing, frowning, eyebrow-raising and other eyebrow movements, eyelid-playing, head movements as if playing hide-and-seek, pouting, thumb and nipple sucking, rubbing, whole-body shaking, eye-contacting, eye-averting and eye-recontacting, tensing and relaxing hands, legs and whole body. If uninterrupted, these mother-infant interactions terminate when the baby finally falls fast asleep.

The curtailment of this sensitive period immediately after birth, by early separation or by lack of mother-infant connection, seriously diminishes the bonding that would otherwise grow over time. For example, compare mothers who deliver by emergency cesarean with mothers who have spontaneous vaginal delivery (Trowell, 1982). The cesarean mothers have longer labors and more medication before, during and after delivery. They are unconscious during the delivery, and suffer a period of amnesia after the birth as they recover from major abdominal surgery. At one month, cesarean mothers show significantly less eye-to-eye contact, are more critical in their attitudes to the pregnancy and birth, more depressed, more resentful of the father, and more anxious with somatic symptoms. One year after the birth, in answer to the questions, "When did you think your baby developed into a human person?" and "When did you think your baby recognized you as its mother?" vaginal delivery mothers report that

they saw their babies as a person at birth or immediately thereafter. Cesarean mothers reveal that their babies became people and could recognize them many hours or days later (average of nineteen hours). Clearly, curtailment of this sensitive period immediately after birth retards the onset of overtly proximity-seeking behavior, and the setting up of an affectional-cognitive bond.

During the first week after birth, the normal baby spends about 10 percent of any twenty-four hour day in this receptive state, promoting bonding from the parents. A dance of mutual curiosity and wonderment (and bonding), begun with the positive feedback spiral at birth, continues between parent and infant. "The interpersonal contexts created in mutual gaze transactions allow for the establishment of 'affect synchrony'" (Feldman et al., 1999). In this process of affect synchrony, or 'contingent responsivity' or 'rhythmic reciprocity,' the more the mother tunes her activity level to the infant during periods of social engagement, the more she allows him to recover quietly in periods of disengagement, and the more she attends to the child's reinitiating cues for reengagement, the more synchronized their interaction" (Schoore, 1999). Studies (Brazelton et al., 1975) show that inappropriate response by the mother leads to confusion in the child. We have referred earlier to the process of 'rhythmic reciprocity' as a very early example of the synthesis of attachment and detachment, i.e., nonattachment.

Birth and death are connected through the experience of struggle and emergence in the later stages of the birth process. Grof's (1988) third stage of birth comes when the cervix dilates enough to allow the fetus to begin its journey down and through the birth canal. Now there is, literally, light at the end of the tunnel. In this stage the fetus assists in its own birth process by struggling and moving through the birth canal. Moving past helpless and hopeless, the fetus no longer resists the change. Sensing the possibilities, the fetus now contributes to and participates in the process. This is the stage of agony and ecstasy. In moving down the birth canal, the fetus encounters struggle, suffocation, fear of death, anxiety and exhaustion, but also determination, hope and progress. Each movement brings the fetus closer to freedom. Birth issues having to do with the life/death struggle derive from birth stage 3, because if a fetus comes close to dying it is in stage 3. Depression, anxious morbidity, or aorgasmia (loss of self) may result from birth stage 3 trauma.

The fourth and final stage of birth begins when the fetus finally emerges from the birth canal and the struggle is over. At this time the

umbilical cord is cut, the baby breathes air for the first time and reconnects to the mother. During this phase of birth the baby experiences relief, completion, independence and success while nursing and being held safely in mother's arms. In a natural process, the baby learns that reconnection and reward follow effort and pain. There is a sense of termination and resolution, survival and accomplishment. In this process of separation, one begins the pattern of completion that is carried throughout life. If there is guilt (for wanting to get out) or anxiety (fear of loss) connected to this first experience of leaving, then this will govern the perception of all future completions. If there is a great deal of pain for the mother, the infant may take responsibility for the pain and conclude, "I hurt the one I love" or "I am bad." The infant may also develop the pattern of holding back in life in order to prevent future pain to him/herself and others.

Problems and substitute behaviors deriving from the separation and abandonment themes of birth stage 4 include not recognizing physical needs or doing anything to get them met; addictive and compulsive behaviors, especially ingestive addictions such as food, sugar, alcohol, pills, tobacco, or eating disorders; inability to ask directly for anything; terror of abandonment; needing external affirmation of one's worth; a deep, basic mistrust or insecurity about having one's needs met; frozen feelings, numbness and dissociation; not enough money, food, time, etc; inability to bond physically/emotionally; and feeling of "I don't want to be here."

Death

Research has documented a connection between attachment style in adults and fear of death (Mikulincer et al., 1990). In general, secure persons report less fear of death than insecure persons. Summarizing their findings, Mikulincer and Florian (1998, p. 149) state that "security or insecurity in one's connection to the world has a strong impact not only on how people cope with life adversities but also on how they manage the terror of their own death." In general, securely attached people's positive attitude toward life assists them to transcend the fear of death through developing a sense of "symbolic immortality," that is, a personal sense of continuity and lastingness. Lifton (1979) suggests that this coping response can be attained through generational continuity, creative contributions to culture and society, the feeling of being a part of a universe that is beyond oneself, spiritual and religious attainments, and the capacity to lose oneself in ecstatic peak experiences. Lifton proposed that a positive and secure

attachment to the world is a basic prerequisite for the development of a sense of symbolic immortality.

In general, avoidant people do not hold a positive connection to the world, suppress their fear of death, and do not develop a sense of symbolic immortality (Mikulincer & Florian, 1998). This lack of a sense of personal continuity is only reflected in below-awareness expression of the fear, not at a conscious level, consistent with their tendency to suppress anxiety-provoking material. Overt fear of death is expressed to be fear of the unknown nature of death.

Anxious-ambivalent people exhibit higher fear of death at both conscious and below-conscious levels of awareness. They carry a high sense of symbolic immortality together with a high level of fear of death. They cannot distance themselves from negative emotions and intrusive worries. Their death fear is egocentric, anticipated as another separation in which they may be rejected by significant others, losing their social identity.

For some people, the experience of near-death situations, most likely at or around birth, left a profound impression on the organism, a vague feeling that one's life is in danger, an imprint that we might call "death anxiety." In Primal Therapy terminology, these are called "first line traumas." Many individuals, in therapies that allow access to very early traumas, have relived near-death situations like suffocating at birth (anoxia) or being strangled by the umbilical cord, in the form of "body memories." Such an experience may contribute to an association between separation and death in the individual's internal model.

The realm of death can be viewed metaphorically as well as literally. Individuals who experience their lives as empty, futile, and meaningless may, in fact, be feeling psychically dead. The search for meaning in life might be characterized as seeking to become psychically alive (Modell, 1996).

The surreptitious ways people have of endangering or threatening their lives mask an unconscious disregard for life, and resistance to it. These behaviors could include smoking tobacco, drug abuse, or high-risk sports (Firestone, 1985, 1987). Firestone and Seiden (1987) define microsicide as behaviors, communications, attitudes, or life-styles that are self-induced and threatening to one's physical health, emotional well-being, or personal goals. Progressive self-denial, withdrawal, withholding, destructive dependency, and physically harmful life-styles function as defenses against separation and death anxieties. Rather than considering suicide and suicidal

ideation as subclasses of mental illness, mental illness is conceptualized as a form of suicide.

For example, a young woman who has a family history of MS feels hopeless and fears the worst. Instead of living her life to the fullest while she is healthy, she has engaged in severe drug and alcohol use which has led to several car accidents. Although this behavior is not a direct suicide attempt, it certainly can have the same effect. Another example is a gay man who reports participating in unprotected sex, taking the risk of developing HIV. In his sessions he has gotten in touch with being unwanted by his mother and thus having a subconscious desire to die in order to comply with her wish.

Indecision, or “decisional procrastination,” putting off decisions or choices, is a common way to avoid and therefore resist life. To “be unwilling to choose is a choice in fact – for death. Life hangs in the air, un-lived” (Ulanov, 1996, p. 163). Underlying this paralyzing behavior is often a fear that a better option, not yet known, may be available, a deep unconscious demand for certainty and absoluteness. Indecisiveness is thus a means of avoiding closure on the impossible demand that every choice be guaranteed to result in the best possible outcome (Salzman, 1979). Indecision may be a means of putting off the terror of abandonment. Obsessions and compulsions are significantly related to decisional procrastination (Ferrari & McCown, 1994).

Ultimately, we must all face death. Those who have lived fully, fulfilling their dreams and accepting themselves in totality have achieved wisdom, ego integrity, and self-actualization. They are prepared to meet death with dignity and readiness. Those who have lived afraid to dream, afraid to excel, afraid to accept themselves in totality, live in fear of death. In the words of Erik Erikson, “it seems possible to further paraphrase the relation of adult integrity and infantile trust by saying that healthy children will not fear life if their elders have integrity enough not to fear death” (1950, p. 269). The concept of death may be expanded beyond the physical to include giving up what is unquestioned to be essential, that is surrendering the components of one’s identity itself.

We all owe God a death, Shakespeare once said, so we owe it to ourselves to practice for the occasion whenever possible. One way we do so is by tending to the small surrenders that come our way almost daily: letting go of a bad mood, making a choice or a compromise, forgiving someone, parting with fear and saying the truth in a moment, spending time with our children instead of working late again (Levoy, 1997, p. 11).

5. *Spiritual development, ego surrender and nonattachment*

We might apply the principles derived from attachment theory in the interpersonal realm to the transpersonal realm. The transpersonal realm of the psyche may include history and prehistory including past life memories, the archetypes of our collective unconscious, animal identification, cosmically unitary experience, or paranormal experience such as communication with distant or deceased individuals. These experiences appear to be tapping sources of knowledge beyond those accepted conventionally, and to be an expansion of awareness beyond one's usual ego boundaries.

Let us use the attachment/ detachment/ nonattachment synthesis process as a model for spiritual transcendence. One way to conceptualize transcendence is finding synthesis of one's attachment and detachment with the spiritual attachment figure (God, Self, Higher Power, Creator, etc.).

In discussing attachment and detachment with the ego, it is important to note the distinction between "dissolution" of the ego and "surrender" of the ego. If an individual's ego functioning is too weak to absorb and integrate unconscious archetypal material and primary transpersonal experiences, he/she is *overpowered* by them and may become psychotic. Here the ego has dissolved and been rendered non-operational. Alternatively, the ego can fracture into competing parts and also be rendered non-operational, or psychotic. Here the personality disintegrates into a plurality of autonomous complexes or subpersonalities which take the place of the ego. Conversely, the individual with sufficient ego strength *loosens identification* with the ego and gains access to the forces of the unconscious.

Another useful conceptualization is "ego-control" (Block & Block, 1980). People with high ego-control are rigid and inhibited, disposed to repress impulses and emotions, to feel anxious in new situations, and to reject unexpected information. Those who have weak ego-control are impulsive and distractible, and do not have the discipline to concentrate on one task for very long. The synthesis of these two polar extremes is not moderate ego-control, but rather "ego resiliency." Ego resiliency is the ability to respond flexibly but also persistently to challenges.

Jung envisioned "the transformation of personality through the blending and fusion of the noble with the base ... of the conscious with the unconscious" (1966, p. 220). Before transformation can occur, the ego must be a unified, complete conscious state. That is accomplished through

achieving security of attachment, incorporation of repressed unconscious material, successful completion of the developmental stages, and the unification of all the fragmented parts of a person's psyche. The possibility of movement into *transegoic* realms, of transcending the ego, was a basic tenet of Jung's departure from the classical Freudian viewpoint. Jung observed a tendency at midlife or later for the ego to undergo a reversal of the "I-Thou" dualistic ego (an *enantiodromia*). He believed that this reversal is a natural part of the movement of life, "the first half of which is devoted to ego development and the second half of which is devoted to a return of the ego to its underlying source in the collective unconscious or objective psyche" (Washburn, 1995, p. 21). Jung asserted that the natural consequence of the ego's descent into the collective unconscious, where it is engulfed and annihilated, is a triumphant return, born anew, regenerated, transfigured (the hero's odyssey): synthesis of attachment and detachment to the attachment figure of ego.

That movement back to the source is also a reversal of the original rapprochement process of the two-year-old. That is, the adult at the outset of this developmental stage develops an intense ambivalence toward its own potentiality as a *Self-oriented ego*. The conflict is based on a growing awareness of its dependence on that aspect of its identity for meaning, purpose and immortality, and simultaneously experiencing its long-standing drive for autonomy and independence. The personality's desires for transcendence and autonomy here clash in a serious way, each one undermining the other: the desire for transcendence making autonomy seem like *alienation* (loss of connection) and the desire for autonomy making transcendence seem like *annihilation* (loss of self).

When the ego, this never-ending procession of momentary 'I's who believe in their own supremacy, recognizes that truth, the second phase of life can begin. However, the first phase must be completed or the second phase will not succeed. In other words, the ego of the seeker must be so strong and healthy that it disidentifies from the myriad of fragmented selves and surrenders itself to a higher purpose than its own self-promotion. It must be strong, well-tested, and secure in its abilities. A metaphor to describe this would be a newly formed clay sculpture. At first it requires a cast or braces to hold it in place while it is forming and solidifying. Only after being baked is it strong enough to stand on its own without support, i.e. to "let go." In the same way, only when our ego is solid are we prepared to move beyond the realm of "I am what I can do," to transcend the normal, to let go of the known and to venture into a wholly

new level of self-exploration. Many people in therapy must first undergo a process of ego-strengthening before they are ready to expand their concept of themselves, to accept their shadow parts, and thus to loosen or stretch, or even begin to let go of, the ego's limited, idealized self-concept.

The normal rhythm of human development, including spiritual development, involves regularly shedding our snakeskins of knowledge, attachments, and identity to make room for expansion into a larger perspective and identity. Wisdom treats the self as a shell, a costume, a transitional object, the vehicle but not the driver, a lease, not a purchase for eternity. The mystics and many sages encourage us to not merely defend our position and our self but to regularly and naturally clean house, sloughing off rigid identity (Hart, 2000, p. 159).

A prototype for the process of transformation into nonattachment in the second phase of life is the process of birth. Leaving behind the security and predictability (and the extreme limitations) of the womb again requires a monumentally trusting leap of faith. The fetus willingly surrenders itself to the unknown force that will carry it to a new infinitely expanded world. Of course, again, it can also be done unconsciously, in fear or pain or rage. The difference between these choices sets in motion influences of vast proportions on the life to follow.

Another prototype for the process of transformation is the gradual growth of the infant and toddler from its identification with its mother or other caregiver into an autonomous individual. That process occurs over years and through the psychosocial developmental stages. Throughout the process, the underlying momentum is ego strengthening without going overboard into narcissism. It is detachment without going into the isolation and limitation aspects of nonattachment.

Adolescents often regressively revisit and "act out" the unresolved rapprochement crisis of year two. To develop identity and a sense of personal power, adolescents must experience secure connection and attachment with their parents *coupled with* healthy separation-individuation (Grotevant & Cooper, 1985; Josselson, 1988; Ryan & Lynch, 1989). Optimal development depends, then, on synthesizing the polar opposites of attachment and detachment, connection and separation. This becomes another prototype of transformation.

Section 5: Attachment implications in psychotherapy with adults

1. Hypnotherapy
2. Attachment implications in marriage and family therapy

3. Attachment implications in addictions treatment
4. Attachment implications regarding shame
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14. Attachment organization of the therapist

Bowlby saw psychotherapy as the process of helping an individual examine and rebuild dysfunctional working models. The therapist's role is to help the client "cease being a slave to old and unconscious stereotypes and to feel, to think, and to act in new ways" (Bowlby, 1988, p. 139).

Jeremy Holmes (1998) suggests that the work of therapy involves both "story-making" and "story-breaking," helping the client to knit together the events of his/her life into a coherent meaning (story-making), and to examine the events of one's life anew in light of new insights (story-breaking). Ideally these two processes form a dialectic that results in synthesis, or psychological health.

Fraiberg (1982; Fraiberg et al., 1975) worked with infants showing severely disturbed attachment patterns, and found that treatment required helping the mothers to change their attachment behaviors. In every case, she found that the stumbling blocks in the current mother-infant relationship were repetitions from the mother's past. Colin (1996) describes the treatment experience:

Distresses, disturbances, and conflicts from the mother's early relationships wrote the script for her baby's life. Painful old dramas replayed themselves with a new actor in an unwelcome but familiar role. The therapists sought to disengage the children from the mothers' old conflicts. . . . To change her caregiving behavior, the mother had to exorcise the "ghosts in the nursery." She had to change her working model of herself as an attachment figure. To change her internal model, she had to rediscover and relive the emotions appropriate to her own early experiences of abandonment, neglect, and/or abuse (pp. 200-201).

Effective therapy is the process of becoming free of the repetition of the painful old dramas that became the script for one's life. As we disengage from the old conflicts, we are freed to explore new possibilities.

One disidentifies from the limited beliefs of who he/she is, exorcising the ghosts in the nursery, changing the working models that have invisibly controlled choices from the beginnings of life.

Psychotherapy that is effective in helping the client to make changes that he/she wants, must create an experience of relationship different from the individual's customary ways. If the client's self-sabotage is successful in the therapy relationship, if they elicit the same responses from the therapist or therapeutic milieu that they do from others, then the underlying working models are reinforced rather than modified. People can be expected to utilize "selective affiliation" (Collins & Read, 1990; Davis & Kirkpatrick, 1991) and "interactional continuity" (Caspi & Elder, 1988) in their therapy relationship just as they do in other relationships. They will structure interactions with the therapist so as to induce him/her to engage in behavior that confirms their lifelong working models. It is vitally important that the therapist working with an avoidant client not collude with his/her attempts to sidestep real issues, or working with a preoccupied client not collude with his/her attempt to meet dependency needs through demands and manipulation.

Without confining our clients into rigid categories, we can use knowledge of their style and tendency to better structure our psychotherapeutic intervention. An individual in the avoidant/dismissing category tends to have rigid structures for regulating, containing and suppressing emotions. In fact, he/she tends to over regulate (contain and suppress) emotions and memories related to early attachment, and will be largely unwilling to openly examine them. Individuals at the far extreme of this category might be described as obsessive, schizoid, or narcissistic. These clients minimize the importance of psychological experience, intimacy, relationships and attachment. They often speak in the second person, e.g., "When someone tells you something like that, you might get a little angry about it." Denial and avoidance keep them detached from their emotions and memory, even from their immediate experience. They often exhibit a seemingly friendly and self-assured exterior, but soon reveal the extent of their defensiveness through denying and minimalizing problems, frozen feelings, and emotional inaccessibility.

For the avoidant client, "therapy revolves around finding ways of allowing affects into experience and into consciousness – that is, of allowing for 'story-breaking.' These are individuals who constrict rather than contain their emotional experience, and who are strangers to feelings, motivations, or inner life" (Slade, 1999, p. 585). Dozier et al. (1996) report

that such clients often seem quite resistant to therapeutic change, and often attempt to divert the clinician's attention from emotional issues. In the context and terminology of Heart-Centered Therapies, with these clients we emphasize the emotional immediacy of experience in repeated regressions to early life events. We use the Gestalt techniques (talking into the pillow, directly to the figures in the regression) and somatic awareness ("where do you feel that in your body?") to engage the individual emotionally.

An individual in the resistant/preoccupied category tends to have attachment-related emotions and memories under regulated (uncontained and unorganized), and may be unable to examine them without feeling overwhelmed. Individuals at the far extreme of this category might be described as hysterical or borderline in personality organization. Because preoccupied individuals often feel overwhelmed and even tormented by emotions, their treatment revolves around containing and managing their emotions. Their general understanding of relationships seems superficial and hackneyed, and not at all deeply related to internal consolidation (Main, 1995). A viable treatment alliance is difficult to create, since they present themselves as needy and dependent, yet they are unable to truly accept the therapist's compassion or support. "Therapeutic insights, instead of paving the way toward the development of real structure, take on a hollow, unintegrated feel. Within the session, these patients are so 'driven' by feeling that they jump from one issue to the next, without any sense of a focus or inner purpose" (Slade, 1999, p. 586). In the context and terminology of Heart-Centered Therapies, with these clients we emphasize the patterns that emerge from repeated regressions to early life experience, and encourage personal accountability. We emphasize development of a compassionate acceptance of the inner child discovered in age regressions, in other words to develop the self-reflective capacity.

Individuals in the secure/autonomous category have achieved a balance of affect regulation. They are able to acknowledge and express a wide range of emotions and memories in a flexible and coherent way, neither constricted nor overwhelming. These are the people most capable of benefiting from almost any modality of psychotherapy.

The fourth category, disorganized/unresolved, may be treated as "in some sense an extreme form of the resistant/preoccupied category, in that it is typified by incoherence and disorganization" (Slade, 1999, p. 583). The disorganized individual is largely dissociated from any emotions related to their unresolved trauma or grief. Therefore, treatment in Heart-Centered

Therapies revolves around overcoming the habitual dissociation pattern, retrieving lost memories, retrieving dissociated or abandoned parts of oneself, and reconnecting to missing emotional reactions to events in one's history.

Hypnotherapy

Recalling Colin's (1996) words quoted above, to change the internal model, one must rediscover and relive the emotions appropriate to one's early experiences of abandonment, neglect, and/or abuse. Because these attachment-related emotions and memories date back to such an early age, we have found the use of hypnotherapy especially helpful in facilitating their retrieval. We can access relatively easily the internal working models (state-dependent early generalized conclusions and decisions) and change them in the ego state in which they were imprinted. The client is fully capable, in a hypnotic trance state, of following an affect or somatic bridge back to early experience and reliving that regressed ego state. The person in age regression can rediscover and enter the childhood experience so early that it predates episodic memory altogether. The hypnotic regression can, indeed, discover and enter experience in the transpersonal realm, e.g., beyond the sensory barrier, womb or birth experience, past life experience, or death experience.

A third state of consciousness, distinct from sleep or wakefulness, is documented by neurological research. This *hypnoidal* state is characterized by synchronization between hemispheres and persisting alpha waves (Barolin, 1982). The state can be induced by hypnosis, meditation, or breathwork. Research on the lucid dream state, wherein one is conscious of being in the unconscious dream, provides a model for examining the hypnoidal state. It is "on the knife's edge between REM sleep and waking. If I push the system too hard, I will wake up. If I let up a bit, I will become reabsorbed in the dream" (Hobson, 1994, p. 173). Hypnosis resembles the lucid dream state: in the hypnotic state we are capable of sending a top-down signal from the cortex (for example, dissociate from a physical sensation of pain) to override a bottom-up pain signal from the brain stem. In these states we have an increased capacity for highly selective dissociation, or splitting mental focus into foreground and background. We can experience an age-regression to infancy in our mental foreground, for example, while retaining enough conscious mental background to put the experience into words.

This third state of consciousness represents a synthesis between sleep and wakefulness rather than a midpoint between them. Weitzenhoffer (1978) reported that subjects identified what was different for them in a hypnotic versus a non-hypnotic state in terms of a state of “effortless concentrated attention” in which their minds were free of extraneous material, allowing a selective experiencing of only what was pertinent to the situation, even “concentrated attention on nothing.” The effortless nature of the experience is associated with alpha brain wave activity (Fehmi, 1978). This effortless concentration is similar to the ambient attention discussed earlier, and can be useful in facilitating access to the early pre-episodic memory experiences.

Attachment implications in marriage and family therapy

The literature on romantic attachment suggests that preoccupied people seek dismissing people, and dismissing people seek preoccupied people for relationship, and that dismissing/ dismissing and preoccupied/ preoccupied pairings are less common (Collins & Read, 1990; Kirkpatrick & Davis, 1994; Senchak & Leonard, 1992). Gottman (1993) describes a common dysfunctional pattern among marital couples involving the withdrawn, stonewalling partner (often the male) and the pursuing, angry partner (often the female). Awareness of the different unresolved and unmet early attachment needs of each individual may provide a means of accommodating the otherwise fractious interactions between the two. In other words, acceptance of the other comes through recognizing that he/she is not acting in a deliberately contrary way, but rather following unconscious working models. Couples hypnotherapy allows each partner to observe the other’s age regressed inner child and the genesis of their working models.

Holmes (1993) suggests the extension of the concept of internal working models to ‘family scripts,’ patterns that are held in common by the entire family. These family scripts serve to enforce family rules (e.g., dangerous topics are avoided, or the authority’s power is unquestioned).

Attachment implications in addictions treatment

We find it useful to characterize addiction as a consequence of disordered attachment. That is, individuals who experience incomplete, disorganized, or anxious attachment in infancy grow up with an unresolved and unmet age-appropriate attachment need, and some of these individuals attempt to fill the resulting lack of satisfying intimacy with substitute

substances or behaviors (Walant, 1995). Thus it is the addict's denial of the need for interpersonal relationship with others, the attachment need, that leads him/her to seek gratification in the compulsion. Completing the self-defeating cycle, the addictive attachment in turn becomes a continuing obstacle to those very relationships. And treatment of addiction, as we shall see, requires addressing and correcting the attachment need and its unresolved status. Otherwise, when one obsessive-compulsive behavior is given up, another is likely to be substituted for it.

Flores (2001) discusses the attachment implications in the treatment of addictions. It must begin, of course, with abstinence and *detachment* from the object of addiction. Only then can the individual establish an effective therapeutic alliance with therapist and/or therapeutic group. Finally, having experienced some degree of security based on the alliance attachment, the individual may be able to explore the inner and outer worlds, to discover character deficits and acknowledge previously denied attachment needs, to develop mature conflict resolution and to allow personal intimacy.

Flores emphasizes the efficacy of treating addiction in a group setting with an attachment perspective in three primary stages of treatment:

1. Abstinence and *detachment* from the object of addiction are required before the individual can make an attachment to group or establish an effective therapeutic alliance.
2. Early in treatment, gratification, support, containment, and cohesion are given priority because these strategies maximally enhance *attachment* possibilities in the group.
3. Once abstinence and attachment to the recovery process are established, *deficits in self and character pathology must be modified*. An essential part of this stage of treatment requires the patient to develop the capacity for conflict resolution in a non-destructive manner while becoming familiar with mature mutuality and the intricacies that define healthy interdependence and intimacy (p. 70, emphasis added).

Here we see the synthesis model at work: balancing the (new interpersonal) attachment with detachment (from the object of addiction), resulting in liberation from subjugation to either, and a healthy adaptive updating of the relevant working models.

Research is beginning to document that individuals with different attachment styles use addictions to achieve different purposes. For example, recent work on alcohol use in general (Cooper et al., 1995) indicates that it serves one of two different motives for a given individual: either to reduce negative affect (e.g., fear, loneliness, shame) or to enhance positive affect (e.g., happiness, inclusion, relaxation). Studies (Magia, 1996) document that adults with a dismissing attachment style drink to enhance positive affect, while those with preoccupied attachment style

drink to reduce negative affect. Attention to the motivation for addictive behavior may be useful in differentially treating it.

Research (O'Connor et al., 1994) shows that among people in recovery from addiction, women score significantly higher on shame and depression scales, and men score significantly higher on detachment. When subjects were compared with a sample of nondrug-addicted subjects, they scored significantly higher in proneness to shame and significantly lower on proneness to guilt. A treatment implication of this finding may be the contraindicated use of confrontational drug treatment strategies that appeal to guilt with the unintended result of reinforcing shame. Also, understanding the difference between men's and women's pathology has obvious treatment implications.

Attachment implications regarding shame

Children learn to inhibit behaviors for which they are shamed (Tomkins, 1963). Shame is created in a child by the experience of defeat, parental contemptuous, derisive or belittling comments or tone of voice, and physical displays of disgust and contempt (Malatesta-Magai & Dorval, 1992). Shaming may take the form of child-rearing disciplinary methods involving physical punishment and withdrawal of love. Parents with fearful avoidant attachment styles are likely to utilize such disciplinary methods, eliciting shame in their children and causing inhibition of their emotional expression. Shame is the mechanism through which the well-documented inhibition in avoidant children is produced. Treatment consists of creating a corrective experience for the age regressed child in which he/she is validated rather than shamed for feelings, beliefs and perceptions.

Attachment implications in treating affective instability

Gruber (1983) argues that many psychiatric patients who display affective instability as their most salient symptomatic feature can be helped by hypnotherapeutic procedures in which they learn to evoke two opposite states of mind and to alternate them voluntarily. Because these individuals lack a sense of personal continuity or identity, their interpersonal relationships are often intense, stormy, and disappointing. Effective treatment of these clients must recognize their suggestibility, their sense of vulnerability to external influences, their defensive clinging to negative mental states, their creativity, and their desire for balance, stability, and self-control. Treatment emphasizing the incorporation of the

“extinguishing process” into age regression therapy will be especially helpful.

Attachment implications in treating eating disorders

de Groot and Rodin (1994) contend women have a particular capacity for and interest in relatedness, and that early experiences of relatedness may contribute to an enrichment of the emotional life of the child and to an enduring value placed on the sharing of subjective experience. If, however, the girl’s own subjective experience is subjugated to the subjective experience of others, she may instead learn to neglect or invalidate her own and come to rely on external confirmation to maintain self-esteem and a sense of identity. In such girls there may be impairment in the sense of effectiveness and in the capacity to identify and regulate emotions. This constellation of disturbances may well contribute to a vulnerability to eating disorders. Treatment would then indicate eliciting and affirming the validity of the woman’s experience, and correcting the original experiences, in age regression, that led to developing the working model of others as trustworthy at the expense of self-image as unworthy.

Implications in treating stress and physical disease

Maunder and Hunter (2001) searched the literature on attachment insecurity over the last 35 years, finding that attachment insecurity contributes to physical illness, and determining three mechanisms through which attachment insecurity leads to disease risk: increased susceptibility to stress, increased use of external regulators of affect, and altered help-seeking behavior. “The attachment model explains how repeated crucial interactions between infant and caregiver result in lifelong patterns of stress-response, receptivity to social support, and vulnerability to illness” (p. 556).

Attachment insecurity contributes to physical illness through increased susceptibility to stress. For example, preoccupied attachment involves a self-perception of vulnerability, which may lead to a lower threshold for activating attachment behavior. In this model of hypochondriasis and somatization, preoccupied persons have developed a sense of personal vulnerability and vigilance so intense that interoceptive sensation (normal perception of physiological operations) is perceived as a potential threat (Stuart & Noyes, 1999). Another example is that avoidant attachment involves an attitude of heightened interpersonal distrust, such that

situations requiring intimacy or interdependence (including a situation of apparent “social support”) may be perceived as threatening.

Attachment insecurity contributes to physical illness through increasing the intensity or duration of the physiological stress response. For example, Sroufe and Waters (1977) measured changes in heart rate in children during the Strange Situation. Heart rate acceleration reflects an aversive or defensive response, and heart rate deceleration reflects attention to the stimulus. The study reported that all children show heart-rate increases during separation, which remain elevated until reunion with the parent. At reunion secure infants exhibit a soothing calm, returning to their baseline heart rate in less than a minute. Both resistant and avoidant children exhibit elevations of heart rate much longer into the reunion sequence, experiencing greater stress. Resistant infants request to be put down before their heart rates recovered to the pre-separation level. Then after being put down, with their heart rates still elevated, they reach up to be held again. Avoidant children show an increased heart rate from the beginning of separation until long into the reunion, despite the fact that they display very little distress. These stress response patterns become habitual and eventually account for susceptibility to physical illness.

Attachment insecurity contributes to physical illness through decreased stress buffering through social support. Secure individuals perceive more available support, and seek out that support more at times of stress than avoidant or ambivalent (preoccupied) individuals (Florian & Mikulincer, 1995; Mikulincer & Florian, 1995; Ognibene & Collins, 1998; Simpson, et al., 1992). Social support is widely considered to be beneficial to a range of health outcomes (House, et al., 1988). Perceiving support as threatening or nonexistent, then, endangers one’s health.

Attachment insecurity contributes to physical illness through increased use of external regulators of affect. Since insecure attachment results in deficits in internal affect regulation (Kobak & Sceery, 1988; Mikulincer, 1999), insecurity is associated with greater use of external regulators. A number of behavioral strategies that are used to regulate dysphoric affect (to soothe, to distract, or to excite) are also risk factors for disease, including smoking tobacco, drinking alcohol, using other psychoactive drugs, over-eating, under-eating, and engaging in risky sexual activity. For example, adults with avoidant attachment drink alcohol to enhance positive affect (Magai, 1999). External regulation through food intake has been shown to be a mechanism responsible for obesity (Raynes et al., 1989). Also, attachment style has a strong influence on sexual behavior (Feeney &

Raphael, 1992). So any tendency to use substances or external behaviors to reduce stress constitute an increased risk for physical illness.

Finally, attachment insecurity contributes to physical illness through the failure or nonuse of protective factors, such as social support, treatment adherence, and symptom reporting. In the absence of positive body image, sensitivity to bodily needs, and sense of self-control that develop along with secure attachment, health crises may produce defensiveness, especially denial. Denial of physical condition and needs during a health crisis results in an inability to benefit from supportive resources, and increases risk. Two studies directly support the link between attachment insecurity and symptom reporting. Avoidant attachment individuals tend to report symptoms less often, relying on emotional self-control instead (Kotler et al., 1994). Fearful and preoccupied individuals tend to report an excess of medically unexplained symptoms compared with securely attached individuals with the same disease (Ciechanowski et al., 1998).

Abuse or neglect in childhood contributes to increased risk in adulthood for terminal disease. Felitti et al. (1998) found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The health risk factors were: heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had four-fold to twelve-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempts.

Treatment of the mind-body connection of physical health involves several areas of focus: (1) increasing the person's trust in self and others, decreasing the sense of personal vulnerability and increasing the willingness to recognize, ask for and accept support; (2) increasing the person's ability to consciously relax and to reverse the habituated stress response; (3) increasing the person's ability to internally regulate his/her emotions through recognizing, acknowledging and expressing them, decreasing reliance on compulsive use of substances or behaviors to artificially soothe, distract or excite internal states; and (4) increasing sensitivity to bodily needs and the resulting self-care and self-protection. Of course, treating and resolving early abuse or neglect will ameliorate the

lingering negative effects on physical health from unresolved childhood trauma.

Attachment implications in treating chronic pain

Chronic pain is a specific example of the effect of attachment style on the experience of stress. Chronic pain is defined as pain that persists beyond normally expected healing time. Avoidant attachment, i.e., dismissing and fearful attachment taken together, is counterdependence, or compulsive self-reliance, expressed through emotional suppression, idealization of relationships, strong work ethic, caregiver role-identity (rescuer position on the Victim Triangle). These traits have been documented to cluster in patients with chronic traumatic pain (Gregory & Berry, 1999). Ford (1978) noted that these individuals tended to start work in childhood and take on excessive responsibility. Coen and Sarno (1989) describe these people as exhibiting emotional inhibition with avoidance of conflict. Pilowsky and Bassett (1982), found that pain patients tend to deny both affective disturbance and life problems.

Barsky (1989) coined the term “counterdependent” to summarize the personality characteristics of patients with chronic pain. How does the counterdependent nature of these patients’ personalities lead to chronic pain? Because of their reliance on productivity and autonomy to support self-esteem, these patients may perceive a greater threat from a disabling pain syndrome, which, in turn, may enhance pain perception and promote chronicity (Beecher, 1956). The same factors discussed in the previous section on how habitual stress contributes to physical disease apply to chronic pain. Treatment follows the same course, emphasizing the remedial resolution needed by those with an avoidant attachment style.

Attachment implications in treating depression

Bowlby (1980) considered the key characteristic of clinical depression to be helplessness or hopelessness. He identified both to be related to three kinds of experience in childhood: never attaining a stable and secure relationship with parents; being told repeatedly about being unlovable, inadequate or incompetent; and experiencing loss of a parent with severely negative consequences that are not easily changed. Such a child develops an internal working model that interprets later loss throughout the lifespan in terms of personal failure or inability to replace what has been lost. As an individual goes back in age regression to heal and resolve the early experiences of insecurity and inadequacy, and to complete the grieving for

early losses, the lingering effects of those primal experiences, including clinical depression, are released.

Unresolved grief as an attachment disorder

Separation or loss of the attachment figure, by definition, leads to distress. This is true for all people, from infants to the aged. Normative reactions to loss, i.e., protest and mourning, are understandable attachment behaviors. The absence of an attachment figure activates the human innate motivational system to search for the lost person in order to regain proximity and security. When the effort fails due to permanent loss, the grieving individual may experience deep sorrow and despair, and often will experience a sense of invalidation of basic beliefs or meaninglessness. "Losing someone you love is less like losing a very valuable and irreplaceable possession than like finding the law of gravity to be invalid. While it would seem only rational to give up a lost object 'at the behest of reality,' it is not at all so obviously rational to give up a relationship whose meaning has been crucial to one's sense of life. Grief is a reaction to the disintegration of the whole structure of meaning [working model] dependent on this relationship rather than to the absence of the person lost" (Marris, 1982, p. 195). Eventually, the grieving gives way to a return to normal activities and renewed social relationships.

This normal process of healing loss through grief is disrupted, however, in insecurely attached individuals. Bowlby (1980, p. 138) proposed two forms of disordered reactions to loss of an attachment figure: "chronic mourning" characterized by protracted grief and prolonged inability to return to normal functioning, and "prolonged absence of conscious grieving" characterized by a conspicuous lack of conscious sorrow, anger, or distress and no noticeable disruption in normal activities. Middleton et al. (1993) labeled essentially the same two forms of disordered mourning as "chronic" and "delayed," identifying both as pathologically unresolved grief. The patterns also seem to correspond to the infant anxious attachment styles of ambivalent/preoccupied and avoidant. That is, the anxious/ambivalent infants "exhibit a miniature version of chronic mourning, becoming extremely distressed by separation and then finding it impossible to 'resolve' this upset when conditions would seem to warrant resolution. Avoidant infants in the strange situation are marked by a kind of cool nonchalance regarding their attachment figures' whereabouts, and – at least in some cases – an active ignoring of them when they return following separation. This can be viewed as a

miniature and very short-term version” of delayed mourning (Fraley & Shaver, 1999, p. 740).

Currently, three patterns of dysfunctional grief have been generally acknowledged: delayed grief, chronic grief, and conflicted grief. While a short period of numbness is normal following a significant loss, if the grieving does not begin within a few days, the delay is abnormal. Delayed grief is associated with people who are compulsively self-reliant or counterdependent, and therefore detached (Parkes, 1991). Chronic grief is severe and protracted grief that does not seem to gradually lessen in intensity, and is associated with people who are in excessively dependent relationships. It affects either partner in such a relationship, the “weak” partner or the “strong” partner, since both obtain role identity from the other (Parkes, 1991). One might see this pattern most frequently in older widows or widowers who have lost a longtime partner. Thus, the spouse who was apparently most independent in the relationship is just as susceptible to chronic grief as the spouse who was apparently most dependent and needy. The third pattern, conflicted grief, is grieving complicated by intense guilt and anger. This individual is struggling to resolve ambivalent feelings, or “unfinished business,” toward the now inaccessible attachment figure.

Here, too, we see the synthesis model at work: synthesizing the attachment and detachment from the separated or lost person, resulting in resolution of the grief. There are two basic tasks in the process of mourning: detachment and continuity (Gaines, 1997). Mourning involves both processes of “letting go” and of “holding on.” Emphasis on the need to detach from the lost object at the expense of maintaining some sense of continuity with him/her is based on denial and leads to insecurity. Creation of continuity is distinguished from denial of loss by the fact that there is always explicit, even if unconscious, recognition that the object is gone. Studying families who experienced the death of a child to cancer, McClowry et al. (1987) found that the death of a child creates an enduring empty space for surviving family members, parents and siblings. Three patterns of grieving were described by family members in response to this sense of emptiness: getting over it (denial), filling the emptiness (distraction), and keeping the connection (creating continuity).

The attachment perspective offers help in treating bereavement and grief. The ways in which people cope with separation and loss are basically the same as the ways in which they handled the relationships before the loss. Healthy people entering adulthood do not completely detach from

their parents, even though they experience separation from them and new attachment figures become predominant. So, too, healthy people are able to navigate the loss of an attachment figure (e.g., a spouse), resolving the grief through mourning and perhaps finding a new attachment figure without severing the bond with the lost one (creating continuity). Secure individuals, then, achieve balance in their attachment and detachment in loss. Preoccupied individuals are out of balance in dealing with loss in favor of attachment, unable to let go, and subject to chronic or conflicted grief. Dismissingly avoidant individuals are out of balance in dealing with loss in favor of detachment, unable to acknowledge or express grief and subject to use denial or distraction to effectively delay grief.

Relationship with God and spiritual fulfillment

The relationship with God in the world's monotheistic religions is primarily that of child to parent ("child of God") and believers rely on God for a personal, interactive, and caregiving relationship (Kirkpatrick, 1999). The same qualities characterize most other religious orientations as well. Even in non-monotheistic religions such as Hinduism and Buddhism, believers often establish the same relationship with personal gods imported from ancient folk religions (Kirkpatrick, 1994) as attachment-like figures. Kaufman (1981, p. 67), a theologian, states, "The idea of God is the idea of an absolutely adequate attachment-figure. . . . God is thought of as a protective and caring parent who is always reliable and always available to its children when they are in need." Believers have attachment-like proximity-seeking behaviors, such as prayer, rituals, and attendance at places of worship. For many, God serves as a secure base from which to explore not only the physical world, but the transcendental domains of the psychic, mystic, and cosmic realms.

In research by Kirkpatrick and Shaver (1992), participants with a secure attachment to God perceived God as more loving, less controlling and less distant than those with insecure attachment. Those with an avoidant attachment to God were most inclined towards agnosticism (indifference) while individuals with an anxious/ambivalent attachment to God reported the highest incidence of speaking in tongues as well as the greatest proportion of atheists and individuals describing themselves as anti-religious (ambivalent between these two extremes of being demonstratively religious or atheistic). Adult attachment style and attachment to God are strongly related for subjects reporting an insecure childhood attachment to their mothers. People whose parental attachments

were disrupted by separation or loss in childhood are less likely to turn to God as an attachment figure (Kirkpatrick, 1999). For subjects with secure childhood attachments, there was no significant relationship between adult attachment and God attachment. Resolving early disordered attachment in psychotherapy may well result in removing the resistance or avoidance in an individual's spiritual relationship. While usually not stated as a desired outcome by new clients, this spiritual reconnection quite commonly occurs in our experience.

Geriatrics and old age

Ultimately, we must all face death. Erikson's eighth and final psychosocial developmental stage involves working through grief and reaching completion. Grief has to do with loss. Loss has to do with change. Some common losses experienced by the aged relate to side effects of medications, relationships, lifestyle, generativity and contribution, spouse, child(ren) dying before the parent, self-respect, trust, memory, health, financial well-being, freedom, ideals, dreams. Problems and substitute behaviors include self-destructive tendencies; deep sorrow and the "pain of loss"; preoccupation with and idealization of what is past; guilt and self-reproach; feelings of "unrealness;" lack of energy and fatigue; death anxiety; death urge or preoccupation; resistance to change; fear of the unknown; and denial of death. Treatment of these issues in old age involves a deep resolution of unmet attachment needs, freeing the individual to explore and accept their approaching death.

Violence

Research (Levinson & Fonagy, 1998) reported by Hesse (1999) found evidence for an association between insecure adult attachment and criminality, especially with respect to crimes against persons as opposed to less violent crimes.

Attachment theory provides an explanation for the seeming-acceptance of abuse by those who have been or are being abused, and the difficulty they often have in separating from the abuser (Holmes, 1993). Attachment behavior is activated by threat, i.e., the attached cling to their attachment figure when threatened. When that attachment figure is also the perpetrator of violence or abuse, an impossible dilemma is created. Both separation and threat arouse unbearable feelings of panic, and promote the need to cling even more.

Treatment of the battered woman will necessarily focus on the detachment process and simultaneous nurturing of the separation/individuation process. Allen (1998) describes a continuum of psychological disengagement by a woman from her batterer, beginning with a high degree of attachment to the abuser and a concomitant loss of sense of self, and movement toward “unbonding,” with an increase in sense of self and a decrease in attachment to the abuser. Women who are more bonded with their partners have higher levels of attachment to partner and Stockholm Syndrome, and lower levels of sense of self. Women who have completed much of the process of “unbonding” are more likely to have taken concrete steps indicative of separation, and to have a higher level of sense of self. Allen identifies the stages a woman goes through as she disengages psychologically from her batterer as: (1) immersion with her partner, (2) out of denial about her attachment to her partner, (3) imaging herself without her partner as confidence overcomes self-doubt, and (4) reclaiming the Self. The findings further support the notion that leaving a battering relationship is a separation/individuation process, not a single event.

Attachment organization of the therapist

It should be noted that research indicates that the attachment organization of the therapist influences treatment outcome (Dozier et al., 1994). Secure therapists are more able to hear and respond to (i.e., challenge, not accede to) the desire not to engage in interpersonal or intrapsychic problem solving of their dismissing clients, and the overtly dependent demands of their preoccupied clients. Insecure therapists are more likely to become entangled with such clients, responding to their superficially presented needs rather than to their underlying needs. “A therapist’s own security, manifested in the capacity to remain open to his or her experience as well as to the patient’s, is likely to be most predictive of a healthy and successful psychotherapy” (Slade, 1999, p. 589).

Secure therapists are comfortable with unpredictability, disorder, and ambiguity. “Therapists in general probably underemphasize how putting contradictions together helps the patient to transcend the problem . . . Transcendent knowledge reveals that, for example, regressed components of the personality can coexist with and even enhance more mature elements, one does not preclude the other. . . . With this approach, there is maintained an aliveness, immediacy, and an excitement with the question rather than a ‘now it is finally solved, and I can go on to something else’

attitude” (Twemlow, 2001a, p. 14). This describes the synthesis of nonattachment in the therapist’s approach to providing therapy.

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