Attachment in the Therapeutic Relationship: An Exploratory Study of Patient's Response upon Reunion Following a Holiday Break

Penelope J. Katz

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A dissertation submitted to the
California Institute for Clinical Social Work
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in Clinical Social Work

By

PENELOPE J. KATZ

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DISSERTATION APPROVAL PAGE

We hereby approve the dissertation

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ABSTRACT

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This study addressed the nature of the therapeutic relationship and the effects of separations from an attachment theory and psychoanalytic perspective. It was based upon the idea that patients' internal working models and attachment patterns, developed in infancy and solidified over time, are transferred onto the therapeutic relationship. This study was designed to observe reunion sessions following a winter holiday break, in particular the attachment patterns exhibited by patients in the sessions.

By analyzing audio recordings of reunion sessions, this study attempted to identify attachment related themes in the material presented by the patients. Additionally, this study sought to observe and describe the ways in which patients engaged or disengaged with their therapists following a planned separation, and the stratagem patients employed in the service of re-connecting with the therapist. In studying these reunion sessions, this researcher attempted to describe and classify behaviors in order to lead to a greater understanding of the nature of the therapeutic relationship.

The data was analyzed using qualitative procedures. Two separate sets of data analysis were conducted. The first round of data analysis yielded three prevailing themes, each with a number of categories, of attachment related

material expressed by patients in the reunion sessions. Theme 1, patients' expressions of feelings of loss, included the subcategories of feelings of sadness, feelings of lack of control, and lack of, or decrease in coping skills. Theme 2, patients' expressions of feelings of anxiety, included the subcategories of fear of death or harm to self or a loved one and feelings of insecurity. Theme 3, patients' expressions of feelings of anger, included the subcategories of feelings of frustration and feelings of impingement.

The second round of data analysis yielded two categories of patient behaviors exhibited during the reunion sessions. They were attachment activating behaviors and attachment deactivating behaviors. Both categories of behaviors included subcategories of direct verbalizations, speech patterns, use of humor and/or laughter, and physical actions.

This study found that all patients were impacted by the separation caused by the holiday break. All of the patients manifested responses to the separation from their therapists in the reunion session that, while reflecting each individual's particular attachment patterns and working models, had enough similarities to be grouped into identifiable themes and categories. Each patient's attachment patterns were visibly displayed both in the material they presented and in their behaviors in session.

This researcher believes that the attachment patterns manifested by patients in the therapeutic relationship, when recognized and addressed by therapists, provide great opportunity for treatment. With the understanding that separations, however brief, can activate old attachment patterns, we as

clinicians can utilize this information to work with our patients both prior to and following a separation. In this way, the therapeutic relationship, with its unavoidable interruptions and attachment ruptures, can become the facilitator of healing and growth.

DEDICATION

Dedicated with profound gratitude to
Dr. Lorraine Gorlick, who has taught me
the true meaning and power of attachment.

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CHAPTER I

INTRODUCTION

It has become a widely accepted idea among many in the mental health field that regardless of which model of therapy one uses, it is the relationship between the therapist and patient that facilitates healing and growth. In order for this to occur, the patient must have a certain level of trust in the therapist; trust that the therapist will not abandon the patient even in the face of destructive thoughts and feelings, trust that when the patient ventures away from the therapist, the therapist will be there when the patient is ready to return, and trust that the therapist has enough strength and wisdom to guide the patient along a difficult journey. The attachment that the patient develops to the therapist is the foundation upon which true healing can occur.

The impetus for this study was this researcher's interest in exploring the therapeutic relationship, in particular, how the attachment patterns of the patient are manifested toward the therapist. This research examined the behaviors exhibited by patients in the first session following a winter holiday break. In studying these reunion behaviors utilizing the framework of attachment theory, this researcher attempted to describe and classify behaviors in order to lead to a greater understanding of how the patient relates to the therapist. In particular, this research attempted to understand more about how the patient manifests attachment patterns and behaviors in the therapeutic relationship.

Introduction to the Theoretical Context

Although attachment theory has been around since the 1940s, and there has been a great deal of valuable research done in the area of infant attachment, it has not been until recently that attachment research has focused upon the implications of attachment theory for the practice of psychotherapy. Bowlby (1988) discussed the use of attachment theory in therapy and stated that the most fundamental therapeutic change involves revisions to clients' internal working models of attachment. Having stated this however, Bowlby seemed to imply that simply making the patient aware of these internal working models would be enough to correct to any difficulties in the patient's attachment patterns or ongoing relationships. Bowlby's position was primarily that the psychological life of the infant was molded by the primary caregiver's response to the child's earliest feelings and needs. Bowlby did not address, nor did he agree with the psychoanalytic notions of internal drives, and the effects of wishes and impulses upon the development of an infant's internal world. It was in large part due to this theoretical difference, that the psychoanalytic community was so late in exploring and utilizing Bowlby's ideas (Slade, 1998).

In the last decade or so, there has been a great deal of interest in the research community in looking at both adult attachment patterns, and attachment theory as it applies to the clinical setting. Just as infant attachment research has helped us to quantify, classify, and identify specific attachment seeking and responding behaviors, adult attachment research has improved our understanding of how adults relate. In the 1990s, clinicians and researchers began to explore the connection between attachment theory and clinical

practice. Most of this research has focused upon the ideas of the secure base and the different classifications of attachment patterns. These ideas have been applied to the therapeutic relationship in regard to creating a secure attachment between the patient and the therapist. The classifications of the secure, anxious-avoidant, anxious-ambivalent, and disorganized styles of attachment have been explored in terms of their clinical relevance to understanding the patient's behavior within the therapeutic relationship.

Theoretical Framework

Typically, unlike the psychoanalytic schools of therapy, psychotherapy with an attachment oriented perspective views the therapist-patient relationship as a real one. Therefore, the different attachment behaviors and patterns manifested by the patient are explored within the therapeutic relationship in the here and now. The role of the therapist in this kind of treatment is to become the older and wiser caregiver with whom the patient can form a secure attachment, the secure base. The idea would be that the therapist-patient relationship may, for the first time, allow an opportunity for a healthy balance between attachment/connection and exploration/autonomy. The patient can begin to experience the comfort and security of the close relationship; a relationship from which the patient can also move away without risking loss of the relationship. Thus the patient can experience a healthy attachment, which Bowlby and his followers tell us allows for healthy exploration, creativity, and growth.

The research of Main (1984, 1985, 1988, 1990), Fonagy (1991, 1994, 1996), and their colleagues has shown us that the attachment patterns between the infant and mother, once the property of that particular relationship, become internalized and therefore become the property of that particular person. These patterns are then transferred onto future significant relationships. If we take this idea and join it with the psychoanalytic concept of transference, then we can see clearly that attachment patterns and behaviors manifested in the therapeutic relationship are representative not only of the actual level of attachment between the patient and therapist, but are in fact the same patterns established in infancy and early childhood. These ideas are very important and very useful in the therapeutic relationship. This researcher is proposing what would seem to be a natural marriage between attachment theory and psychoanalytic theory. If we as clinicians look at the patient's attachment behaviors and patterns as they manifest in the therapeutic relationship, we not only gain important information about the current relationship, but we also gain important information about our patient's earliest attachments. This is information that our patients may not have conscious memory of, and because many of the experiences were preverbal, they certainly would not have the words to describe these earliest attachment experiences.

With this understanding comes the realization that utilizing attachment theory in the therapeutic relationship not only gives us a powerful framework from which to work with our patients in the here and now, but also has the potential

to give us important information about our patients' earliest relationship experiences. This is an exciting idea, and gives as a whole new tool to utilize in working with our patients to uncover the mysteries of their past and how it has affected their present lives. It is a new road into the unconscious, to be used in conjunction with whichever theory the therapist and patient feel most comfortable.

Attachment theory fits naturally with, and does not conflict with, any style of therapy. In fact, it has the potential to enhance any style and any level of therapeutic work. It combines the biological, behavioral, emotional, cognitive and spiritual realms of thought and ways of working. What this researcher planned to do, by carefully exploring the reunion behaviors displayed by the patient toward the therapist following a separation, was to begin to identify, classify, and categorize these behaviors. In doing so from a psychoanalytic and attachment theory perspective, this researcher hopes to offer therapists and patients some new ways of understanding and exploring the patient's patterns of relating. Then, in true therapeutic fashion, the patient can take these understandings, discovered in the context of the therapeutic relationship, and apply them to the other relationships in their lives.

It is clear that there is much to be gained in observing, identifying, classifying, and therefore coming to understand the different biologically and emotionally driven attachment behaviors. In regard to the clinical setting, if we agree with the idea that the therapeutic relationship is the window into all of our other

significant relationships, then it becomes important for us to look at these attachment behaviors as they play out in the therapeutic relationship.

Additionally, disruptions in the therapeutic relationship caused by holidays, vacations, illness and other life experiences, are something that every therapist and patient encounter. A greater understanding of the impact of these disruptions from an attachment theory perspective would clearly prove useful in the clinical setting. This research can provide valuable information to be applied to the treatment of adults and children, who may not have the words or understanding to describe the nature of those earliest relationships. In these cases the behaviors exhibited in the therapeutic setting will give us this important information that they themselves are not able to verbalize.

As Freud first told us, "the child is father to the man", meaning that what occurs in childhood colors our perceptions, relationships and behaviors for the rest of our lives. Just as Melanie Klein's pioneering work in child analysis gave us invaluable insight into the internal world of children, thus allowing us to more deeply understand adults, so too has attachment research and theory opened up a new world of understanding of human behavior in both children and adults. Attachment theory has allowed us to observe, measure and classify behaviors, thus identifying patterns of relating in very real, concrete ways which previous developmental psychology had not been able to do.

These observations and classifications have given us a common language that allows us to communicate complex ideas and basic truths about human interaction in a direct and clear manner. This researcher believes that

attachment is the core of all development, both normative and pathological. Being able to identify the varying components and qualities of attachment has added great strength to our work with our patients, both children and adults. Attachment theory, when utilized in combination with the powerful concept of transference, allows for a deeper understanding and ability to treat our patients.

Additionally, because attachment theory uses a common and clear language, it allows our patients to better understand themselves and their relationships. It is a theory that makes psychoanalytic concepts much more accessible, and therefore more valuable to our patients.

Human beings, for emotional and biological reasons, are object and attachment seeking. One could argue that all human behavior is in the service of our efforts to form attachments that meet our emotional and biological needs. Therefore, in our quest to understand ourselves and our behaviors, as individuals and as a community, what could be more important than exploring these ideas?

Utilizing the attachment theory concept of "working models" in reference to the therapeutic relationship, we can look at how breaks (either vacation, weekend breaks, even the time between sessions) however long they may be, are comparable to some aspects of the strange situation research that Ainsworth conducted. In particular, the behaviors upon reunion, displayed by the infant toward their primary caregiver, can be likened to the behaviors upon reunion displayed by the patient toward their therapist after the above

mentioned breaks. Ainsworth et al. (1978) found that the period of reunion following a separation contained the most concentrated display of attachment patterns and behaviors. For that reason, this study utilized the period of reunion following a holiday break to observe these theoretically stipulated concentrated attachment patterns and behaviors in the therapeutic setting. A holiday break was utilized as this was a naturally occurring break, and therefore this study did not impose any unnecessary disruption upon the therapeutic relationship.

Statement of the Problem

Patient attachment style is an important variable that therapists need to assess in order to be attuned to their patients. Dolan, Arnkoff, and Glass (1993) stated that "Therapists continually assess and observe a variety of client behaviors, and seek to adjust their own styles as therapy proceeds" (p. 408). These client/patient behaviors would include attachment behaviors, and a sensitive level of attunement to a patient's attachment style would be crucial to the development of a positive therapeutic alliance.

Attachment theory describes attachment as a strong, affective bond with someone who is perceived as stronger and wiser. This description of a stronger, wiser individual who can guide, teach and protect certainly fits the role of a therapist under the best of circumstances. Bowlby (1978) discussed the idea that working models endure from early development, and patients may "assimilate any new person - a spouse, a child, a therapist - to an existing model and often continue to do so despite repeated evidence that the model is

inappropriate" (p.16).

The working models of an insecurely attached patient are characterized by rigidity and new information is not readily incorporated. Therefore, a patient with an insecure attachment pattern may not experience a therapist's consistency, availability and empathy as such. For this reason, it is crucial that the therapist strive to understand the patient's attachment patterns and internal models. One way to develop this understanding is through careful listening to the patient's narrative of her early childhood experiences. Often, however, this will not be enough. Patients' memories become distorted overtime, as seen through the filters of denial, fantasy, and other defenses. It therefore becomes important to develop other ways of identifying and understanding our patients' attachment patterns and internal models or transferences.

Bowlby (1988) stated that the most fundamental therapeutic change involves revisions to patient's internal working models of attachment. For the patient to reorganize working models, the models must be explored and understood in the therapy. In addition to examining memories of early attachment experiences, and current experiences with significant others, this would involve the therapist encouraging the patient to explore expectations and experiences of the therapist.

The literature on infant and adult attachment has focused primarily on attachment with the primary caregiver (Ainsworth et al, 1978) or in the case of adult attachment, with a romantic partner (Hazen and Shaver, 1987). It is only been the last several years that the role of attachment in therapeutic

relationships has been studied more carefully. Mary Dozier (1990) and her colleagues have utilized the adult attachment literature to explore how these working models affect how people interact with their therapists. Based upon their findings, Dozier and Tyrrell (1998) have developed a model of therapeutic change that indicates that the therapist must provide a secure base in order to promote safe exploration. Dozier and Tyrrell stated that this is a difficult task for the therapist, as it may be that she will need to compensate for the failures of other attachment figures. This research and theory will be presented in more detail in chapter 2.

Thus, as therapists, we must have effective ways of assessing and understanding our patients' internal working models and attachment patterns. It is only through this understanding and consequent attunement that we can become a secure base from which our patients will be able to explore and eventually challenge working models based upon previous experiences with unavailable or rejecting caregivers. If we cannot rely solely upon our patients' memories of these early in attachment experiences, then we must have other ways of gaining this information. In this researcher's opinion, valuable information about our patients' internal working models and attachment patterns is presented to us in every session in the form of our patients' expectations of and reactions to us as attachment figures. Additionally, as all therapeutic relationships have separations and reunions, it is important for us as clinicians to understand the impact of these events upon our patients.

Purpose of the Study

This study was based upon the idea that patients' internal working models and attachment patterns, developed in infancy and solidified over time, are transferred onto the therapeutic relationship. Ainsworth's (1978) "Strange Situation" research found that infants' already existing attachment patterns were visible in their most concentrated form upon reunion following a separation from their primary caregiver. This study was designed to observe the reunion session following a separation/break in the therapy, in particular the attachment patterns exhibited by the patient.

In observing the behaviors displayed by the patients upon reunion with their therapists, this study attempted to identify attachment seeking or avoiding behaviors as they manifested in the therapeutic relationship, and attempted to note if these behaviors tended to cluster into identifiable categories.

This study sought to observe and describe the ways in which patients engaged or disengaged with their therapists following a winter holiday break, and the stratagem patients employed in the service of re-connecting with the therapist. This study was intended to be observational in nature. This researcher analyzed the audio recordings of reunion sessions in order to attempt to describe the reunion behavior of the patient.

Research Design and Questions

The research design of this study was qualitative. Audio recordings of the first session following the winter holiday break were transcribed and analyzed to observe the reunion behaviors of the patients. The research questions this study sought to answer were as follows:

1. How do patients demonstrate attachment patterns and style to their therapists following a planned missed session?

2. What feelings about the separation and reunion do patients verbalize in the reunion session?

3. What behaviors do patients display in the reunion session which may indicate thoughts and feelings about the separation and reunion?

4. What is the range of reactions displayed, and/or verbalized by the patient about the separation and reunion?

5. How are feelings such as anger, sadness, anxiety and loss manifested in the reunion session?

6. What do patients report regarding thoughts about the therapist during the separation? For example, thoughts of missing the therapist, curiosity about where the therapist is and what she is doing, distressing thoughts of the therapist, and comforting thoughts of the therapist.

Significance of the Study

The potential significance of this study derives from the idea that the patient's behaviors upon reunion will give information regarding the patient's internal

working models and attachment patterns which the therapist and patient can utilize in a variety of ways. This would include allowing the therapist to be more attuned to the patient, thus allowing for a greater therapeutic alliance, as well as giving insight into the patient's early history with primary caregivers. With this information the therapist and patient can work together to create a secure base and reformulate old working models and attachment patterns which were based upon unavailable, rejecting, or otherwise disappointing caregivers. The information to be gained by a greater understanding of the patient's internal working models and attachment patterns could potentially also result in more effective, and therefore more cost-effective, therapeutic treatment.

Additionally, separations and disruptions are common to all therapeutic relationships in all settings. This study can potentially provide a framework for understanding the process that patients go through when there is a separation and reunion during the course of treatment. If we can gain a greater understanding of the effects that these separations and reunions have upon patients, and a greater understanding of how this manifests in the therapeutic relationship, this study can provide very valuable data in regard to helping our patients manage breaks and disruptions in treatment.

This study has significance to the field of social work, in that the study's theoretical foundation of attachment theory is particularly useful to clinical social work. Attachment theory is based upon the biological and emotional needs that human beings have for attachment. Attachment theory addresses the biological, psychological and social needs of the patient in a

complementary fashion with social work's "biopsychosocial" model. In regard to clinical practice, attachment theory, and this study in particular, seeks to address the needs of the patient in their environment.

Social work strives to heal by building upon the existing strengths of the individual, and strengthening the areas of need. Utilizing attachment theory in clinical practice allows the therapist to strengthen and heal the patient's internal working models and attachment patterns through the therapeutic relationship. This newly created secure attachment can then be generalized to other relationships in the patient's life. Additionally, utilizing attachment theory in clinical practice allows therapists and patients to address issues of the past by dealing with the patient's present relationships. In other words, the patient does not need to wait until all past issues are identified and processed to reap the benefits of an increased understanding of their behaviors, resulting in improvement in their current life and relationships.

Assumptions

1. This study assumes the idea that, in the therapy setting, the patient will have a reaction to separations and reunions.

2. This study assumes that a patient's existing internal working models and attachment patterns, based upon prior experiences with caregivers, will be seen in their most concentrated form (as per Ainsworth's 1978 strange situation research with infants and their caregivers) upon reunion from a separation.

3. This study assumes that all of the participating therapists will be receiving supervision from an experienced clinician, and will be guided to address the separation, as clinically appropriate, both prior to and following the break.

Definition of Terms

1. Separation refers to the planned missed session or sessions due to the winter holiday break.

2. Reunion refers to the first session back following the winter holiday break.

3. Internal working models refers to Bowlby's concept of the affective-cognitive processes for assimilating new information, created from infant experiences with their primary caregivers. These representations endure from early development, and people tend to assimilate any new person to an existing model and often continue to do so despite repeated evidence of that the model is inappropriate. Main, Kaplan, and Cassidy (1985) describe working models as a "set of conscious and/or conscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information" (p. 71).

4. Attachment patterns/classifications refer to the categories created by Ainsworth and her colleagues, Main and her colleagues, and the more recent categories created by other adult attachment researchers.

CHAPTER II

REVIEW OF THE LITERATURE

This review of the literature covers the development of attachment theory and research. The chapter will begin with a review of early infant attachment theory and the seminal research done in the field of infant attachment. It will then move onto later studies, tracing the development of the secure base idea and the classification of qualities of attachment. The chapter will include a review of the development of adult attachment theory and research, and a review of the literature on the implications of attachment theory and research in the clinical setting. The chapter will conclude with a brief review of literature on the effects of disruptions in the therapeutic relationship. This literature, while not necessarily from an attachment theory perspective, is being included as this study is addressing the holiday break as a disruption in the therapeutic relationship.

Attachment theory, rather than being one single theory, is actually an overall framework for thinking about relationships, specifically the aspects of relationships that are shaped by the need for security. Attachment theory was first developed by John Bowlby in the 1940s, in response to the movement in psychoanalysis from drive theory toward the object relational theories reflected in the work of Melanie Klein, Winnicott, Fairbairn and Balint, as well as the new science of ethology as presented by Lorenz and Harlow (Holmes, 1996). The sciences of ethology and evolutionary biology introduced the idea that social

and intrapsychic behavior could be instinctive. Object relations theories were describing an internal world comprised not so much of mechanistic "psychic apparatus" but rather representations (albeit distorted by phantasy) of people, the self and significant others.

It should be noted that although attachment theory has been more closely linked to object relations theory than earlier drive related theories, it was Freud who first made key insights regarding the importance of the infant-mother relationship and it's affects upon all later love-relationships (Waters et al, 1991). It is also important to note that although the terms *bonding* and *attachment* are at times (mistakenly) used interchangeably, they in fact refer to different experiences. Bonding refers to the parent's tie to the infant and is thought to occur in the first hours or days of life. In contrast, attachment refers to the relationship between infants and primary caregivers, which develops gradually, building over time and evolving through a series of characteristic phases, with each phase building upon the one before.

The Origins of Attachment Theory

In 1939, John Bowlby presented a paper to the British PsychoAnalytic Society titled *The influence of early environment in the development of neurosis and neurotic character* (Bowlby, 1940). In this groundbreaking paper, Bowlby stated that when assessing children brought in for treatment of emotional disorders, attention must paid to the emotional quality of the home environment. He stressed the importance of assessing this emotional quality not only at the time the child was being brought in for treatment, but going back to

birth or even earlier (Karen, 1998). Bowlby felt that the emotional quality of the home was in fact more important than the physical or religious qualities. These ideas became the seeds of attachment theory.

Bowlby's ideas were based upon the opposing themes of attachment and separation and loss. Bowlby's definition of attachment focused upon the developmental and purposeful nature of the infant's behavior with its primary caregiver. He saw the biological function of attachment as protection from predators, with the primary function of the attachment bond being to provide security.

Bowlby, and those who have followed him, believe that attachment is not simply a childhood need that one outgrows in adulthood, but rather an ongoing need that manifests in a variety of forms throughout life. Consequently, adult relationships can be understood in terms of attachment theory just as those of infants and children (Bowlby, 1969). In his 1988 text, A Secure Base, Bowlby stated that "the propensity to make intimate bonds to particular individuals is a basic component of human nature, already present in germinal form in the neonate and continuing through adult life into old age" (pp. 120-121). Bowlby viewed the capacity to make intimate emotional bonds with other individuals as a "principal feature of effective personality functioning and mental health" (p. 121).

Research done by Main and Cassidy (1988) and Wartner (1986) has indicated that patterns of attachment (either secure or insecure, to be described in more detail in the next section of this chapter) formed as early as 1

year of age, tend to persist throughout the individual's lifetime. Meaning that although the pattern may initially be the "property" of the particular relationship, if the nature of the relationship does not alter, the pattern increasingly becomes the "property" of the child himself, who will then tend to impose it upon future relationships. This research has validated Bowlby's views that the child internalizes the attachment patterns of the infant-caregiver relationship, forming what Bowlby termed a "working model" of expectations which is then applied to future relationships.

Seminal Research on Attachment

Shortly after Bowlby began his work on attachment, he was joined by Mary Ainsworth. Together, they founded a new school of empirical research in developmental psychology. Ainsworth made very significant contributions to attachment theory. Among them are the invention of the "strange situation" as a measure of attachment status in 1 year olds (Ainsworth et al, 1978), and the study of the links between the parent-infant relationship in the first year of life and the subsequent relationship patterns which persist throughout life.

The research conducted by Ainsworth and her colleagues provided information and validation for Bowlby's ideas. More importantly, it allowed Bowlby and Ainsworth, who believed that attachment was not an all or nothing proposition, but rather ran along a continuum, to distinguish distinct patterns of attachment. Initially, Bowlby utilized Ainsworth's research to identify the category of anxious attachment and equated it with insecure attachment. As research progressed, Bowlby and Ainsworth added three additional

classifications of insecure attachment, anxious-ambivalent, anxious-avoidant, and disorganized. Sable (1997) described Ainsworth's (1978) and Main's (1984) research as identifying "two developmental pathways of insecure personality organization, one representing a tendency toward intensification of attachment behavior and the other a deactivation and avoidance of attachment feelings and behavior. The former classification is called anxious-ambivalent or preoccupied, and the latter avoidant or dismissing" (p. 289).

In a secure attachment, the individual is confident that the primary caregiver will be available, responsive and helpful should something unpleasant or dangerous occur. This pattern is promoted by the caregiver being readily available, sensitive to the child's signals, and "lovingly responsive" when the child needs comfort. Individuals with a secure attachment feel able to explore the world, have a belief that they are capable and competent, and are able to reach out to others for assistance and affection.

An anxious-ambivalent or preoccupied attachment is characterized by uncertainty about whether or not the caregiver will be available, responsive or helpful in times of need. This results in separation anxiety and difficulty in exploring the world. This pattern is promoted by the caregiver being available and helpful in some situations but not in others or by actual loss experiences or threats of abandonment. Individuals who are anxiously attached "do not have the inner feeling of a secure base from which to venture forth, and are prone to separation anxiety and alarm at the prospect of losing whatever support does

exist" (Sable, 1997, p. 290). These individuals may appear overly dependent, demanding and clingy.

An anxious-avoidant or dismissive attachment is characterized by an individual who has no confidence that when he seeks care he will be responded to in a helpful manner. This pattern is the result of a caregiver constantly rebuffing a child when the child approaches the caregiver for comfort or protection, or by actual abandonment (Bowlby, 1988). "Unreliable caregiving and unexpected separations have been compounded by rejection, pressure to inhibit feelings, or ridicule of acting childish when seeking comfort, so information that would activate attachment behavior is defensively excluded" (Sable, 1997, p. 290). These individuals avoid and in fact reject assistance and support from others. They deny having the need for such support as a defense against the belief that if they do have needs and reach out they will be rejected or abandoned.

In Ainsworth's "strange situation" test, attachment status is classified by the response of the infant to the mild stress of being brought into a strange room in a clinic, exposed to the entry of a stranger, and then separated from his caregiver for a series of 3-minute periods. Children who protest upon separation and can be pacified upon reunion, after which they return to exploratory play, are classified as *securely attached*. Those who protest little upon separation and upon reunion hover nervously nearby are classified *anxious-avoidant*. Children who protest upon separation, but cannot be pacified upon reunion, clinging to the caregiver, are classified *anxious-ambivalent*.

During research conducted by Main and Solomon (1990), a fourth type of attachment category was developed. An examination of 200 unclassifiable "strange situation" videotapes revealed infants who displayed conflicted behaviors upon reunion with a parent. These behaviors included rocking on hands and knees with faces averted, freezing, collapsing to the ground, or leaning vacantly against a wall. These children were classified as having a *disorganized* version of one of the three typical patterns, most often the anxious-avoidant type. These characteristics are most often seen in severely abused and neglected children. This attachment pattern is believed to be created when a parent's behavior toward an infant is directly alarming. In these cases, the infant simultaneously experiences conflicting impulses to seek out the parent for safety and to flee from the parent as the source of alarm. This situation creates a paradox for the infant who cannot rely upon prior behavioral strategy to either approach the parent (as in secure or anxious patterns) or shift attention (as in avoidant patterns). As one might expect, many parentally abused children have been found to display a disorganized type of attachment pattern (Main, 1996).

Ainsworth, and later Bowlby, described a "secure base" phenomenon which is necessary for the healthy development of the child. Essentially, the secure base idea indicates that the more securely attached a child feels to her primary caregiver the more able/willing the child will be to go out and explore the world, knowing that her parent is still there for her in times of need. This idea fits

nicely with Margaret Mahler's concepts of rapprochement and separation/individuation.

Through her research, Ainsworth was able to categorize and describe the behaviors and roles of both the infant and caregiver in the attachment process. Ainsworth conceptualized the caregiver's responsibilities as sensitivity to signals, cooperation vs. interference with ongoing behavior, physical and psychological availability vs. unavailability, and acceptance vs. rejection of the infant's needs. Ainsworth specified that the key components of sensitivity to the child's signals are detecting the infant's signal, correctly interpreting signals, appropriate response selection, and timely response (Ainsworth, 1978). Again, one can see both the influence of object relations theory. Examples include Klein's ideas regarding the necessity for a timely response to the infant's needs lest too much frustration be experienced by the infant, resulting in splitting and fragmentation (1946-1963) as well as the influence these ideas had upon the later work of Stern (1985, 1995) and others who wrote about the importance of attunement.

In addition to describing the caregiver's responsibilities and behaviors, Ainsworth did the same in regard to the infant. She described the infant or "secure base seeker's" responsibilities as being to clearly signal distress, maintain the signal until the caregiver can respond, have active interaction or proximity seeking and maintaining, and find contact and interaction with the caregiver an effective source of comfort.

Where attachment theory differed from object relations theory was in its focus upon the biological and evolutionary purpose of attachment, and the

behavioral component of the process. Ainsworth went on to categorize a number of attachment seeking behaviors which she presented as biological as well as emotional in nature. These included crying, smiling, clinging, rooting, postural adjustment, and vocalization, all of which are exhibited by infants a few days after birth. Ainsworth stated that these behaviors are goal oriented and are the infant's way of making contact and encouraging the caregiver to respond to him (Ainsworth, 1985).

Longitudinal Research and its Implications

In the 1980s, Mary Main and her colleagues created the Adult Attachment Interview (Main and Goldwyn in press). This measure has been used by Main to test the prediction that there would be connections between attachment status in childhood and later in life. The AAI is an audiotaped semistructered psychodynamic assessment session, whose aim is to "surprise the unconscious" into revealing itself by asking detailed questions about relationships with parents and significant others, and about losses and separations and how the subject coped with them (Holmes, 1996). Paralleling the "strange situation" classification system, the AAI classifies narratives as *secure-autonomous, insecure-dismissive, insecure-enmeshed,* and *disorganized.*

In secure-autonomous narratives the subject speaks coherently, logically and concisely about her past and its vicissitudes, however problematic these may have been. Insecure-dismissive narratives are unelaborated and unrevealing, while in insecure-enmeshed narratives the subject appears bogged down in her history, telling rambling and inconclusive stories. The disorganized category, as

in the "strange situation" classifications, is rated separately and coexists with the others. It refers to points in the narrative where the logical flow is interrupted or disjointed. Main suggested that this might represent the emergence of previously repressed traumatic memories (Holmes, 1996).

Peter Fonagy, a researcher working in London, used the AAI to correctly predict, in 75 percent of the cases, infant "strange situation" classifications. He showed that the outcome of the AAI administered to prospective parents was a good predictor of attachment status of their subsequent 1-year-old children. Mothers with secure-autonomous narratives tended to have children who were found to be secure in the "strange situation", while dismissive parents tended to have insecure-avoidant infants (Fonagy, 1991).

Through further research, both Fonagy and Main concluded that the most important quality that distinguishes the secure from the anxious adults is their ability to self-reflect and have some insight into their, and their parents, behaviors and interactions. Fonagy and Main's studies showed that the secure adults tended to be better able to understand themselves and their parents and recognize their own inner conflicts. In contrast, anxious adults either failed to have insights into themselves and their parents, or offered explanations that were self-deceptive or self-serving. Fonagy's work also showed no evidence that education, intelligence, socioeconomic status or ethnic background have any relationship to this ability to self-reflect and have insight (Fonagy, 1994). Fonagy's work is part of a new group of research which is re-integrating attachment theory with its roots in object relations theory.

Recent Adult Attachment Research

In recent years, the research that has emerged from Bowlby's (1988) and Ainsworth's (1982) attachment theory has focused upon attachments in adulthood such as close peer relationships, romantic relationships, and parenting experiences (Main, Kaplan and Cassidy, 1985; Shaver, Hazen, and Bradshaw, 1988). While originally the theory was aimed at explaining child and adult psychopathology in regard to disturbed relationships between children and their caregivers, as the research showed the long-term effects of early experiences with caregivers, more attention was drawn to adult attachment experiences. The research took two distinct paths; one focused on parenting and the other focused on romantic relationships.

As discussed above, Main and her colleagues focused upon the idea that adult "states of mind with respect to attachment" affected parenting behavior, which in turn influenced the attachment patterns of the parent's young children. The development of the Adult Attachment Interview (AAI) by Main and her colleagues has allowed researchers to explore adult attachment patterns in a variety of settings. Some of this research will be discussed later in this chapter.

Hazen and Shaver (1987), who had been studying adolescent and adult loneliness, began to explore the idea that chronic loneliness is associated with insecure attachment. They began to research ideas regarding the unsuccessful search for romantic relationships and it's possible link to previous attachment experiences. Hazen and Shaver devised a self-report questionnaire for adults based upon Ainsworth's three patterns of childhood attachment. The

instrument asked people to review their most important romantic relationships and decide which of the three types of attachment was most self-descriptive. In subsequent studies, this measure and a variety of versions of it have been used to explore personality variables, behaviors, and experiences in close relationships (Shaver and Clark, 1994; Shaver and Hazen, 1993).

Bartholomew (1990) utilized Bowlby's ideas about positive and negative models of self and of other to propose four adult attachment patterns. These are secure, preoccupied, dismissing, and fearful. Three of these attachments styles, preoccupied, fearful, and dismissing, represent insecure attachment patterns. These three are assumed to arise out of negative or inconsistent experiences with attachment figures. All four patterns are related to both positive and negative views of self and other.

Collins and Read (1994), have proposed that working models include four interrelated components: 1) memories of attachment related experience; 2) beliefs, attitudes, and expectations about self and others in relation to attachment; 3) attachment related goals and needs; and 4) strategies and plans associated with achieving attachment goals. Up to this point, most research has focused upon the second component of Collins and Read's model, that is the aspects of working models that are consciously accessible. There has been very little work done in the area of the aspects of working models that are not consciously accessible, and therefore may be expressed through behavior and other coded means.

Klohnen and John (1998) challenged the existing instruments being used to assess adult attachment styles, and developed a prototype measure of working models. They did this by reviewing self concept and personality measures and taking from them all of the adjectival descriptors and short phrases that "seem to be potentially or even vaguely related to attachment" (p. 119). They created a master list of 280 descriptors, and then took this master list to seven individuals familiar with the adult attachment literature.

Klohnen and John then asked these experts to rate each item in regard to its connection to each of the four attachment styles. The experts "rated the degree to which prototypical preoccupied, fearful, dismissing, or secure individuals would view each item as characteristic (or uncharacteristic) of themselves" (p. 121). These ratings were then placed on a 5 point rating scale that ranged from " definitely uncharacteristic" to " definitely characteristic." Klohnen and John found that the experts achieved considerable interrater agreement. Using this measure the researchers conducted two longitudinal studies, finding that the subjects had fairly distinct working models that were maintained over time.

Attachment Theory Applied in the Clinical Setting

Understanding and addressing working models of attachment is central to the therapeutic process. Bowlby (1988) stated that revisions to clients' internal working models of attachment are necessary for fundamental therapeutic change. It is only recently that attachment researchers have begun to make empirical connections in these areas. Attachment researchers' focus upon the

development of sound methodology for assessing internal working models of attachment (Main and Goldwyn, in press) has resulted in methodologies suggesting that working models affect how people interact with others generally (Kobak and Sceery, 1988) and with their therapists (Dozier, 1990; Dozier, Cue and Barnett, 1994).

Dozier and Tyrrell (1998) challenged previous methods of assessing adult attachment through self-report. They referenced Main, Kaplan and Cassidy's (1985) definition of working models of attachment which includes unconscious defensive exclusion of information from awareness. They stated that because of the role that unconscious rules and defensive exclusion are thought to play, self-report would not be an effective method of assessing adult attachment. Instead, Dozier and Tyrrell (1998) suggested that working models must be assessed through "discourse analysis of subjects discussion of their early attachment relationships. The analysis considers the role of unconscious process in the recall and manipulation of attachment related information" (p. 224).

Additionally, Dozier and Tyrrell (1998) made an important point in regard to the distinction between the constructs of attachment styles and internal working models. They stated that although these concepts share a conceptual framework, there are key differences that lead to different operationalizations. They stated the following:

> Assessments of internal working models are made through discourse analysis as subjects talk about thoughts and feelings regarding attachment figures. Attachment style is assessed through subjects' self report of relationships with currently important figures in their lives. Additionally internal working models are assessed in relation to earlier attachment figures whereas

> attachment styles are assessed in relation to current significant others. (p. 225)

Dozier and Tyrrell examined therapy relationships by distinguishing between the assessment of unconscious versus conscious process. Again a distinction was made between which attachment figure was the target; meaning an earlier attachment figure versus a current significant other.

Dozier and Tyrrell (1998) proposed a model of therapeutic change that suggested that changes in the client's working model of the therapist will result in, and in fact are prerequisites to more "fundamental change in working models of the generalized self and other" (p. 232). They referenced Bowlby's statements that there are three tasks in the therapist's work with a client. The first and primary task is to provide a secure base that promotes safe exploration. The second therapeutic task is exploration of current interpersonal relationships, and the third therapy task is the exploration of working models of earlier attachment figures and attachment experiences. Dozier and Tyrrell's model of therapeutic change proposed that changes in internal working models of self and other are created by corrective experiences with the therapist, psychological and behavioral exploration of current relationships, and psychological exploration of relationships with prior attachment figures. Dozier and Tyrrell stressed that these three tasks are not linear, and in fact must occur concurrently and in relationship to one another. For example, as client's working models frequently lead to expectations that are rigid and inconsistent with reality, "exploration of prior working models cannot wait until after a secure bases established; rather, the processes occur in tandem" (p. 238).

Using this theory, it would then follow that as the therapist responds to the patient in ways which do not match the patient's prior experiences and working models, the patient is able to gradually explore alternative models. Initially, the patient may experience the therapist's unfamiliar and unexpected responses as misattunement, and may react with displeasure, anger and dismay. These feelings and responses must be worked through both in the transference and the actual relationship between the therapist and the patient. As the relationship between the patient and the therapist becomes more secure, the patient is able to explore the nature of his expectations of significant others and the patient will feel safer in exploring other interpersonal relationships as well as prior attachment experiences.

Dozier and Tyrrell (1998) referenced Bowlby's (1977) definition of a true attachment figure as being perceived as " stronger and/or wiser" when they suggested the following:

> The therapist is perhaps a prototypical example of an attachment figure in adulthood. The relationship is care taking and non-reciprocal, and the client typically perceives the therapist as stronger and wiser. Thus, we expect that internalized representations of earlier attachment figures are central to approaches to the therapist. (p. 245).

These ideas of Dozier Tyrrell's match those of this researcher and are part of the theoretical foundation of this study.

Main and Goldwyn (in press) defined adult attachment as the individual's state of mind with regard to attachment. Different states of mind are associated with different patterns of processing attachment related thoughts, feelings, and memories. Main (1990) described three states of mind:

autonomous, deactivating and hyperactivating. Main described the autonomous state of mind as being related to primary attachment strategies, meaning that this is a state of mind related to having had appropriately available caregivers or having reformulated experiences with less available caregivers. In this state of mind, attachment related information can be processed non-defensively. Main described this as a primary strategy, because it allows the biologically based attachment system to achieve the intended outcome of providing protection to the organism. Secondary strategies are developed when autonomous strategies fail to produce desired outcomes. In an infant one might see this in the adoption of avoidant or resistant behavioral strategies for coping with unavailable caregivers. Rather than directly seeking out and obtaining comfort from the caregiver, the infant utilizes strategies that involve the deactivation or hyperactivation of the attachment system. Deactivation of the attachment system is characterized by attempts to turn attention away from the caregiver when the infant is distressed or needy. Hyperactivation of the attachment system is characterized by excessive vigilance and preoccupation with the caregiver. Main suggested that adults' secondary strategies parallel these infant behavioral strategies. Again, these ideas are part of the theoretical foundation of this study.

Dozier and Tyrrell (1998) described secure or autonomous working models of attachment as being characterized by opening, flexible, and non-defensive attention to attachment related issues. Therefore, one would imagine that a patient in this state of mind would be able to utilize therapy in a helpful manner.

Preoccupied states of mind are characterized by vigilant attention to evidence of caregiver availability. Kobak and Sceery (1988) found that college freshmen in this state, which can also be called hyperactivating, were perceived as dependent and vulnerable to others. A dismissing or deactivating state of mind could be manifested in a devaluation of significant relationships. It would follow that these different working models of attachment would be associated with different qualities of relationship with therapists. Dozier (1990) and Dozier and Tyrrell (1997b) suggested that individuals internal working models do affect their approaches to therapy. They reported that people approach therapists in much the same ways that they approach significant others in their lives.

In a study of client-therapist interactions (Dozier et al., 1996) patients were observed interacting with their significant others and with their clinicians on two tasks. The first was a low involvement task that provided baseline data for observational and self-report measures. The second task was more involving interpersonally, requiring that participants and partners work through interpersonal problems. Their findings suggested that patients using deactivating strategies have a tendency to reject significant others who raise issues that activate their attachment systems. Interestingly, the findings were very different when clinicians were considered as partners. In these cases, patients relying on deactivating strategies tended to reject clinicians less than patients who tend to utilize preoccupied or hyperactivating strategies.

Disruptions in the Therapeutic Relationship

While there has been a fair amount written, especially in the psychoanalytic literature, about disruptions in the therapeutic relationship, it has been primarily anecdotal and theoretical. There has been very little done in the way of empirical research in this area. The literature in this area has typically explored patients' reactions to disruptions in the therapeutic relationship in regard to planned vacations and therapist illness. There has also been a small amount written about disruptions caused by therapist pregnancy. The literature addressing disruptions caused by therapist illness or pregnancy (van Dam 1987, Schwartz 1987, Hernandez 1990, Schwartz 1993) has examined the transference issues that arise. These articles, using clinical examples, have approached the issue in a manner consistent with psychoanalytic theory, and have pointed out the necessity of clinically addressing patients' responses to the disruptions.

Ernest Wolf's 1993 article addressed disruptions in the therapeutic relationship from a Self-Psychology perspective. Wolf took up the idea of the significance and potential damaging affects of therapeutic disruption upon the patient. He wrote that "to the extent that the state of one's self depends on the relatively undisturbed functioning of a relationship with another person, so will the disruption of that relationship have serious consequences for the state of the self" (Wolf, 1993, p. 675).

Additional articles have been written (Abend, 1982; Dewald, 1982) addressing the countertransference issues that can arise for the therapist when he is dealing with an illness. These articles, again from a psychoanalytic perspective, challenged therapists to examine their own issues in regard to

mortality and helplessness. The articles pointed to therapists' denial, grandiosity and fantasies of "analytic immunization from the affects associated with life's disruptions" (Schwartz, 1993, p 191).

Eric Nuetzel took up the issue of therapeutic disruptions from another perspective in his 1991 article. In this article, Nuetzel examined the phenomenon of patient initiated interruptions and terminations. He reviewed Freud's case of Dora, and then described his own similar experience with a patient. He pointed to countertransference issues related to his decision to terminate his own training analysis as contributing to his patient's premature departure. Nuetzel's article again points to the necessity of addressing issues in the treatment related to interruption, lest they go unexplored and result in more permanent disruption.

Stein, Corter and Hull (1996) utilized both attachment and object relations theory as theoretical background for their study of the impact of therapist vacations on inpatients with borderline personality disorder. The findings of this study, one of the only empirical studies in this area, challenged the commonly held belief that self-destructive acts in borderline patients may be especially prevalent around therapist vacations. Their findings did however indicate that other symptoms, including somatic complaints did increase directly before, during and after therapist vacations.

While the literature addressing disruptions in the therapeutic relationship is written from a variety of perspectives, with very little research available, two conclusions are common to all of the articles. Disruptions occur in all

therapeutic relationships and the importance of understanding and addressing the affects of these disruptions must not be overlooked.

Conclusion

Although direct evidence that working models and attachment patterns affect the treatment relationship (and consequently the efficacy of the treatment) is limited, the research and theory in infant and adult attachment reviewed in this chapter provide a solid foundation for further study. The research reviewed, as well as this researcher's own experience, indicates that working models and attachment patterns are brought into the therapeutic relationship. This can provide the therapist and patient with an invaluable, and in fact crucial, opportunity to explore these working models and attachment patterns as they manifest in the therapeutic relationship. This knowledge can then be generalized into the patient's other significant relationships. In order to successfully do so, however, there must be more research to provide information about how these attachment issues actually manifest in the therapeutic setting.

Additionally, the very nature of relationships, including the therapeutic relationship, involves separations and interruptions. Holiday breaks, illness and other disruptions are inevitable in all therapeutic relationships. In fact, one might argue that they are crucial in order for the patient to be able to rexperience and work through prior experiences of separation and loss. In this view, the more we can learn about the effects of these disruptions upon our patients, the more equipped we will be to assist our patients in negotiating and

learning from these separations and reunions. This researcher hopes that this study will be of some value in that area.

CHAPTER III

METHODOLOGY

This chapter describes the methodology of the study. The chapter will begin with a description of the research design with particular focus upon the framework of qualitative research. Following this will be a description of the procedures used for selecting subjects, and the details of the data collection process. The chapter will conclude with a description of the data analysis process.

Introduction

In the literature of human and social sciences, two paradigms are most widely discussed. They are the qualitative and quantitative theories and methods utilized in these fields. Creswell (1994) defined a qualitative study as being one that is "an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting" (p. 100). In a qualitative study, the individuals involved in the research situation are the ones who " create the reality." This is differentiated from quantitative research that views reality as objective and independent of the researcher.

Qualitative research has underlying assumptions that are distinct from that of quantitative research. Merriam (1988) described underlying assumptions of qualitative research as including concern primarily with process, rather than outcomes or products, interest in meaning, involvement in fieldwork, being

descriptive and inductive. In a quantitative project it is important for the researcher to keep her values out of the study. In qualitative research, the investigator acknowledges her values and biases, in keeping with the nature of information gathered from the field.

Morse (1991) stated that one of the characteristics of qualitative research problem is that the need exists to explore and describe the phenomena and to develop theory. This researcher feels that this is the case in this study. Although there has been some research relating to the use of attachment theory in the clinical setting and other research on attachment patterns as manifested in adult relationships (see chapter 2), there has not been research which describes the ways in which attachment patterns may be manifested by the patient in the therapeutic relationship upon reunion following a separation. This study intended to do just that, by utilizing a qualitative paradigm in the collection and analysis of data.

By definition of qualitative work, this research would be classified as descriptive study of the therapy process, with the intent being to describe specific phenomena of separation and reunion in the therapeutic relationship. It is the hope of this researcher that this preliminary study has lain the groundwork for further research and generation of theory.

Research Design

This research was intended to describe and explore the response of the patient following a separation and upon reunion following a planned winter holiday break in the therapeutic setting. This researcher was particularly

interested in any possible relationship between the patients' responses and attachment patterns. This study was intended to be exploratory and descriptive in nature, with the hope of beginning to identify ways in which patients manifest reunion behaviors, and consequently attachment patterns, in the therapeutic relationship. As is the nature of qualitative research, data was analyzed in a manner to seek out patterns in the observed responses. In order to do this, audio recordings were made of the first session following the winter holiday break. Additionally, clinician ratings were obtained regarding the patients' use of therapy as well as some basic demographic data regarding the patients' length of time in therapy. These measures were scored and utilized to provide additional information regarding attachment style, behavior in therapy, and response to the separation and reunion in therapy.

The decision to use a holiday break was made because this provided a naturally occurring separation and reunion to study without unnecessarily imposing one upon the therapeutic relationship. This researcher felt strongly about being sensitive to and respectful of the therapeutic relationship, and attempted to take all measures necessary to ensure that this research did not create undue stress for the subjects. By audio recording an already scheduled session following a break that was occurring independently of this study, this researcher hoped to create as little disruption as possible in the therapeutic relationship. In fact, it was the hope of this researcher that this study would provide information for the subjects and their therapists which would serve to enrich the therapeutic process.

Procedures for the Selection of Subjects

Participants in this study were recruited through Airport Marina Counseling Service, a mental health clinic located in the West Los Angeles area. This researcher presented a request for participants in this study, along with a brief description of the study, to the board and staff of the clinic. The clinical supervisors at the clinic then presented the request for participation in this research study to their supervisees in individual and group supervision sessions. Any interested therapists were then instructed to discuss their interest with their supervisors. The supervisors and therapists worked together to determine if there were any patients who would be appropriate for this study. Therapists and supervisors were instructed to screen out any patients who may be prone to experiencing undue stress as a result of participating in the study.

Following these initial determinations, three therapists consulted with this researcher to have any questions or concerns about the study addressed. At this point, the therapists were instructed to approach their patients, with the guidance of their supervisors, about participating in the study. All patients were informed that their participation in the study was purely voluntary, and that they may decline to participate, or withdraw from the study at any time without penalty.

This researcher met individually with each of the three therapists prior to the reunion session to go over the informed consent forms as well as the data collection procedures. The therapists were asked to wait until after the reunion session was completed to look at and complete the demographic information and clinician rating scales, so as to avoid any unnecessary influence upon the

session completing these forms may have had. Two of the therapists selected two patients to record, and the third therapist selected one patient.

The patients, as the subjects of the study, were all voluntary clients of the clinic. Although this study did not control for diagnosis, no patients with active psychotic disorders were included. Additionally, as the clinic is psychodynamic in orientation, all of the subjects were at a level of functioning that allowed for exploration of the relationship between the therapist and patient, both in the transference and in the external reality. While the subjects all had a certain level of ego strength and psychological sophistication, there was diversity in regard to ethnicity, educational level, age, gender, socioeconomic status and prior therapeutic experience. As this is an outpatient clinic, one can make certain assumptions regarding the general population who accesses these services, as differentiated from a private practice setting or a county run facility.

This setting was chosen for several reasons. Due to the training nature of the clinic, all clinicians providing therapy were supervised interns. In addition to being supervised by experienced, licensed practitioners, all of the participating clinicians were in, or had recently been in a graduate program setting where process and audio recordings of sessions were part of the training process. Patients at the clinic came from a variety of socio-economic, ethnic, cultural and educational backgrounds. They were all oriented as to the training nature of the clinic upon their initial intake, and were therefore made aware of the dynamics common to training facilities such as their therapists' intern status and time limited length of stay at the clinic. Due to these conditions, this researcher

believes that the patients, as the subjects of the study, were protected from any undue stress as a result of participating in the study. Again, it is the belief of this researcher that participation in the study may have been beneficial to the patients in regard to providing valuable clinical information to the therapist and patient.

In regard to the relationship between the clinicians and the patients, as the clinic was a training facility, it was typical that the therapeutic relationship had beginning and ending dates determined by the intern's academic schedule. As a naturally occurring holiday break was used, there was no undue disruption of the therapeutic relationship caused by the research study. Additionally, the participants were assured of confidentiality. According to the Department of Health, Education and Welfare Policy on Protection of Human Subjects guidelines as adopted by the California Institute for Clinical Social Work, all participants in this study were "at minimal risk".

While the number of subjects was small, and not randomly selected, in qualitative research this is not considered a problem. Glaser and Strauss (1967) stated that when the purpose of research is to generate theory, the number of cases is less crucial. "...a single case can indicate a general conceptual category or property: a few more cases can confirm that indication" (p. 30).

Data Collection

Two methods of data collection were used. The first was an audio recording of the first therapy session following the separation caused by the winter holiday break. The second method of data collection was a clinician rating scale

adapted from one used by Dozier (1990) to assess patients' level of functioning in treatment. Additionally, the therapists were given a brief demographic questionnaire regarding the patients to give the researcher information that will assist in controlling and/or assessing variables such as length of time in therapy with this therapist and previous therapeutic experiences. Both the therapists and the patients were given an informed consent form by the researcher, and offered the opportunity to ask any questions they may have regarding the study and/or data collection procedures. All subjects were asked to sign the informed consent form, and were verbally reminded that they may refuse to answer any question and/or withdraw from the study at any time with out penalty or adverse response.

Instrumentation

In addition to the audio recording of the reunion session, a demographic questionnaire and a clinician rating scale was administered to the therapists. The items in the demographic questionnaire gathered the following demographic data: Date of birth, gender, ethnicity, length of time at Airport Marina Counseling Services, level of education, current employment status, length of time in treatment with the current therapist, anticipated termination date if any, and any prior treatment history.

Clinician Ratings

An eight item clinician rating scale adapted from one utilized by Mary Dozier (1990), with her permission, in her study of attachment organization and treatment use was administered to the clinicians participating in the study.

Clinicians were asked to rate patients on continuous ratings scales with defined end anchors. Clinicians rated the patients in four areas regarding compliance with scheduled appointments, level of help seeking or rejecting behaviors in therapy, level of self-disclosure, and overall use of treatment. There were two items in each of the four areas.

Data Analysis

Analysis of the audio recordings was done following qualitative procedures. After the data collection, it was discovered that one of the therapists had used a tape recorder that did not function properly. Attempts were made to improve the sound quality of the recordings in order to transcribe the data, but these proved unsuccessful. At that point, it was decided to not use these two sessions, and to proceed with the data analysis of the three remaining sessions recorded by the other two therapists participating in the study. A total of three audio taped sessions were transcribed and coded.

Creswell (1994) described a process of data analysis whereby the researcher takes "a voluminous amount of information and reduces it to certain patterns, categories, or themes" (p. 154). Additionally, Creswell (1994) stated that "Flexible rules govern how one goes about sorting through ...material" (p. 154). In this study, both the audiotapes and the transcriptions were used in the analysis. This researcher then listened to each audio taped session two times. This researcher then read each transcript, and followed this by reading each transcript while listening to the audiotapes. At this point notes were made upon the transcripts to indicate particular inflections, pauses and other affective data

that was gleaned from the audiotapes. Each transcript was then reviewed line by line, and then broken up into units of analysis that consisted of each single idea, thought and feeling communicated by the patient. This at times took the form of a partial sentence, a complete sentence, or a string of connected sentences.

In the data analysis, the patients' ideas, thought and feelings were coded. These formed the basis for generating categories and themes based upon this researcher's clinical judgement and knowledge of the attachment literature. It is important to note that as the focus of the study was on patients' attachment behaviors, the therapists' comments were not coded. They were used only for contextual information to help establish how the patients' material would be coded. As more data were introduced, this researcher assessed to see if new categories and codes emerged. Additionally, as an ongoing process in the data analysis, relationships and interrelationships among the categories were examined.

The coding was done sequentially with the coding of one patient's entire session being completed before moving on to the next patient's session. As the coding of the first therapy session progressed, it became clear that there were two distinct kinds of data emerging. One was attachment related themes in the material that the patients presented in the reunion session, and the other was behaviors in which the patients engaged during the session while they were presenting their material. This researcher made a decision to analyze the data twice in order to code the data in these separate areas. What resulted was

one set of attachment related themes as presented in the patients' material, and another set of categories of attachment activating and attachment deactivating behaviors in which patients engaged during the reunion session simultaneously to their presentation of material.

Cresswell (1994) cited Yin's (1989) proposed model of data analysis which included

> "a) Searching for patterns by comparing results with patterns predicted from theory or literature; b) 'explanation building' in which the researcher looks for casual links and/or explores plausible or rival explanations and attempts to build an explanation about the case..." (p. 156).

This model provided guidance in analyzing the data provided by the audio taped sessions and transcripts. The analysis of the clinician ratings was done by scoring the ratings and utilizing the findings only as descriptive data regarding the subjects.

CHAPTER IV

RESULTS

This chapter presents the findings of the study. It begins with a brief overview of the methodology used in the study, including the data collection and data analysis procedures. The demographic information on the subjects and the presentation of the results of the clinician ratings follow. The results of the data analysis as relevant to the research questions of this study are presented, and the chapter concludes with a summary.

Overview of the Methodology

The coding was done sequentially with the coding of one patient's entire session being completed before moving on to the next patient's session. Patient "Anne's" data was coded, followed by patient "Louisa" and then patient "Mary". As the coding of the first therapy session progressed, it became clear that there were two distinct kinds of data emerging. One was attachment related themes in the material that the patients presented in the reunion session, and the other was behaviors in which the patients engaged during the session while they were presenting their material. This researcher made a decision to analyze the data twice in order to code the data in these separate areas. What resulted was one set of attachment related themes as presented in the patients' material, and another set of categories of attachment activating and attachment deactivating behaviors in which patients engaged during the reunion session simultaneously to their presentation of material.

In the course of the data analysis this researcher observed that changes in the patients' attachment related behaviors occurred over the course of the session. These changes in patients' interaction with the therapists over the course of the session suggested phases of beginning, middle and end. This was taken into consideration when conceptualizing the themes as they were identified from the clusters of categories that were formed.

Demographic Information and Clinician Ratings

As a background to the data analysis, the demographic information pertaining to the subjects and the results of the clinician ratings are presented. Throughout the presentation of the data, any information that may threaten the confidentiality of the patients and therapists has been omitted.

Three patients contributed material for analysis, two who worked with one therapist, and a third who worked with a different therapist. All subjects were voluntary patients at Airport Marina Counseling Service, a private, non-profit mental health and family counseling agency located in Los Angeles. All three patients were given pseudonyms to protect their confidentiality. The therapists were interns who were receiving supervision by the same seasoned, licensed clinician. The general orientation of the therapy was psychodynamic.

"Anne"

Anne was an American born Asian female in her 30s, who had completed an undergraduate degree and was professionally employed full time. At the time of the data collection, Anne had been at the clinic for approximately 6 months, and her current therapist was the original one assigned to her. Anne reported

two very brief prior experiences with therapy, one for 2 months 5 years prior to this treatment episode, and another for 5 sessions, 4 years prior. Both prior episodes were for depression. Although Anne's therapist was an intern, there had been no specific date set for the termination of the therapy.

On the clinician-rating scales, Anne's therapist noted that, at the time of the data collection, Anne was consistently present and on time for scheduled appointments. She had never requested a session outside of regularly scheduled ones, and consistently sought out the therapist's opinions and support. Anne did discuss significant problems, and "usually" acknowledged feelings of distress and anger. Anne's therapist reported that Anne utilized therapy very well and had benefited from it.

"Louisa"

Louisa was a biracial female in her 20s who completed high school and a two-year professional certificate in the health field. She was employed part time in sales. At the time of the data collection, Louisa had been at the clinic for 1 1/2 years and had been with her current therapist for 2 1/2 months. Prior to the current therapy episode, Louisa reported several brief experiences with therapy over the previous 10 years. Louisa had been aware from the beginning of this therapeutic relationship that it was time limited to 8 months.

On the clinician-rating scales, Louisa's therapist noted that, at the time of the data collection, Louisa was consistently present and on time for scheduled appointments. She had never requested a session outside of regularly scheduled ones, and "usually" sought out the therapist's opinions and support.

Louisa "usually" discussed significant problems, and "usually" acknowledged feelings of distress and anger. Louisa's therapist reported that Louisa utilized therapy well and had benefited from it.

"Mary"

Mary was a Caucasian female in her 40s, who completed 10th grade and worked part time in a service related field. At the time of the data collection, Mary had been at the clinic for 1 1/2 years and with her current therapist for 2 months. Mary reported one prior therapy experience lasting 2 years at the same clinic, 10 years prior to the current therapy episode, following a divorce. Mary had been aware from the beginning of this therapeutic relationship that it was time limited to 8 months.

On the clinician-rating scales, Mary's therapist noted that, at the time of the data collection, Mary was consistently present and on time for scheduled appointments. She had never requested a session outside of regularly scheduled ones, and sought out the therapist's opinions and support "about half of the time." Mary "usually" discussed significant problems, and acknowledged feelings of distress and anger "about half of the time." Mary's therapist reported that Mary utilized therapy well and had benefited from it "somewhat."

The above demographic data and clinician-rating information are presented as a background to the data analysis. Because of the small number of subjects involved in the study, no generalizations or correlations between patient characteristics and observations made during the therapy sessions can be established with any degree of confidence.

Overview of Findings

In the first round of data analysis, the data were coded for any attachment related material presented by the patients in the reunion session. The coded data was then clustered into categories based upon similarities in content. Three distinct themes were identified from the categories. The themes were chosen to describe the affective reactions of the patients to the separation, as expressed in the reunion sessions.

Each theme consisted of a number of categories of expressed thoughts and feelings comprising a portion of the theme. The three major themes with their categories follow.

Theme 1, "Patients' Expressions of Feelings of Loss." Categories included three related issues:

1. Feelings of sadness.
2. Feelings of lack of control.
3. Lack of, or decrease in, coping skills.

Theme 2, "Patients' Expressions of Feelings of Anxiety." Categories included two related issues:

1. Fear of death or harm to self and/or a loved one.
2. Feelings of insecurity (defined as lack of confidence or apprehension.)

Theme 3, "Patients' Expressions of Feelings of Anger." Categories included two related issues:

1. Feelings of frustration.

2. Feelings of impingement (defined as feeling that a person or thing has encroached upon ones' self or ones' rights.)

The second round of data analysis resulted in two categories which examined patient behaviors engaged in during the sessions. The categories and their subcategories included:

Category 1, "Attachment Activating Behaviors." Subcategories included three related types of behaviors:

1. Direct Verbalizations
2. Speech Patterns
3. Humor and/or Laughter
4. Physical Actions

Category 2, "Attachment Deactivating Behaviors." Subcategories included four related types of behaviors:

1. Direct Verbalizations
2. Speech Patterns
3. Humor and/or Laughter
4. Physical Actions

Another aspect of the data analysis that should be noted has to do with the concept of shame as related to perceived attachment ruptures (Karen 1998). While this researcher found evidence of shame reactions in the data of all three patients, categorizing it was found to be problematic. This was because what this researcher identified as shame reactions proved difficult to separate from what was viewed as patients' defensive reactions to the shame. For example,

this researcher believes that patients' defensive responses to feelings of shame resulted in what was directly verbalized by the patients as feelings of anger, lack of control, frustration and impingement. The shame reactions cut across several categories, and were not as readily identifiable as the other affective states that were identified as categories as the patients did not directly verbalize them. It was therefore decided to address the issue of shame further in the discussion section rather than to attempt to fit it into the presentation of the results of the data analysis. The findings that pertain to each major theme and its categories will now be presented.

Theme 1: Patients' Expressions of Feelings of Loss

This theme emerged out of the relationship among several categories found in the data. The categories; feelings of sadness, feelings of lack of control, and lack of, or decrease in, coping skills, were expressed by all three patients to varying degrees. Each individual seemed to have her own way of manifesting and expressing feelings of loss. Anne was consistently more able to identify these feelings and relate them to the separation. Louisa seemed to be highly defended against feelings of loss, in particular feelings of sadness, and repeatedly denied having these feelings. Mary verbalized the feelings, but this tended to be in a more displaced fashion, with less inclination to explore these feelings as related to the separation and her own dynamics. All of the patients expressed having experienced feelings in each of the three categories, as did they express having experienced them with a sense of loss. Feelings of sadness were related to a sense of loss or unmet need, and feelings of lack of control

and lack of coping skills were experienced as a loss of a previous or desired level of functioning.

Category 1: Feelings of Sadness

All three patients in this study expressed feelings of sadness in the material they presented in the reunion session. As noted above, Anne expressed feelings of sadness in a variety of ways through out the session. Anne's expressions of sadness tended to be related to memories and experiences where she felt she had unmet emotional needs. This was typically related to feelings that she did not have the emotional support, love, containment, and sense of self that she wished she did.

An example of this was observed in Anne as she described feeling physically ill over the break. Anne stated that she felt there must be some "psychological reason" for her illness which manifested in "sleeping and not having any energy at all, and then just feeling totally sorry for myself."

Anne was then able to relate these feelings to childhood, when she reported that she would "make herself sick" in order to seek out nurturance from her mother. Anne expressed feelings of sadness that she did not receive the care she longed for, both in the past, as well as during the separation from her therapist by stating:

> I don't remember what it was like - what it was like to be loved.

Later in the session, Anne further expressed her feelings of loss and sadness when she stated the following in regard to her boyfriend:

> I mean, I'm getting something I never had before. I had a secure home, I always got fed, but I didn't get heard and listened

> to and responded to and touched and loved and stroked and cuddled. I never had that...

As noted above, Louisa's expressions of sadness tended to be a direct denial of such feelings. Louisa displayed a pattern of presenting material about interactions with others that seemed to cause her some distress. While presenting material Louisa would express feelings of sadness or loss, and would then go on to contradict herself stating that she did not have these feelings. An example of this reaction to feelings of loss and sadness occurred when Louisa was describing her ongoing struggles to trust people, and how painful this can be for her. When her therapist reflected these feelings of sadness, Louisa explained why she was not going to have them.

> Forget that. You know. My life is too short. I mean, I've been through like --- You know, I almost died three times, you know, in my life. You know. I was like in -- I... I , you know, if I didn't wake up in time I would've been burned in 1990 because a space heater caught onto my bed, and I woke up in time to smell the flames. You know. And then...and then a gun was pulled on me. And then I almost committed you know suicide. If I had taken three more bottles of pills, of sleeping pills, really I would have been dead. So, I guess I decided you know that my life is you know too short you know, to to be a (sighing) to be unhappy, or to..to waste time being unhappy.

Louisa also described feelings of sadness and longing, but rather than attributing these feelings to herself, displaced them onto a coworker.

> She just has these needs to have everybody love her, and she's like that all the time...She's just waiting, you know? It's sad.

Another way that Louisa presented feelings of loss and sadness was different from the findings of Anne and Mary. Rather than expressing these feelings about past or current experiences, Louisa expressed sadness about anticipated

losses. An example of this occurred when Louisa described conflicts with a peer at work, and her inability to resolve them. While describing her attempts to discuss her difficulties with her boss, Louisa then anticipated that this would not work out, her boss would take the other woman's side, and Louisa would lose her job.

Like Anne, Mary's expressions of sadness were related to feelings of loss and unmet needs as well. However, Mary had a tendency to shift away quickly from feelings of sadness to feelings of anger or to other topics. An example of this was seen when Mary discussed her concerns about her teenage son who is having a relationship with a younger girl whom Mary feels is "troubled." As Mary described her concerns, she recalled her own experience as a teenager.

> When I decided I was having kids...I really wasn't...I was only a year older than her when I started to try to have kids so I could get married. So, I mean, I know what it's like to be a teenager and have like all your teen years, or most of them, like swallowed up being a parent...My mother wanted me to have an abortion after she found out I was pregnant with, oh, all of my kids...

In the audio recording, it was clear from the tone of Mary's voice that she felt sadness and loss as she presented this material. However, she quickly moved away from discussing her own feelings and spoke about her daughter when the therapist probed for more of Mary's feelings. Mary was able to continue to express sadness and loss, but displaced onto her daughter's experience of an abortion.

> My youngest one didn't want to (have an abortion), but she was...her husband made her do it. He said, "If you don't do it I'm going to steal the baby and move to Mexico." You know, so, I took her. I mean, I didn't want to, I wanted to run in there every five seconds, "Don't do it, don't do it!" But I knew I couldn't do that.

> I had to keep my mouth shut. That's her decision, and she's the one who had to live with it, not me. She...she had it...So, it's always bothered her since she did it. So...how weird...

Another example of Mary's expression of sadness occurred in the last third of the session when she was describing her relationship with her boyfriend, a married man. Mary described feeling sadness and loss due to the fact that she was beginning to accept the reality that her boyfriend was not going to commit to her in the way she wanted. Mary was only able to briefly express the feelings of sadness as she described leaving the relationship.

> That is what I need to do. It is what I have to do. And that is...it's what I need to do for me. It's what I have to do for me emotionally. And it's going to be hard for me to let go of that...I've been grieving for a long time now really...

All three patients expressed feelings of sadness in the reunion sessions. The feelings of sadness were related to a sense of loss. An interesting aspect of the findings was the differing nature of the feelings of loss. Included in the data were feelings of anticipated loss, loss of something in the past, and loss of what never was, but was longed for.

Category 2: Feelings of Lack of Control

All three patients expressed having had feelings of a lack of control during the holiday break. Anne recognized these feelings as related to her internal state. Louisa and Mary were more prone to viewing the loss of control as externally located and tended to feel more persecuted by it. Louisa and Mary's feelings of persecution as a result of perceiving a lack of control could be viewed as an anxiety reaction (as per Klein's 1946-63 discussion of persecutory anxiety). The feelings of lack of control were clustered into the overarching

theme of loss, as they were reported in the context of a decrease in, or loss of a previous or desired level of control.

Anne described repeated instances of feeling a lack of control, and described her discomfort with this feeling. This feeling of lack of control manifested itself in a variety of ways during the holiday break. Anne described the instance of being physically ill and becoming distressed at feeling out of control of her physical health. She also reported how she felt compelled to do certain things, such as buy a particular kind of lotion and get a dress that was on sale. Anne described the feeling connected with these events as being a strong sense that if she didn't do these things, everything would "disintegrate." Anne explored these feelings and related them to a general feeling of lack of control, and her efforts to feel a sense of control in her life.

> Sometimes you just you just focus on something that you know is you gotta have it, now, I have to have it. And it's usually something really insignificant. I can't remember, what was that thing? It has to do with this dress -- It has such a long story. I had to somehow get the sale price, and I obsessed for it -- This took me, oh a good three hours to take care of this thing. This was on my day off. (laughing) I don't know what that's about. Maybe my wanting to control, I think. Wanting to control things... I feel like I don't have any control anyway sometimes, that the little control that I do have -- like stupid things, like making sure I get the sale price for this dress, or...making sure I get this lotion. Somehow almost reinforces my having any control.

Anne also described an incident during the break when she became upset at the noise her neighbor's children were making. She stated that she recognized that the noise wasn't very loud, but that,

> It is that sense of like...I feel out of control. I want to control it. I want them to be quiet...to tell them to be quiet. And it's not even anything really big.

Anne then related her feelings of lack of control to her overall sense of loss during the break. She was able to identify that attempting to control the things she could, like the lotion and the dress, temporarily soothed her. She was also able to recognize that the feeling of lack of control was a result of her internal state rather than external events.

Later in the session, Anne brought up the feeling of lack of control in reference to a number of different issues including her eating and her job. Toward the end of the session, Anne related her feelings of lack of control to an overall fear of loss. She described feelings of conflict with her boyfriend when he didn't respond to her the way she anticipated he would. This led her to have a more conscious understanding of how her desire for control was a defense against fear of loss.

> Yeah, because like ... 'cause when I -- I don't know. Then, when you said I was afraid, that was like the first thing that I could think of, that I... I gotta -- really know... like, okay -- so, what if I couldn't get this dress on sale? So what if I couldn't get this lotion? Then having the... how I would look at it -- as sort of a loss or something? Like, what...okay, so the the control is wanting ...it's like a what... I equate that control or whatever -- If I don't have the control I'm afraid of losing control... or losing...

Louisa's expressions of feelings of lack of control manifested differently from Anne. While Anne was aware of her feelings and the discomfort associated with them, Louisa seemed to be less conscious of the feelings and related behaviors. As stated above, Louisa viewed her feelings of lack of control as being caused by external factors, and tended to defend against these feelings using the defenses of projection and reaction formation (Freud, 1963-74).

Examples of the projected feelings of lack of control included Louisa discussing at length her frustrations with her coworker, whom she reported to be unreasonable, bossy, agitated and controlling.

> She's sensitive, and the only way for her to feel control over the whole situation, I figured out...is to be you know, this us versus them kind of thing.

During this discussion, Louisa exhibited the defense of reaction formation as she alternated between expressing her displeasure and feelings of lack of control over the situation, and stating:

> No. It's a bad situation with her. She's a difficult person. But she is warmhearted, at times. And I did, you know, it was liberating for me was -- for me to say to Gary, "I don't like Erica. I don't like her at all. And then um I told him I don't like her, but I love her you know. I love her as a person. You know, so I love Erica, and I don't, I don't like, you know, her things, her stuff. You know. I don't like it. But I do, I do like her. She's a nice person. I don't personally like want her in my life. I don't hate her, I love her, she's a great person.

Another example of Louisa's expression of feeling of lack of control was noted in her discussion of her attempts at problem solving with this coworker and her boss at work. Louisa stated her intention to address this issue again with her boss and expressed her feeling of lack of control by anticipating that her boss would take her coworker's side, and she would "have to terminate the job."

Louisa expressed her feelings of lack of control and displayed an attempt to regain some control in a concrete manner. Louisa brought in a list to show her therapist. When asked what she was holding, she replied:

> Oh, stuff looming in my head, literally. I wrote all the stuff that's bothering me in my head.

Later in the session, Louisa showed the list to her therapist. She explained in detail how, in her efforts regain a sense of control, she had written down all of her goals on one side of the paper, and all of the things she perceived as obstacles to these goals on the other.

Mary's feelings of lack of control were expressed in a general feeling of powerlessness. She described this in a variety of situations, primarily having to do with interpersonal relationships. Specifically, Mary described feeling a lack of control over her three children's behaviors. She expressed this feeling in regard to her son's risk taking behaviors with his girlfriend, her youngest daughter's apparent very poor judgement, and her elder daughter's struggles with substance abuse and suicidal ideation. Examples of this include the following:

> (In regard to her son's sexual activity) Well, I wish he wouldn't, but I know no matter whether I say yes or no he's going to do it anyway. I really know that.

> (In regard to her daughter's hospitalization) There were some pretty scary-looking kids there. I really didn't like leaving her there, but I didn't have much of a choice. They took that out of my hands and put her there anyway. And, um, she, you know, she wanted to have sex, so they they put her on the pill. They told me, Well, this is what she wants to do, you know, and what's your thought on it? And I thought, well, you know, how could this happen in a hospital? So, they said, Okay, fine. That's what they did. So, as soon as it took effect for her she was right on that. So... I was like God, I couldn't believe she did that in the hospital. I mean, they were supposed to have been you know, really watching them real well.

Although she did not identify the connection between her feelings of lack of control as a child and her current feelings, Mary did discuss how she got pregnant as a teen in order to get married and move away from her parents.

She identified this as a somewhat unsuccessful attempt to feel some control over her life.

All three patients described having ongoing feelings of lack of control during the holiday break. Additionally, all three patients expressed a level of discomfort with these feelings, and the sense of lack of control was related to feelings of vulnerability and powerlessness. While in some cases, patients reported attempts to regain a sense of control, they reported that these attempts were not ultimately successful.

Category 3: Lack of, or Decrease in Coping Skills

Attachment theory would explain the lack of, or decrease in coping skills as a result of a separation from an attachment figure as indicating the individual's inability to keep an internal representation of the attachment figure sufficiently in mind. A decrease in coping skills can be viewed, among other things, as a decreased ability to regulate the affective states (sadness, anger, and anxiety) that appear in the other themes. This researcher included the data related to decrease in coping skills in this category, as the patients spoke of experiencing it as a loss. The data relating to the specific affective states is presented in the other themes.

All three patients reported a lack of, or decrease in coping skills over the holiday break. Anne was aware of the decrease in her coping skills, and made some connections between this decrease and the separation from her therapist. Louisa and Mary also described a lack of or decrease in coping skills, but did not express a direct connection to the separation. However, both

Louisa and Mary did express their feeling that therapy sessions and contact with the therapist increased their coping skills.

Anne described a number of situations over the holiday break where she felt a decrease in her coping skills. She attributed her negative emotional reaction to her physical illness as a loss of coping skills as she and her therapist discussed Anne's "critical voice." Anne described feeling very critical of herself in regard to her appearance, her ability to relate to her boyfriend, and her work performance. Anne specifically identified the "return of the critical voice" as occurring during the week that she did not see her therapist, and stated that now that she was back with the therapist,

> It was like all of a sudden I realized today that that's kinda what I've been doing to myself all week.

Anne also attributed her decrease in ability to tolerate the stresses of work and her personal life to the missed therapy sessions. She described feelings of inability to cope the way she "has learned to in here (therapy)" in instances with herself, her boyfriend, and at work. Anne described a situation with her neighbors making noise and stated:

> Something like that again is totally out of my control. But, It's like my inability to kind of like cope or something.

Anne also described a process that occurred over the break when she recognized that she was being overly critical of herself, but could not seem to pull herself out of that state of mind until she was reunited with her therapist.

> Well, and then the awful part of me is like, okay, you thought you liked yourself, (patient's name), but you REALLY don't. You know, it's like, why can't I just maintain this, that? Why can't I just say I like myself. I like who I am, I like where my life is -- I love the relationship I'm in -- and then when I start getting negative, it, it's

> almost like I take that and go -- that's the real me. Oh, you just think you're happy. Or, ooo -- God, and when I'm saying this now I can clearly see it ...

Louisa expressed a decrease in coping skills over the holiday break in two primary areas, interpersonal relationships and independent living skills. Louisa described in detail the conflicts she had over the break with a coworker, and her inability to resolve them in a satisfactory manner. Louisa described feeling particularly negatively affected by interactions with her coworker, and reported that the attempts she made to address the situation were not helpful. Louisa expressed a sense that she should have been able to resolve this situation and that she just wasn't as able to do so as she thought she would be.

> So, I'm not handling it well, I just can't stand her negative energy. You know. And I don't know if there's any scientific proof, or if it's just all what I'm you know construing in my head, but I feel uneasy around her you know. I feel like you know I'm coming to you and I'm unraveling my nerves on Monday, you know. And all this tenseness. She's just -- She.. I'm tense around her. You know, and it's not a little thing. I'm really uneasy around her. Uneasy. She just -- She's a toxic person. She's toxic to my system. I don't like those people. You know.

Louisa also described feeling overwhelmed with "life tasks" over the break. She described a feeling that she simply couldn't seem to keep her thoughts organized in regard to the things she needed to do in order to move forward with her life. Although she did not relate the overwhelmed and disorganized feeling directly to the separation, it is notable that she reported that she was able to implement a solution to this problem on the day of the reunion session.

> So, I I've gone back. I'm going ... today I decided to go back to writing things down. That way I can keep track of everything. I've got my goals over here...and her is the stuff I need to do. You

> know? So I've got it numbered here like in order of importance and like what has to come first.

Louisa then went on to express satisfaction with this plan and an increase in her feeling of ability to manage her life.

Mary's expression of decrease in coping skills focused upon her children and her boyfriend. Mary expressed an overall sense of an increased level of stress and a decrease in her ability to tolerate the various stressors in these relationships. While Mary did not directly express a connection between the break and her decrease in coping skills, she did express her belief that her relationship with her therapist is important to her and assists her in coping with life stressors. When describing her attempts to look for a job, she stated the following:

> See, I've got, I picked up two applications, um, that I could work night shifts or day shifts. I think, with, you know, the anxiety and the pressure and all that stuff which is too -- I would much rather do something physical, because when I was doing the housekeeping stuff I felt so much better emotionally, physically, mentally, everything. I felt better, because I was actually doing something, not just sitting there thinking, you know. And I, and it seems to work better for me, so, this is going to be a total career like thing for me to change, to try to do something different. I don't care if I have to do stock. I don't care if, you know, what I have to do exactly, just as long as it's something that um -- and I may have to get two jobs -- one in the day and one at night. But, I always put on there my Wednesdays <u>have</u> to be free, because I have to come here. You know, it's like my serenity, you know, my place for me.

In this category, all three patients expressed a feeling of increase in stress and decrease in coping skills during the separation. Anne was more able to directly relate the decrease in coping skills to the separation from her therapist. Louisa and Mary, who did not make a direct verbal connection between the

decrease in coping skills and the separation, did both express a strong sense that their therapy significantly assisted them with their coping skills. All three patients described the decrease in coping skills as being experienced as a loss of a prior level of functioning, which seemed to be linked to the loss of the missed therapy session.

Theme 2: Patients' Expressions of Feelings of Anxiety

As discussed in Chapter II, the literature on attachment indicates that individuals have reactions to separations based upon their existing attachment patterns and internal working models (Bowlby, 1988). Attachment research has repeatedly shown that anxiety is one of several expected responses that an individual may have to separation (Ainsworth, 1978). This study's findings are consistent with that premise. All three patients reported feelings of anxiety experienced during the separation. In the data analysis, two related categories of anxiety were identified; fear of death or harm to self and/or a loved one and feelings of insecurity. As noted in the prior section of this chapter, certain persecutory feelings, which can be categorized as an anxiety, were identified in the data, but were coded as related to feelings of lack of control as this is how they were directly expressed by the patients. In this theme of patients' expressions of feelings of anxiety, persecutory anxieties were also found, but expressed by the patients as being related to fear of death or harm to self or a loved one.

As in previous themes, each patient manifested anxieties in different ways. Anne's anxieties were most closely related to fear of loss (as differentiated from

feelings of loss), while Louisa and Mary's anxieties appeared to be more related to persecutory anxieties and feelings of vulnerability.

Category 1: Fear of Death or Harm to Self or a Loved One

For all individuals, separations bring out reactions. One kind of reaction may be a feeling of anxiety. The defenses that the individual may use to cope with this anxiety vary and may be more or less effective depending upon the security of the original attachment. An individual may become more preoccupied with an attachment figure during a separation, or may defend against the feelings of loss and anxiety by denying a need for the attachment figure. This study found that all three patients reported that they felt fear of death or harm to themselves and/or a loved one during the separation from their therapists.

Anne articulated having felt this anxiety both in regard to herself and her boyfriend. Anne described that when she felt physically ill over the break, while there was no indication that she had anything other than the flu, she began to have excessive worry about what might be wrong with her. In describing the fear that arose around her boyfriend, Anne stated the following:

> Okay, now that you're saying this I do remember exactly what I was going through the week that I didn't see you. Everything between me and (boyfriend's name) has been going just just in ways I didn't ever anticipate, you know. I'm totally satisfied ...but then, it was like this -- the fear thing was so... and it has been not so much this week but last week, very very thick fear of, My God, he's gonna die in a car crash... Oh, my God, he's gonna -- like...that... and it was usually that, like -- and it was really like so clear to me. (patient's name), he's going to die. And it was so -- like...and every time I tell him -- like when I say goodbye to him, or whenever he leaves me I'm always like drive really really slow (laughing) or just take really good care of yourself -- But, it's out of

> fear. I mean, I generally want him to take care of himself. But that underlying thing of it is, My God, he's going to die now. (laughing) It's really weeeird. And I don't really know why exactly, other than -- (laughing) you know, I don't really know...

In this exchange, Anne expressed her anxiety about her boyfriend, a very important figure to her, dying. She also indicated that this fear was related to the separation from her therapist when she stated that the fear occurred "not so much this week, but last week."

Louisa expressed concern about her own safety when describing the conflict she was having with a coworker. Although there seemed to be no logical cause for her to feel this way, i.e. no prior episodes of the coworker being violent or threatening, Louisa described feeling fear that her coworker might harm her.

> But, you know, I think later down the line you know this situation arises again, you know, I envision a meeting between the three of us to be volatile. 'Cause she's just waiting to just kill somebody, you know. She's just -- She has that anger in her. You know. She's just like really -- She's just looking for an excuse you know.

Louisa also expressed anxiety about harm coming to herself in regard to having outstanding bills that she had not paid. Louisa described a fear that her situation would become such that she would not be able to pay rent or care for herself properly.

Mary's expression of anxiety manifested itself primarily in regard to her children. She repeatedly presented concerns that harm would come to her son because of his involvement with his girlfriend. At the beginning of the session, Mary voiced her concerns.

> You know, sometimes I don't know about him. He uh, I had told him I was worried about him with his girlfriend. You know the one I told you about... and she's been pressuring him heavily for the past few weeks. To go there in the middle of the night. And I said, okay, what about her dad? If he doesn't kill you, then he's gonna, you know, he might just decide to press charges against you, and I said, besides that, if you leave after 10 o'clock at night from our house and then, you know, you take a chance on being picked up for you know, being out after 10, and going to jail, and so, you know... and I'm like, what if he thinks you're a burglar, and he kills you, you know, I mean...I'm just thinking about all of these horrible things that can happen.

Mary additionally expressed anxiety about the physical and emotional well being of her other children. It is notable that in this session Mary's anxiety was focused almost solely upon her children. The only expression of anxiety that Mary presented about her own well being was in regard to finding a job and breaking up with her boyfriend. These expressions of concern for her own well being were brief in comparison to the amount of time she spent discussing her anxieties about her children's safety and well being.

All three patients reported experiencing fear of death or harm to themselves and/or a loved one during the separation from their therapists. Two of the three patients reported fear of harm coming to a loved one, and the third patient reported a feeling of fear about her own safety. The patients reported that this fear was unusual and not clearly related to potentially threatening external events.

Category 2: Feelings of Insecurity

Attachment theory states that an individual looks to an attachment figure to be a stronger and wiser person to lead the way. Therefore, a separation from the attachment figure can result in feelings of insecurity and uncertainty. In this

study, two of the three patients expressed experiencing significant feelings of insecurity during the separation. The other, Louisa, did not overtly express feelings of insecurity that she attributed to herself, but did discuss feelings of insecurity as related to her coworker.

Anne expressed overt feelings of insecurity that occurred during the separation. She described several times having the experience during the break of feeling insecure about her looks. This feeling was so strong that it kept her from going out to an event with her boyfriend, even though she wished to feel able to go. Anne described her feelings of insecurity in the following way:

> Like when I was talking to (boyfriend's name) about...and it's usually when... in relation to like how I look. Like sometimes I can get so... like -- oh, I'm -- I feel like I'm sooo like blah -- Like we were going to go to this art opening, (therapist's name), and my thing at the time when I'm telling him, Yeah, I want to go. I want to be part of that scene. You know, the scene to be seen -- art scene. To look good -- I want to -- And I was half-joking with him -- I want to go out and I want to look good and be with the... beautiful people. And I'm going on and on about that. But, inside I'm like feeling like, Oh, you look like garbage,(patient's name). You know, you feel like garbage. You look like garbage.

Anne also expressed feelings of insecurity about her job performance. As with her feelings of insecurity abut her appearance, there did not seem to be logical grounds for her to feel this way. Anne expressed her insecurities about her job performance in the following statement.

> Like I feel like all this is getting really old, and ... it looks okay, but -- sometimes -- can't I do something different?... And so, it is like this feeling of when I'm not good enough...

Mary's expressions of feelings of insecurity focused upon her abilities to care for and protect her children and herself. Mary described concerns that she had

was not being a good enough mother to her children, and that she was not doing enough to help them. She also expressed insecurity about breaking up with her boyfriend and being able to support herself emotionally and financially.

> I've had a financial dependency on him, too. I don't know, I've got this... I'm just like scared, I guess, kind of gun shy, whatever. Kind of scary to think about. Goin' back to work...for somebody...

Both Anne and Mary manifested insecurity in regard to their sense of self-worth and abilities. Anne made a more direct link between these feelings and the break in therapy. As with feelings of sadness, Louisa's experience of feelings of insecurity were either denied, or projected onto others such as her coworker and her boyfriend. In describing her coworker, Louisa stated:

> It's sad really, she just needs everybody to love her. That's what she's waiting for, that's why she acts that way. She just doesn't like herself - she doesn't feel good about herself and all of her problems.

All three patients described experiencing feelings of insecurity over the holiday break. These feelings were reported as being disproportionate to whatever external event may have triggered them. The feelings of insecurity were related to feelings of vulnerability and low self worth, and were experienced as unpleasant and disruptive to the patients.

Theme 3: Patients' Expressions of Feelings of Anger

In attachment theory, feelings of anger in response to a separation can be viewed as a defense against feelings of helplessness and dependency. This idea and the related concepts found in Klein's (1946-63) discussion of the depressive position are relevant to the findings in this area. This study found that all three patients expressed having experienced feelings of anger during the

separation from their therapist. The feelings of anger tended to manifest in two primary forms, feelings of frustration, and feelings of impingement. Anne was able to not only identify and express her feelings of anger, but also to explore what she believed to be the dynamics of feelings of dependency underlying the anger. Louisa had difficulty acknowledging her feelings of anger. Although she expressed them repeatedly in the session, this was often followed by a denial of the feelings. While Mary described situations that occurred to which one might be expected to have an angry response, it wasn't until the last third of the session that she was able to directly express having feelings of anger.

Category 1: Feelings of Frustration

This study found that all three patients expressed having had feelings of frustration over the break. Anne's feelings of frustration were primarily related to not feeling like she wanted to feel. For example, Anne described being frustrated with herself for "being so insecure" and for "going to that place again." By this she was referring to a state of mind in which she feels very critical of herself and very vulnerable. Anne expressed a belief that without her therapist, during the separation, it was too difficult a task to do on her own.

This frustration, which Anne initially described as being at herself, took on a different meaning when Anne explored it further. She described her reaction to feeling physically ill, and the vulnerability and feelings of dependence that came with the experience. In this material, Anne described how the feelings of neediness she experienced made her angry.

> I'm fighting it, like -- I'm not sick. I am FINE. You know, I'm going to take all this homeopathic stuff and it's just going to miraculously

> go away. I'm going to be FINE. I'm FINE I'm FINE. So, over the weekend when I'm like rolled up in a ball, like "I hate staying in bed -- I hate," you know, "I don't wanna -- this is my weekend -- I should be able to go out and do what I want -- go see who I want, have a good time -- and I feel like garbage. Well, and there is always that way when I am sick and there's like -- I feel needy or something like that, and then I get like angry or something. I go, just, well, I want this to be over with...

While Anne identified her frustration as being related to her own feelings of dependency, Louisa described her frustration as being externally stimulated. Louisa expressed her primary source of frustration as being her coworker's difficult behaviors. Louisa described in detail a number of examples of her coworker's difficult behavior, and reported her analysis of what was underlying the coworker's frustrating behaviors. An example follows:

> This girl at work. She's just a difficult person for me to be with. I don't know. She's crazy, I think. It's really her stuff and not my stuff. She uses anger to you know um -- she uses anger as a buffer you know. She uses anger because of her lack of inability to you know um face confrontation with people. So, instead of speaking like you and me she'll yell at somebody, because I think -- I think she's afraid of confrontation.

Louisa described her reaction to the coworker's behaviors by stating:

> I feel it. I gotta feel it, you know. I can't just like you know roll it off like everybody says you know. It affects me. Because I don't want to be like that. Or, I'll just shut down. I'll walk away from the situation. It would happen -- which happened a couple of times during our break. She yelled at me and I walked away from the situation.

While it is certainly important to recognize the possible realities of the coworker's behaviors, it would also be reasonable to view some of Louisa's material in this example as projection. It is also notable that in her description of these difficulties, Louisa made a specific reference to the separation from her

therapist by stating that she had the reaction of "shutting down" "a couple of times during our break."

As noted above, it is an interesting finding that throughout the first two thirds of the session, while describing what could reasonably be considered to be frustrating experiences involving her children, Mary did not directly express feelings of frustration. It was not until the last third of the session that Mary expressed these feelings. As Mary began to speak about her boyfriend, her frustration with his behavior was gradually expressed. While Mary initially seemed to be defending her boyfriend's avoidance of dealing with the issues of their relationship, she later expressed feelings of annoyance and frustration with what she described as his manipulative pattern.

> So, I asked (boyfriend's name), I said, well, what I want to know is, Are you going to be in my life, or are you not gonna be in my life? And I told him this yesterday. I said, we have to talk about it tomorrow for sure. I wanted to talk about it yesterday. He said Okay, fine. Let's just talk about -- I'll come over there in the morning, and we'll go for a drive or something like that, and we'll talk about it. Well, by 2 o'clock I still hadn't heard from him, so, I paged him. And then he shows up at the door with food, and all this pasta and everything. And I think he did that so that he wouldn't feel guilty. And, I'm getting pretty good at figuring him out. If that's not important to him, and what he did today proved it to me that it wasn't important to him -- It was something that was important to me, for him to, you know, say, Okay, yeah, this is what... We're going to be together. I want to be with you, blah blah blah. And, by telling me, I'm too tired, and putting it off till today when I wanted to discuss it last night -- Now, he's put it off another day -- That says, Okay, fine. You don't want to do it, then this is what's going to happen. You're just going to have to stay out of my life. Period. You know, but I was just -- when I get mad I usually shut up, and I don't talk.

All three patients described feelings of frustration in their reunion sessions. In one case, the feelings of frustration were related to a patient's wish to feel better

about herself. Feelings that others were not meeting their needs were also the cause of feelings of frustration for the patients during the holiday break.

Category 2: Feelings of Impingement

The second primary category of feelings of anger that the data showed was feelings of impingement. Winnicott (1989) described impingement as a being a traumatic disruption of the sense of continuity occurring when the individual is not ready to encompass this disruption. The paradox of impingement, whether in an infant-caregiver or patient-therapist relationship, is that the very person who is supposed to protect the infant/patient from these impingements, may be the one perceived to have been the source of the impingement. For the purpose of this study, feelings of impingement were defined as a feeling that a person or thing has encroached upon ones' self or ones' rights. This is more along the lines of persecutory feelings, and differentiated from the sense that the actions of others inadvertently caused the patients distress.

Anne reported one episode of feeling impinged upon when she was home ill. She reported that the noises her new neighbor's children were making felt very invasive and upsetting to her. This upset her to the extent that she called the police to complain. Anne reported that just after she called the police, her boyfriend called, and as she reported to him what she had done, she was able to see more clearly why she had become so upset.

> And it's like, when I was growing up, when people were around me, I was taught like to be quiet, you know, and we don't live in the country. If we lived in the country they could scream all they want. You know, and I'm trying to like justify why they shouldn't be loud...sometimes it feels like a trauma.

Louisa described feelings of impingement she has had with her coworker and others she has encountered when she stated:

> She just -- She's a toxic person. She's toxic to my system. I don't like those people. You know. So, you know, sometimes to the point where I you know, I feel like I'm crazy, you know. I'll walk down the street and you know I'll get a freaky vibe from somebody and I'll like walk away around that person, you know, because I don't you know, I don't like them. There's a reason why I don't like people. And the reason why I don't like people is because either they have it in for me or they don't like me. I think everybody wants to have the position where you know they're in a loving environment.

At the end of the above statement, Louisa described the feeling of impingement that can occur when an individual feels that another is misattuned. She reported that she might dislike or feel threatened by a person if "they don't understand me - they don't know who I am."

Mary's feelings of impingement were expressed in two areas. The first, like Anne, had to do with neighbors, who in Mary's case were experienced as both annoying and threatening. The finding that both Anne and Mary felt impinged upon by neighbors is an interesting one in light of the idea of the neighbors' breach of physical boundaries being experienced by the patients as a breach of mental boundaries as well. Additionally, in both cases, the patients called the police. In Chapter 5, the idea of these boundary impingements as well as whom or what the police might represent in efforts to repair the breach will be discussed.

The other area in which Mary expressed feelings of impingement was in regard to her boyfriend's response to her request that they discuss the nature and future of their relationship. The boyfriend's avoidant response to this request

was experienced by Mary as misattuned and rejecting, both of which were experienced as impingements.

All three patients reported feeling impinged upon during the holiday break. The feelings were related to a sense that their boundaries were being threatened and/or violated as well as a sense that they themselves were not being understood or attended to properly. These experiences were reported as resulting in a desire for greater protection, both physically and emotionally.

Attachment Activating and Attachment Deactivating Behaviors

The terms attachment activating and attachment deactivating behaviors refer to the already existing classifications in the literature of attachment theory. The assumption, as explained in Chapter II, is that an individual's attachment patterns, consisting of defensive reactions to affective experiences triggered by feelings of dependency, can be seen in their most concentrated form in a reunion situation following a separation. Attachment activating and attachment deactivating behaviors are a part of these attachment patterns.

Ainsworth (1985) described behaviors that infants engage in to either activate or deactivate attachment with the primary caregiver. For the infant, attachment activating behaviors include cooing, smiling, crying and eye contact. Attachment deactivating behaviors gaze aversion, pushing away from the caregiver, emotional withdrawal and even going to sleep. This researcher was particularly interested to see if the data provided any information on how attachment activating and deactivating behaviors,

analogous to those employed by infants, might manifest in the adult therapeutic relationship.

The second round of data analysis identified the behaviors that the patients displayed toward their therapists in the therapy session itself. This is differentiated from the three themes which describe the attachment related ideas identified in the material that the patients discussed in the reunion sessions. The behaviors that were identified occurred simultaneously to the presentation of material by the patients, but were analyzed and coded separately. The subcategories included in these categories are direct verbalizations, speech patterns, use of laughter/humor, and physical actions.

Attachment Activating Behaviors Employed by the Patient

Attachment activating behaviors in the reunion sessions took a variety of forms including direct verbalizations, speech patterns, use of laughter or humor, and, and physical actions in the session. Again, it should be noted that in this presentation of the data, therapists' comments and interpretations are included only for contextual information, and were not analyzed separately. The process of the interaction, rather than the content of the therapists' comments, was the important factor in analyzing the data.

Direct Verbalizations

As noted above, Anne displayed a series of attachment activating behaviors over the course of the reunion session. Some behaviors that were employed were direct statements. She began the session by stating the following:

> So, so, it's been a long two weeks. Um, gosh, where do I even start (therapist's name)?

Later in the session Anne made a number of statements that indicated an increasing level of reattachment, such as "Now that I am here I can really hear what I am saying" and "You usually can help me." She also frequently responded to her therapist's comments and interpretations by stating "Yes!" before continuing on with her material.

Anne also utilized questions as attachment activating behaviors. In the first half of the session, the questions seemed to be rhetorical (as indicated by syntax and inflection). As the session progressed, the questions became ones that clearly indicated a desire for a response from the therapist.

Examples at the beginning of the session of the rhetorical style of question can be seen here:

> "Um, gosh where do I even start (therapist's name)?"
> "You know, what am I doing wrong?"
> "Why can't I look at like...why can't I look at like the black and white situation?"

As the session continued, and reconnection was more established, Anne was able to ask the therapist questions seeking a response, thus indicating a greater level of interaction and reconnection.

> And that's what's weird, (therapist's name), because I thought I had reached a point where I do like who I am. But, I guess it's just not that -- what? What is it?

Mary utilized direct verbalizations as a method of attachment activating as well. In one instance, at the very beginning of the session, Mary attempted to reactivate the attachment by asking "OK, last week, remember what we were talking about?" This finding is interesting both in that it reflects an attachment

activating behavior, but also in that Mary indicated that she and her therapist had met "last week" when in reality, they had not due to the holiday break.

Another example of attachment activating behavior occurred when Mary utilized a question to reach out to her therapist during an exchange. When her therapist made an interpretation and asked her if she agreed, Mary paused and stuttered for a few moments, seeming to have lost connection. She reactivated the connection by asking the therapist "what do you mean?" In this manner, Mary was able to reconnect with the therapist. Mary also made a direct reference to the value she placed upon the therapy sessions when she reported how she always told perspective employers that she needed a particular time free (the time of her scheduled therapy appointment.)

Direct verbalizations and questions were utilized by the patients as attachment activating behaviors. The patients seemed to have a desire and need to reconnect with their therapists after the separation caused by the holiday break. Direct verbalizations and questions were used as effective methods of engaging with the therapists.

Speech Patterns

The patients' speech patterns, which can be understood to be unconscious methods of communication, were analyzed for attachment activating and attachment deactivating behaviors. All three patients displayed a number of speech patterns that can be viewed as attachment activating. Additionally, changes in speech patterns over the course of the sessions indicated changes in the level of reconnection between patient and therapist.

In the first half of the session, Anne trailed off the ends of her sentences, pausing in a manner that encouraged her therapist to engage with her by finishing her sentence. Anne also employed a speech pattern with her therapist where she would give incomplete or vague answers to the therapist's questions, thus encouraging her therapist to engage by asking more questions. An example of this follows:

P: Yeah, and that's where I've been for ...
T: That's where you've been...
P: For a long time (laughing) and I mean.. Yeah. God, it feels...
T: You went back on the fourth?
P: I went back last week...
T: That was what?
P: My first day.

Later in the session when a greater level of reconnection had occurred, Anne's speech patterns changed. At one point, Anne's therapist made an interpretation that Anne experienced as very attuned, and she encouraged her therapist to continue by making sounds such as "yeah" and "um hmm" as her therapist was speaking. This resulted in the therapist elaborating further on the interpretation.

In the last third of the session, after a number of interpretations made by the therapist which Anne experienced as attuned, an attachment activating speech pattern emerged which indicated a significant level of reconnection between Anne and her therapist. The pattern consisted of Anne and her therapist finishing each other's sentences and seeming to understand each other without verbally completing their own thoughts. An example of this

occurred at the end of the session when Anne and her therapist discussed the effects of having the session taped.

> T: Did you forget...
> P: Yes, I did. This wasn't a factor in .. as much as I thought it was...
> T: Going to be...Good. Yeah. I thought it -- I thought it was gonna...
> P: Me, too. I think in the beginning, but once I started focusing I think more on what I wanted to talk about...
> T: Yeah.
> P: Then that was really of no concern.

Like Anne, Louisa and Mary utilized pauses, sounds of encouragement, agreement, and questions to encourage engagement on the part of the therapist. Louisa and Mary displayed other attachment activating speech patterns as well. An interesting finding in Louisa's data was her use of repetition to engage with her therapist. Louisa, at varying times throughout the entire session, would begin her response to her therapist's comments and interpretations by repeating verbatim the last phrase her therapist had spoken. Examples of this include the following:

> T: Her ego.
> P: Her ego. Yeah...

And:

> T: So, she runs the show?
> P: She runs the show.

An additional attachment activating speech pattern that Mary employed was a frequent use of the phrase "you know." An interesting aspect of this finding was that Mary's use of the phrase "you know" was higher at the beginning and end of the session than in the middle.

All three patients utilized unconscious speech patterns to attempt to activate attachment with their therapists. Each patient utilized attachment activating speech patterns throughout their session, and each patient's speech patterns were unique to the individual. For example, while Louisa and Mary both used the phrase "you know" in their sessions, Louisa's verbalization of the phrase was as a question (as based upon inflection) while Mary's use of the phrase was verbalized more like a statement.

Use of Humor and/or Laughter

An interesting finding of this study was that humor and laughter were used both as attachment activating and attachment deactivating behaviors. Anne used laughter in a manner to engage with her therapist. She used laughter frequently to break tension and to elicit an attuned response from her therapist. This served to solidify the reconnection process. Additionally, Louisa used laughter to indicate a feeling of connection in the following instance:

> I'd like to share with somebody. I mean it's the natural thing to do, you know? So, you know I figured out that we have like the same types of problems (laughing)...

Mary utilized laughter as a way to activate a level of attachment with her therapist that would allow her to discuss uncomfortable material regarding her worries about her son. An example follows:

> ...and I said, OK, if he doesn't kill you (laughter)...I didn't know exactly what I was gonna do, but... (laughter) I said, if I have to go tell her mom or her dad, you know...but I don't want him to get in trouble.

There were a variety of ways in which humor and laughter were used by all three patients to attempt to activate attachment with their therapists. Humor

and laughter were used by the patients to engage with their therapists, and to allow for continued interaction and reconnection.

Physical Actions

While visual evidence of physical actions was not available in the data, an instance of an attachment activating behavior was identifiable on one of the audio recordings. Louisa displayed an attachment activating behavior at the beginning of the session by taking out piece of paper, but not offering an explanation of what it was. This encouraged the therapist to question her about it, thus starting an interaction where Louisa could begin to describe the difficulties she had had over the separation.

> T: What do you have there?
> P: Oh, stuff looming in my head, literally. I wrote all the stuff that's been bothering me in my head.

Later in the session Louisa brought out another list, but this time did not wait for her therapist to question her about it, and instead offered him a detailed explanation of its contents, thus indicating a greater level of reconnection.

One can imagine that a variety of other attachment activating physical actions occurred throughout the sessions as would be seen in body language and other visual cues.

Attachment Deactivating Behaviors Employed by the Patient

In the attachment literature, attachment deactivating behaviors are viewed as defensive behaviors utilized by some individuals to cope with feelings of dependency and vulnerability. Additionally, they can be understood to be an

individual's attempt to regulate affect. Incidents of attachment deactivating behaviors were found in all of the reunion sessions.

Direct Verbalizations

Examples of direct verbalizations that served as attachment deactivating behaviors were found in Louisa and Mary's sessions. For example, at times, Louisa would contradict both herself and her therapist when her therapist would reflect a feeling that Louisa had just stated. An example of this follows:

> P: I just don't want to be around her. She's a difficult person.
> T: She's hard for you to be around.
> P: No, I don't dislike her or anything. I mean, she's a good person.

Mary displayed attachment deactivating behaviors in response to her therapist's questions or interpretations. She at times would avoid a direct response to the question or interpretation by slightly changing the topic. An example of this follows:

> T: So what about what you want? I though you said you were going to move on three months ago no matter what he said.
>
> P: He doesn't want to deal with it. It's like he always does, he says he's gonna come to talk about it and then there's an excuse.

In the above exchange, Mary avoided directly responding to her therapist's question about her own feelings by talking about her boyfriend. The attachment deactivating verbalizations in the data were not found to be direct statement of " I don't want to be here." or " I don't want to talk about this." They were found to be less direct verbalizations, but carrying the same message by dismissing the therapists' interpretations and reflections.

Speech Patterns

Speech patterns were also used by the patients as attachment deactivating behaviors. Louisa displayed a speech pattern that can be viewed as attachment deactivating during the first half of the session. When Louisa's therapist made interpretations or reflected a feeling that Louisa had expressed, Louisa would sometimes start her response with the word "No" even when she was not disagreeing with her therapist. An example of this is the following:

> T: So you think she wants to control the office.
> P: No, she's insecure, she feels she has to control everything.

Mary displayed an attachment deactivating speech pattern that seemed to arise when she was presenting material that stirred up difficult affective responses for her. In these instances, Mary's speech became very disjointed and hard to follow. This is differentiated from a somewhat similar speech pattern mentioned earlier that encouraged the therapist to complete that patient's sentences, and was thus categorized as an attachment activating behavior. An example of the attachment deactivating speech pattern follows:

> Well, I don't know...It's like she just...you know. Sometimes I think I should...well you know. Then I just don't... I said well, that should be something right there.

The attachment deactivating behaviors engaged in by the patients seemed to be related to both the difficulty of the material they were presenting, as well as the level of reconnection they felt with their therapist. While some of the behaviors seemed to be engaged in on a more conscious level (direct verbalizations, use of humor, physical actions) and others seemed to be more

unconscious (speech patterns) all of the behaviors can be understood to be the patients' attempts to regulate affect and manage the reunion.

Use of Humor and/or Laughter

Louisa and Mary displayed inappropriate use of humor and laughter as attachment deactivating behaviors. As noted above, humor and laughter were used both as attachment activating and attachment deactivating behaviors. When used as an attachment deactivating behavior, laughter and humor were interjected in a manner that did not match the nature of the material being presented. Thus, they did not result in an attuned response from the therapist or a breaking of the tension that allowed the discussion to continue. Rather, in this context, they served to interrupt the flow of discussion and avoid further exploration of the painful material.

An example of inappropriate humor and laughter being used by a patient to cause a rupture in the attachment occurred when Louisa described her attempts to gather some cash to pay off her significant debts. She mentioned that her father had offered to buy her car for a sum of money that she then stated was much more than the car was worth, since she knew that the car needed significant repairs. When the therapist asked Louisa how she would feel about misleading her father this way, Louisa's response to the question was to laugh.

Another example of humor being used as an attachment deactivating behavior occurred when Mary was describing her daughter's hospitalization for suicidality and substance abuse. While describing painful feelings of

incompetence and powerlessness, Mary repeatedly made self-deprecating remarks and laughed.

In these instances, it can be seen that humor was used to avoid painful affect in the patient's material that is felt to be too difficult to tolerate. Additionally, humor as an attachment deactivating behavior was used to avoid addressing therapist interpretations.

Physical Actions

Louisa displayed an attachment deactivating strategy at the end of the session. When Louisa's therapist indicated that the session was coming to an end, Louisa interrupted, not allowing her therapist to conclude the session, and left the office abruptly.

T: Well, we just about at the end of our time. Why don't...
P: Oh, O.K. O.K., bye
T: We can talk more about this..
P: Right, O.K. bye...
(Rushing out - cutting off therapist, nervous laughter)

As noted in the section on attachment activating strategies, it is likely that other attachment deactivating physical actions occurred in the session, but were not visually available to the researcher.

With all of these attachment deactivating behaviors, it is important to note that they did not simply serve the purpose of indicating resistance to the therapeutic material or relationship. They served as attempts on the part of the patients to communicate a need for affect regulation. The patients used attachment deactivating behaviors to move away from a connection or affect that was experienced as too threatening in the moment.

Summary

This chapter has presented an overview of the procedures used in data collection and analysis, demographic information, and the results of the data analysis. The categories in each theme were defined and examples from the data were utilized to illustrate the findings. Chapter 5 will contain a discussion of the findings, including their relationship to the existing literature, limitations of the study and recommendations for further research.

CHAPTER V

DISCUSSION

This chapter will present a discussion of the findings presented in Chapter IV with respect to the themes identified in the data analysis. The chapter will also discuss limitations of the study, as well as implications for clinical practice and further research.

Review of the Purpose of the Study

This study was based upon the ideas that patients' internal working models and attachment patterns, developed in infancy and solidified over time, are transferred onto the therapeutic relationship, and that they are most visible following a separation and upon reunion. This study was designed to observe the reunion session following a planned separation/break in the therapy, in order to examine the attachment patterns exhibited by patients.

As discussed in chapter II, infants and children develop unconscious defensive strategies, or attachment patterns, for dealing with the external realities of their relationship with their primary caregivers. They also develop unconscious defensive strategies for dealing with the affective reactions they have to perceived ruptures in the relationship (Karen, 1998).

This study found that these unconscious strategies are also manifested in the therapeutic relationship following a holiday break, which seems to be experienced by the patient as a rupture in the relationship. In observing the behaviors displayed by the patients upon reunion with their therapists, this study attempted to identify attachment seeking or avoiding behaviors as they were

manifested in the therapeutic relationship, and attempted to note if these behaviors tended to cluster into identifiable categories. Additionally, this study sought to observe and describe the ways in which patients engaged or disengaged with their therapists following a separation and the stratagem patients employed in the service of re-connecting with the therapist.

This study was intended to be observational in nature. The researcher analyzed the audio recordings of reunion sessions in order to attempt to describe the reunion behavior of the patient. This researcher postulated that patients would display attachment patterns through behaviors and attachment related material presented in the sessions upon reunion following a separation from their therapists, and that these patterns could be observed and described in a manner that can potentially prove quite beneficial to the therapeutic relationship and process of healing.

As noted in Chapter IV, this researcher analyzed two distinct types of data in the data analysis. One was the specific attachment themes expressed by the patient in their clinical material and the other was the attachment activating and deactivating behaviors displayed by the patient simultaneously to the presentation of the material in the reunion sessions. The results found fulfilled the purposes of the study, as a variety of attachment related themes and behaviors were identified in the data.

Review of Findings

Themes

Three major attachment themes, each with several categories, were identified in the analysis of the data. They were the following:

Theme 1, "Patients' Expressions of Feelings of Loss." This theme included three related issues:

1. Feelings of sadness.
2. Feelings of lack of control.
3. Lack of, or decrease in, coping skills.

Theme 2, "Patients' Expressions of Feelings of Anxiety." This theme included two related issues:

1. Fear of death or harm to self and/or a loved one.
2. Feelings of insecurity.

Theme 3, "Patients' Expressions of Feelings of Anger." This theme included two related issues:

1. Feelings of frustration.
2. Feelings of impingement.

Themes 1 through 3 describe the affective reactions of the patients to the separation and reunion as expressed by the patients in the reunion sessions. The categories of attachment activating and attachment deactivating behaviors describe the attachment behaviors utilized by the patients in the reunion session with the therapist.

Sable (1997) stated that "Symptoms of anxiety, depression, or anger are responses to disruptions of personal bonds" (p. 288). As illustrated by the themes identified in the data, this study found that these were the very reactions experienced by patients as a result of a separation from their therapists during a planned holiday break.

This researcher believes that there were two very important attachment related ideas that came up in many of the themes and categories. These were the concepts of shame and affect regulation. A brief definition of the two concepts will follow, with further elaboration presented in the discussion of the themes.

As noted in Chapter IV, the data reflected a variety of manifestations of shame responses to the separation. As these shame responses were typically then defended against by affective states such as feelings of anger, feelings of loss and feelings of anxiety, they were coded as the latter. However, this researcher believes that shame states are a significant aspect of attachment experiences, and will discuss the data as related to shame states in each theme.

It is only recently that attachment literature has included the idea of shame as related to attachment experiences. Karen (1998) stated that "there can be little doubt that shameful feelings about the self are an important component of relational insecurity" (p. 238). Schore (1994) brought the attachment literature and shame literature together in discussing the emotional and physiological role of shame in development, as well as highlighting the significant role that

attunement (or misattunement) plays in the emergence of and ability to tolerate shame. This researcher believes that for the patients in this study, the absence of the therapist, and their resulting affective responses, resulted in shame states. Each patient manifested this in a different manner, as will be discussed further in this section.

Another important idea that related to the themes was the issue of affect regulation. Schore (1994) drew attention to early infant relationships and attachment as related to cognitive, emotional and physical development. Schore stated that in order to physiologically and emotionally develop the capacity to regulate affect, an infant must have enough positive experiences with a primary caregiver being attuned to their physiological and emotional states and/or being able to engage in an interactive repair of misattunements. In that way, an infant is able to experience the caregiver's assistance in regulating their affect. As development continues, the infant is then able to turn both to herself to auto regulate, as well as have moments of connectedness with another in order to experience interactive regulation.

Therefore, it would follow that an individual, who had experienced a dearth of attuned moments and affect regulation with a caregiver as an infant, would have ongoing difficulties with affect regulation as an adult. This becomes a crucial aspect of the attachment experience for the individual. The issue of affect regulation will be discussed in each theme as related to the data.

Theme 1: Patients' Expressions of Feelings of Loss

In viewing separation from an attachment-oriented perspective, one could

anticipate that feelings of loss would occur (Bowlby, 1980). What was particularly interesting to observe in the data of this study was the different ways in which the patients experienced and described their feelings of loss. While this researcher anticipated finding feelings of sadness in the data, the two other categories of loss related experiences were not as expected.

As this researcher analyzed the data that was forming regarding patients' feelings of decrease in coping skills and decrease in feelings of control, the theme of loss began to emerge. As the data analysis continued, the theme of loss emerged in such a way as to encompass not only the affective state of sadness, but the patients' experiences of loss of parts of themselves in regard to self-control and coping mechanisms as well.

In attachment theory, feelings of sadness would be one of several anticipated reactions to a separation. As noted above, all three patients verbalized experiences of sadness that occurred during the separation. This would lead us to understand that even a short, planned break can be experienced by patients as a loss, activating old attachment patterns. Reactions seen in the patients in this study included direct expressions of sadness as well as denial of feelings of sadness.

A denial of sadness can be understood to be a defensively manifested reaction to the feelings. An attachment pattern associated with avoidant attachment would include a denial of painful feelings, due to the individual's unconscious belief that she cannot tolerate certain feelings. This can be understood to be an affect regulation problem in the individual. For example, a

patient described feelings of distress she was experiencing due to interpersonal conflicts at work. When the therapist reflected her feelings, the patient then responded by denying the feelings. Another defense used to deny painful affect found in the data was displacement, for example when a patient described feelings of sadness and longing, but attributed them to a coworker. Rather than indicating a lack of feelings of sadness and loss, these dynamics can be understood as an expression of the patient's deep level of these feelings, and her need to keep them from becoming conscious.

The findings also indicated that patients may show a tendency to shift away quickly from feelings of sadness. In one case, when feelings of sadness came up, the patient quickly shifted to feelings of anger, changed topics, or showed a distinct lack of affect when describing painful experiences. Again, this can be viewed as an attempt at affect regulation in an individual who can not tolerate the painful feelings. It would be consistent with the attachment literature (Ainsworth, 1985, Bowlby, 1988) for an individual who has little or no faith that her attachment figure will be able to meet her needs for containment or affect regulation to show limited ability to tolerate painful affect.

One way to understand the feeling of lack of control as instigated by a separation from an attachment figure is that it resulted from an individual's unconscious feeling that she could not control the attachment figure by keeping her from leaving. All three patients described feeling a lack of control during the separation. The study showed that some patients tended to view the loss of control as externally focused, and thus felt more persecuted by it. Klein's

(1946-63) discussions of persecutory anxiety are relevant to these findings in regard to attachment experiences. Mrs. Klein described an unconscious process whereby an infant (or adult), when experiencing unmet needs, will in phantasy destroy the individual perceived to be withholding. This then leaves the infant in fear of retaliation for their destructive phantasy. Additionally, this leaves the infant bereft, as they have destroyed the person upon whom they rely the most.

These ideas have great relevance to the findings of this study and attachment theory in general. One can speculate that a patient with a limited ability to regulate his affect will be more prone to experience separations in therapy as persecuting, and may therefore show more symptomatic regression during the separation. Additionally, one may expect to see some patients increase their symptomotology or awareness of their distress upon reunion rather than during the separation. This has historically been understood to be the result of anger at the therapist for leaving. This researcher would like to propose another interpretation of this behavior. An increase in negative symptoms and/or feelings of distress upon reunion with the therapist can be viewed as the patient's somewhat successful attempts to contain their distress until such time as it is safe to feel it. The patient can be viewed as having an unconscious understanding that the therapist's return indicates the possibility of repair of the rupture. This could, in fact, indicate a more secure level of attachment to the therapist on the part of the patient, and thus be an indicator of positive change.

The study showed patients displaying ambivalence about the reunion with their therapist. From an attachment perspective, this can be interpreted as linked to the separation, with patients' feelings of neediness and dependency upon their therapists stirring up anger and feelings of loss of control. This can be understood to be a patient's response to a feeling that he did not have control of the therapist over the break; the therapist was not there to help him in a time of need, and thus the patient felt bereft and a loss of control. It is important to note the impact of shame here as well. In this study, patient material indicated that anger at feelings of dependency was used as a defense against feelings of shame about dependency needs.

The study also showed patients engaging in efforts to self-soothe during the time of separation. One patient described a number of external events that she had felt compelled to control, and stated that she felt if she were unsuccessful in doing so, "everything would disintegrate." The choice of the word disintegrate is a fascinating one if one looks at it in regard to the concepts of internal integration and dis-integration. One can hypothesize that by using this word, the patient described her internal sense that the rupture in the attachment caused by the holiday break left her without an attachment figure to help her be integrated. Without this assistance, the patient unconsciously felt that her internal world could disintegrate.

Patients also showed defensive reactions to feelings of loss. The defenses of projection and reaction formation were used to ward off intolerable feelings of

loss. One patient attributed her own feelings to her coworker when she stated that her coworker was overly controlling.

> She's sensitive, and the only way for her to feel control over the whole situation, I figured out...is to be, you know, this us versus them kind of thing.

The use of the defense of reaction formation was evidenced in the data by a patient's repeated discussion of how much she disliked her coworker and felt out of control of the situation, alternating with statements that she liked her very much such as the following:

> No. It's a bad situation with her. She's a difficult person. But she is warmhearted, at times. And I did, you know, it was liberating for me was -- for me to say to Gary, "I don't like Erica. I don't like her at all. And then um I told him I don't like her, but I love her you know. I love her as a person. You know, so I love Erica, and I don't, I don't like, you know, her things, her stuff. You know. I don't like it. But I do, I do like her. She's a nice person. I don't personally like want her in my life. I don't hate her, I love her, she's a great person.

Slade (1998) stated that "A vital aspect of security is the ability to regulate, and thus fully experience, a range of affects, specifically distress and pleasure" (p. 16). Thus, the use of these defenses could be understood to be indications of an inability to tolerate uncomfortable or painful affect and difficulty in affect regulation and attachment.

Feelings of lack of control were also described by patients as a general feeling of powerlessness. This was illustrated in the data by one patient in regard to her children, her boyfriend, and her life situation in general. These feelings of powerlessness can be interpreted in regard to attachment as an internal loss of the attachment figure triggered by the separation, leaving the patient without

a sense of security or strength. While this may be an ongoing state of mind for a patient, separation from the therapist may trigger these feelings in a more intense manner.

Attachment theory would understand a lack of, or decrease in coping skills as a result of a separation from an attachment figure as indicating the individual's inability to keep an internal representation of the attachment figure sufficiently in mind. A decrease in coping skills can be viewed as a decreased ability to regulate the affective states (sadness, anger, and anxiety) that appear in the other themes. All three patients reported a decrease in coping skills during the separation.

The data reflected that a patient's internal experience of loss of the therapist during the separation, resulted in a lack of ability to cope as well as a feeling of "fogginess". This can be understood as not only a result of the separation, but shame and anxiety regarding the patient's ability to reconnect with the therapist.

In an attempt to regulate affect, one patient called to mind what the therapist had said in the past:

> And I remember you were saying that even though, you know, if you begin to deal with those things that you're going through, it doesn't mean they ever go away.

This was used in an attempt to self-regulate, to call up the internalized therapist. By the end of the interaction, the patient was able to directly state her need of the therapist by saying, " you usually can help me."

An increase in feelings of stress and a decrease in coping skills during the separation were seen in the theme of patients' expressions of feelings of loss. Patients reported feeling overwhelmed with "life tasks" and feeling unable to cope with the stress of work, as well as an overall decrease in ability to tolerate the stress of interpersonal relationships. Although the decrease in coping skills was not always directly verbally related to the therapist's absence by the patients, patients did express a sense that their therapy assisted them with coping skills. One could then conclude that the absence of the therapist was experienced as a loss if the patients' attachments to their therapists were not secure enough to be maintained internally during the separation.

Theme 2: Patients' Expressions of Feelings of Anxiety

As discussed in Chapter II, the literature on attachment indicates that individuals have reactions to separations based upon their existing attachment patterns and internal working models (Bowlby, 1988). Attachment research has repeatedly shown that anxiety is one of several expected responses that an individual may have to separation (Ainsworth, 1978). The findings of the present study are consistent with that premise, as all three patients reported experiencing feelings of anxiety. In the data analysis, two primary categories of anxiety were identified; fear of death or harm to self and/or a loved one and feelings of insecurity. As in previous themes, each patient manifested anxieties in different ways. Some anxieties were most closely related to fear of loss, while other anxieties appeared to be more related to persecutory anxieties and feelings of vulnerability.

Attachment theorists have stated that separations can bring about great anxiety. The defenses that the individual may use to cope with this anxiety vary. An individual may become more preoccupied with an attachment figure during a separation, or may defend against the feelings of loss and anxiety by denying a need for the attachment figure (Slade, 1998).

This study found that all three patients reported that they felt fear of death or harm to themselves and/or a loved one. The fear of loss of the loved object that was seen in the data can be understood as resulting from an attachment pattern activated by the separation from the therapist. In one case, one could postulate that these feelings of fear of harm that arose were reflective of a patient's projections. Patient material indicated a fairly consistent use of projection and other defenses in response to unconscious beliefs that painful affect could not be tolerated or regulated. One could theorize that forming a more secure attachment with their therapists could allow patients to begin to integrate some of these feelings. Without a more secure attachment, patients cannot feel safe enough to accept these feelings as their own and they must be split off and projected into others.

The study found that patients also showed difficulty in consciously acknowledging feelings of fear in regard to themselves. One patient reported a variety of concerns about the safety and well being of her children. While it would be natural for a mother to have concerns about her children, the patient's expressed fears seemed to be heavily weighted upon her children and

away from herself. This may be a way in which the patient can tolerate the affect by having it be somewhat removed from herself.

As with anxieties about harm coming to self and/or others, feelings of insecurity could be an expected response that an individual with an anxious attachment would have to a separation from an attachment figure. This could be attributed to Bowlby's (1988) idea that an individual looks to an attachment figure to be a stronger and wiser person to lead the way. For an individual with an insecure attachment, a separation from the attachment figure can result in feelings of insecurity and uncertainty. In this study, two of the three patients experienced significant feelings of insecurity during the separation. The third did not overtly express feelings of insecurity that she attributed to herself, but her material could be interpreted to be defensive reactions to feelings of insecurity caused by the separation.

In attachment theory, a secure attachment is understood as a factor that would allow the infant to be able to go out and explore the world. In other words, if the infant has a secure base from which to explore, he is more likely to be able to do so without anxiety. One patient described a circumstance that occurred over the separation when her feelings of insecurity kept her from going out to an event.

> Like when I was talking to (name of boyfriend) about...and it's usually when... in relation to like how I look. Like sometimes I can get so... like -- oh, I'm -- I feel like I'm sooo like blah -- Like we were going to go to this art opening, and my thing at the time when I'm telling him, Yeah, I want to go. I want to be part of that sceeene. You know, the scene to be seen ...art scene. To look good ...I want to... And I was half-joking with him -- I want to go out and I want to look good and be with the... beautiful people. And I'm

> going on and on about that. But, inside I'm like feeling like, Oh, you look like garbage,(name of patient). You know, you feel like garbage. You look like garbage.

In this case, the patient's feelings of insecurity were focused upon her looks, but on a deeper level, it was her sense of herself internally that kept her from wanting to go out. The patient reported that she viewed these feelings as a regression to a negative state of mind that she and her therapist have been working on. Thus, one can speculate that the experience of insecurity that the patient struggled with was the result of a perceived rupture in the attachment caused by the holiday break.

Theme 3: Patients' Expressions of Feelings of Anger

Bowlby (1980) described that, among other reactions, individuals may experience anger in response to separations from an attachment figure. This study found that all three patients expressed having experienced feelings of anger during the separation from their therapist. The feelings of anger tended to manifest in two primary forms, feelings of frustration, and feelings of impingement. Sable (1997) stated the following:

> With either separation or loss, portraying responses along a continuum, and including the possibility of anger at any phase, makes it possible to explain the fluctuating variety of emotions reported by clients. (p. 287)

In this study, one patient was able to not only identify and express her feelings of anger, but also to explore the dynamics of feelings of dependency underlying the anger. Others had difficulty acknowledging feelings of anger. Although these feelings were expressed repeatedly in the session, they were often followed by a denial of the feelings. While one patient described

situations that occurred to which one might be expected to have an angry response, it wasn't until the last third of the session that she was able to directly express having feelings of anger.

One patient initially described her experiences of frustration as being directed toward herself. When the patient explored these feelings further, they took on a different meaning. She described her reaction to feeling physically ill, and the vulnerability and feelings of dependence that came with the experience. In this material, the patient described how the feelings of neediness she experienced made her angry.

> I'm fighting it, like -- I'm not sick. I am FINE. You know, I'm going to take all this homeopathic stuff and it's just going to miraculously go away. I'm going to be FINE. I'm FINE I'm FINE. So, over the weekend when I'm like rolled up in a ball, like "I hate staying in bed -- I hate," you know, "I don't wanna ...this is my weekend... I should be able to go out and do what I want -- go see who I want, have a good time -- and I feel like garbage. Well, and there is always that way when I am sick and there's like -- I feel needy or something like that, and then I get like angry or something. I go, just, well, I want this to be over with...

Attachment literature (Ainsworth, 1985; Bowlby, 1973; Fonagy, 1996) has hypothesized that individuals with a history of rejection by a primary caregiver in times of need will develop a defensive response to feelings of dependency. As seen in this study, this could include feelings of anger. It is clear that this dynamic would be crucial to identify and address in the therapeutic relationship in order for a reworking of internal working models to occur.

One patient avoided expressing feelings of frustration until the last third of the session. At that point, the patient was able to express, and stay with, feelings of frustration at her boyfriend for his lack of ability to meet her needs. The patient

began by excusing her boyfriend's behavior, but as she continued to discuss the matter, she was able to acknowledge feelings of frustration. One could hypothesize that the patient 's increased ability to express painful affect resulted from an increased sense of reconnection with her therapist over the course of the session, and therefore a greater sense of security and ability to tolerate painful affect.

As noted in Chapter IV, the second primary category of feelings of anger that the data showed was feelings of impingement. Winnicott (1989) described impingement as a being a traumatic disruption of the sense of continuity occurring when the individual is not ready to encompass this disruption. The paradox of impingement, whether in an infant-caregiver or patient-therapist relationship, is that the very person who is supposed to protect the infant/patient from these impingements, may be the one perceived to have been the source of the impingement. In this study, feelings of impingement were defined as feelings that a person or thing has encroached upon ones' self or ones' rights. This is more along the lines of persecutory feelings, and differentiated from the sense that the actions of others inadvertently caused the patients distress.

A very interesting finding of the study was that two of the three patients reported feeling impinged upon by neighbors who were making noise. Additionally, both patients acknowledged that their feelings of impingement were not necessarily reasonable or logical responses to the level of noise created by their neighbors. The finding that both patients felt impinged upon

by neighbors is an interesting one in light of the idea of the neighbors' breach of physical boundaries being experienced by the patients as a breach of mental boundaries as well. It is as though the separation from an attachment figure left the patients in an internal state where they felt more vulnerable to these breaches of boundaries. This would fit with the idea of the attachment figure providing affect regulation and increased ability to tolerate outside stimulus. In these findings, it is as though the patient's were less able to regulate their stimulus barrier without the assistance of their attachment figure. It could then be viewed that the feelings of impingement were a response to internal states brought on by the separation from an attachment figure who was unconsciously viewed as protecting the patients from potential impingements.

This idea is also supported by the fact that in both instances, the patients considered calling the police. The police can be viewed as representing the therapist; the stronger, protective attachment figure who can protect the patients in their time of need, and provide the boundaries and affect regulation that the patients feel they cannot call up on their own.

One of the patients showed an ability to engage in interactive affect regulation in this instance. She described that after her initial upset with her neighbors, her boyfriend called and she was then able to feel more contained and less impinged upon.

Another area in which a patient expressed feelings of impingement was in regard to her boyfriend's response to her request that they discuss the nature and future of their relationship. The boyfriend's apparent lack of willingness to

do so was experienced by this patient as an impingement. This can be understood to be connected with an insecure attachment pattern in that rather than understanding her boyfriend's response as being related to his own avoidant issues, she perceived it as rejecting and misattuned, both of which are connected to shame reactions in the attachment relationship.

Attachment Activating and Attachment Deactivating Behaviors

The categories in the second round of data analysis reflected the behaviors that the patients displayed toward their therapists in the therapy session itself. These were differentiated from the three themes which relate to the patients' verbal presentation of attachment related material in the reunion session. The subcategories included in attachment activating and deactivating behaviors are direct verbalizations, speech patterns, use of humor and/or laughter, and physical actions. As in the literature on infant attachment, this researcher believes that these behaviors are largely unconscious attempts on the part of the patient to either reattach, or deny attachment needs.

Attachment Activating Strategies Employed by the Patient

Ainsworth (1985) identified a variety of attachment activating behaviors that the infant displays in efforts to make contact with the caregiver. These include crying, smiling, clinging, rooting and vocalization. This researcher was particularly interested in seeing if patients displayed behaviors upon reunion with their therapists that could be identified as attachment activating, and found that patients did indeed display a variety of behaviors that can be seen as attachment activating in the reunion sessions with their therapists.

One example reflected both attachment activating behaviors, as well as a process of reconnection. In the first half of a patient's session, while the reconnection had not yet solidified, there were a number of speech patterns that the patient exhibited that can be viewed as attachment activating behaviors. These included pauses which lasted long enough that the therapist either completed the patient's thought or asked a clarifying question.

Another attachment activating behavior was the patient engaging the therapist in a rhythm of question and answer. The therapist would ask questions to which the patient would give very brief or incomplete answers, then pause, thus encouraging the therapist to ask more questions. This can be viewed as attachment activating in a more anxious state of mind where the patient/child needs the therapist/caregiver to be more active in the reconnection process. This study found that at times, patients spoke with many false starts, half sentences, and incomplete thoughts. This actually can be viewed as either attachment seeking or avoiding. In some cases, it appeared to be related to a more anxiously attached state of mind and attachment activating behaviors. Patients seemed to need their therapists to pull them back into the relationship as indicated by the changed in these speech patterns when patients began to feel more secure in the reconnection.

Patients in this study displayed attachment activating behaviors that showed specific changes over the course of the session. One patient exhibited excessive use of the phrase "you know." The patient's use of this phrase was notably higher at the beginning and end of the session than in the middle. The

use of the phrase "you know" can be viewed as an attachment activating behavior in an individual in a more anxious attachment pattern in that it seemed to serve the purpose of "checking in" or making sure that the therapist was still there with the patient. The finding that the patient's use of this mechanism was more frequent at the beginning of the session, when reconnection had not yet occurred, and at the end, when separation was drawing closer, would again support the idea of the pattern being one of an anxiously attached state of mind.

As noted in Chapter IV, the use of humor and laughter was found to be both attachment activating and attachment deactivating, depending upon the context. When used in an appropriate manner, humor and laughter served to elicit an attuned response from the therapist, thus activating attachment and reestablishing connection. Additionally, humor and laughter were at times utilized by the patients to break tension and mitigate feelings of shame during experiences of painful affect, thus allowing for continued expression of feeling.

Attachment Deactivating Strategies Employed by the Patient

In describing infant attachment, Main (1990) reported on three potential states of mind: autonomous, deactivating, and hyperactivating. The prior section of this chapter described what Main would identify as hyperactivating strategies. This section addresses what Main would identify as deactivation of the attachment system. This is characterized by attempts to turn attention away from the caregiver when the infant is distressed or needy. Main suggested that adults' attachment strategies parallel these infant strategies.

The present study found that while a patient may have exhibited a tendency more toward one or the other, incidents of both attachment activating and attachment deactivating behaviors were indeed found in all of the reunion sessions.

All three patients utilized humor and laughter in a manner to deactivate attachment. This included inappropriate use of humor and laughter while presenting painful material. Dozier and Lee (1995) reported that when individuals with dismissing attachment organizations confront emotional issues, they often try to divert the clinician's attention. While this researcher did not know the attachment patterns of the patients, instances of this type of diversion were found. In addition to the use of attachment deactivating behaviors as a defense against feelings of dependency, this can be understood as a defensive response both to the painful affect, as well as the feelings of dependency that the affect triggered.

Patients displayed interesting attachment deactivating behaviors in their speech patterns. One patient would at times contradict both herself and her therapist when her therapist reflected painful feelings that the patient had expressed. When this occurred, the patient denied having feelings that she had just presented. Additionally, the patient at times began her response to her therapist's interpretations with the word "no" even when she was actually agreeing with her therapist. It would seem that both of these attachment deactivating behaviors were not conscious for the patient. One could postulate that in an unconscious manner, the patient utilized these behaviors to

defend against reconnecting with her therapist, to avoid the painful feelings of loss and abandonment that are triggered for her as a result of separation. If a patient's attachment patterns are such that he cannot hold an internal sense of his attachment figure during separations, then each separation, even those between scheduled sessions, would be experienced as a renewed loss and abandonment.

Process of Reconnection and Nature of Therapeutic Relationship

An important finding of the study was that a process of reconnection occurred over the course of the session. Changes in patient speech patterns, affective states and responses to therapist interpretations illustrated this process of reconnection. As the process of reconnection progressed between patient and therapist, increased verbalization, exploration of affect and positive response to interpretation was seen. It can also be understood that the verbalization and expression of the affect facilitated the reconnection as well. The process of reconnection is interactive, building upon itself, and is not linear. Additionally, the process of reconnection is not linear. A patient will move back and forth along a continuum of reconnection throughout the session.

The data showed that two of the three patients experienced and expressed affective reactions often associated with separation (loss, anxiety and anger), and engaged in behaviors activated by the separation and reunion (attachment activating and attachment deactivating behaviors). However, these two patients rarely attributed these affective states and behaviors directly to the separation from and reunion with the therapist. The other patient was

more often able to make the connection between her feelings and the separation, in particular after some amount of reconnection had occurred between herself and her therapist. This finding could be related to the differing nature of the relationships between the patients and therapists.

It could be hypothesized that some patients, due to preexisting attachment style, developed relationships with their therapists that allowed for identification and exploration of these issues, while other patients' attachment styles caused them to be more defended against these feelings. If this hypothesis is true, therapists need to be alert for each particular patient's manner of manifesting attachment issues in the therapeutic relationship.

In the course of the data analysis this researcher observed that the patients seemed to verbalize their feelings and thoughts about the separation more often in a coded manner rather than directly. The implication of this could be that as therapists, we must be sensitive to this coded material in order to address and interpret it, thus allowing our patients to more consciously and directly deal with their feelings and thoughts.

This observation highlights the importance of therapists having greater understanding of the effects of separations upon patients, as patients will often not be able to consciously articulate what they experience. As therapists become more aware of these complex dynamics, they can assist the patients in understanding and exploring the affective experiences and defensive reactions they have in relationships when separations and reunions occur.

Additionally, this finding raises an interesting question. Are patients who have been in treatment with their therapists for longer periods of time, having experienced a greater number of separations and reunions in the therapeutic relationship, more likely to be able to be aware of and discuss in therapy the experience of the separation and reunion? This question, while beyond the scope of this study, would be an important one to explore in the future.

Implications for Clinical Social Work

Attachment and relational issues affect every aspect of human life from cognitive functioning to interpersonal relationships. The development of the self emotionally, cognitively and physically is dependent upon early attachment experiences. Research has shown (Schore, 1994; Seigel, 1998) that the development of the infant brain is significantly impacted by these earliest experiences. When a caregiver provides an infant with an accurate reflection of the infant's internal state and engages in interactive repair of misattunements, dyadic regulation of emotion occurs and the infant develops the ability for affect regulation. When an infant experiences his caregiver as misattuned on a regular basis, the infant will have developmental delays in the ability to regulate affect, to reason, to perceive and to attend. The impact of the caregiver upon the infant, combined with constitutional factors such as the infant's temperament, will impact that infant's ability to function in the world.

As clinical social workers, we have the opportunity to address and repair some of the difficulties that result from these early experiences. However, in order to do so we must be able to understand and relate to our patients in a

manner that promotes affect regulation and repair of the early ruptures and misattunements. Attachment theory has given us valuable tools with which to work in our efforts to treat our patients. The importance of this study may well lie in looking at infant attachment patterns and categories from the perspective of the adult in psychotherapy.

Adult attachment literature has studied and defined a separate set of categories to describe adult attachment patterns. As noted in Chapter II, these have primarily related to either romantic attachment or to parenting. They do not address the nature of the therapeutic relationship. The present study raises the question, do these adult attachment categories best inform our work with adult patients, or should we be looking at the relationship between patient and therapist from a different perspective? The themes of feelings of loss, anxiety and anger, as well as the attachment activating and deactivating behaviors found in the data seem to indicate a link to infant attachment literature.

This researcher believes that the existing methods of determining the attachment patterns of our adult patients are not sufficient. There is question as to whether existing self-report measures are effective because they leave out the unconscious process. The AAI, which is a well-validated and very useful measure, may provide accurate and useful attachment classification information. However, it does not give real information about how the particular attachment style may be manifested in relationships. Additionally, it is a very lengthy process to administer and score the AAI, requiring special training, and therefore not as useful to practicing clinicians.

Perhaps the most significant reason that the adult attachment literature does not fully address the dynamics of the therapeutic relationship is that the nature of the therapeutic relationship is very closely related to that of the infant and caregiver. This researcher believes that the findings of this study confirm that the models of infant attachment patterns and behaviors are more relevant in understanding the variety of complex and subtle dynamics that exist in the therapeutic relationship. Additionally, this researcher believes that the findings of this study indicate that Bowlby's ideas regarding internal working models, as well as Bowlby and Ainsworth's ideas of a secure base are most relevant to the therapeutic relationship. As this study showed that patients manifested attachment related reactions to the separation and reunion with their therapists along a continuum of attachment patterns, the discrete categories of attachment developed by Ainsworth and those who followed her maybe less relevant in these circumstances.

Slade (1998) stated the following:

> The impulse to seek therapy may well derive from a healthy sense that one can be helped by someone stronger and wiser...however, for individuals with insecure attachment histories, such normal human processes often become distorted and transformed by what are rightly called transferential expectations that the therapist will not understand, will not be available, or will in some way violate the patient's sense of (albeit shaky) safety and security. (p. 31)

It therefore becomes the responsibility of the therapist to identify and address these "transferential expectations" in order to begin the process of a reconfiguring of the patient's internal working models. Dozier and Tyrrell (1998) proposed a model of therapeutic change that suggested that changes in the

client's working model of the therapist will result in, and in fact are prerequisites to, more " fundamental change in working models of the generalized self and other" (p. 238). They referenced Bowlby's statements that there are three tasks in the therapist's work with a client. The first and primary task is to provide a secure base that promotes safe exploration. The second therapeutic task is exploration of current interpersonal relationships, and the third therapy task is the exploration of working models of earlier attachment figures and attachment experiences. This researcher is in agreement with Dozier and Tyrrell's model, and believes that a key factor in being able to do what they have suggested is the ability to recognize and address the attachment patterns that the patient brings into the therapeutic relationship.

As with any physical, emotional, cognitive, or psychological issue or diagnosis, broad categories are very helpful in giving us a structure into way to think about these particular diagnoses. However, understanding that each individual will manifest a particular syndrome or cluster of symptoms different from any other individual is crucial to good therapeutic intervention. The same would be true of attachment patterns and classifications, due to both individual differences in human beings as well as differences in internal working models.

Therefore, this researcher feels that looking in the actual relationship, being able to observe, identify and classify behaviors as they manifest in the relationship gives the therapist and patient rich information which could not be gathered in any other way. As the therapist does not typically have the opportunity to observe the patient's interpersonal interactions with others, the

therapeutic relationship becomes an important resource for information about the patient's ways of interacting.

In addition to giving us specific information about how patients' particular attachment patterns may manifest both in the therapeutic and other significant relationships, this method of observation would allow for each individual issue as it arises to be addressed and understood in context of the early attachment experiences. This also allows us as clinicians to have a broader way of understanding our patients' behaviors in the therapeutic relationship. It allows us to think about transference in the relationship from an additional perspective.

The findings of this study highlight the unique ways and the extent to which patients' attachment patterns are manifested in the therapeutic relationship. Slade (1998) stated that "an understanding of the nature and dynamics of attachment inform rather than define intervention and clinical thinking" (p. 7). This study has shown that people manifest aspects of insecure attachment issues along a continuum from anxious to avoidant, not in discreet categories, although their behavioral and emotional responses may be more weighted toward one end or the other. The findings of this study indicate that the ways in which attachment patterns manifest in therapeutic relationship are closely linked to the relationship patterns between the infant and caregiver. In becoming more attuned to these patterns, we as clinicians will be better able to assist out patients in healing these attachment ruptures, and living their lives to the fullest extent they can.

The use of the holiday break in this study also provides us with valuable information regarding patients' responses to separations from us. Breaks in the treatment, whether planned or unplanned, are unavoidable, and a part of every therapeutic relationship. Attending to the attachment issues triggered by these separations allows us to utilize them as opportunities for further growth and healing, rather than perpetuating further trauma. While this researcher believes that attachment issues are omnipresent in the therapeutic relationship, it seems clear that, as in Ainsworth's Strange Situation research, the separation brings them out in a concentrated form, thus giving opportunity to see them more clearly.

This study raises the question of how we as clinicians should address these separations. Clearly, being attuned to our patients' responses after the separation is indicated. However, this researcher believes that the information gathered in this study also indicates that we can and should be addressing these issues prior to the separation (if it is a planned one as in this study.) With the understanding that separations, however brief, can activate old attachment patterns, we as clinicians can utilize this information to work with our patients both prior to and following a separation. It is beyond the scope of this study, but tempting to speculate, that just as attachment patterns are manifested by patients in the therapeutic relationship following a planned separation, so too would they be manifested in the relationship in the sessions prior to the planned separation. If this is so, and this researcher believes that it is,

this gives us additional opportunity to assist our patients in addressing attachment patterns that may be otherwise less accessible to us.

The great value of attachment theory is that it touches upon omnipresent aspects of life. All people seek attachment, thus creating a sensitivity and vulnerability to separation and loss that is a universal part of the human experience. It is deeply relevant and offers understanding and the opportunity for healing in any context and with any therapeutic modality. These ideas can be used not only in long term psychodynamically oriented therapy, but as shown in this study, in shorter term, cognitive behavioral, crisis intervention, or any other method of treatment. It also has great potential to be used proactively, with new parents and caregivers, and for early intervention with children who have suffered some kind of attachment trauma. It is the belief of this researcher that the ideas presented in this study offer a valuable and hopeful perspective on the treatment of our patients.

Limitations of the Study

1. As the participants in this study were not randomly selected, the generalizability of the findings was limited.

2. While audio recordings of the sessions provided important data, such communication as may have occurred nonverbally in the session were not available to the researcher.

3. This study only provided observation of the reunion behaviors

exhibited by the patient participants in these particular sessions. Information about the patient participants' early attachment experiences and current relationships was not taken into consideration. This study examined a time limited, and situation specific experience.

4. While this researcher understands the impact that a therapist's attachment patterns and countertransference reactions have upon the therapeutic relationship, as well as the views stated by interpersonal and intersubjective theorists which indicate that one cannot examine the responses of a patient without examining those of the therapist as well, for the purposes of this study, only the reactions and behaviors of the patients were examined.

Recommendations for Further Research

While this study provided exciting and rich information about attachment in the therapeutic relationship, there is a great need for further research in this area. The recommendations for further research follow.

This study should be replicated by another researcher, using other patients, to see if similar themes emerge. The researcher was not able to study and analyze the important non-verbal communication that occurred between the patients and their therapists. Therefore, a valuable future research project could include analyzing video taped reunion sessions.

It was beyond the scope of this study to analyze the therapists' interactions with their patients in regard to attachment patterns. A future study might look

at attachment in the therapeutic relationship from the therapists' perspective and/or from an intersubjective perspective.

Due to the limited number of reunion sessions examined in this study, a wide variety of demographic variables could not be examined for impact upon behavior. A future study with a larger number of subjects might be able to examine possible correlations between demographic data and attachment pattern manifestations in the therapeutic relationship.

Another potential study might include administering the AAI or other adult attachment measure to determine attachment categories of patients. Then when the reunion sessions were coded, the researcher could look for any relationship between the attachment categories and the findings in the therapy sessions.

As noted in this chapter, this researcher believes that patients' attachment patterns are in existence in the therapeutic relationship at all times. Given that any separation may trigger old attachment patterns, it would be useful to examine a number of sessions both prior to the separation and upon reunion. This might reveal other attachment patterns and behaviors in the therapeutic relationship, as well as providing greater information about patients' experiences of separation.

A longitudinal study would prove very interesting as well. If researchers were able to examine reunion sessions following separations in a therapeutic relationship over a period of months or years, this could provide rich data regarding the process of attachment in the therapeutic relationship and it's

changes over time. It would be fascinating to look for patterns maintained over time, as well as indications of changes in patient response to separation and reunion.

All of the above recommendations for further research are noted with the idea of gathering more data about the therapeutic relationship. This researcher believes that the more we explore this area, the greater our ability to assist our patients will be.

Conclusion

This study found that all patients were impacted by the separation caused by the holiday break. All of the patients manifested responses to the separation from their therapists in the reunion session that, while reflecting each individual's particular attachment patterns and working models, had enough similarities to be grouped into identifiable themes and categories. Each patient's attachment patterns were visibly displayed both in the material they presented and in their behaviors in session. The patients displayed a clear process of reconnection with their therapists over the course of the session, each in their own particular manner.

The extent to which each patient manifested her attachment patterns did not seem to be impacted by whether or not the therapist overtly addressed the issues. In spite of each patient's unique history and personality, the experience of the separation had impact upon her internal state and level of functioning.

This study was undertaken to attempt to further understand the unique, rich and powerful nature of the patient/therapist relationship, in the interest of

increasing our ability as clinicians to offer assistance to our patients. It is the great hope of the researcher that this study has made a contribution to that end.

Appendices

Appendix A.

Introductory Letter

September 14, 1998

Dear Sirs and Madams:

My name is Penelope Katz. I am a licensed clinical social worker in Los Angeles and a doctoral candidate at the California Institute for Clinical Social Work. (As well as an Intern Alumnus of AMCS.) I am in the dissertation phase of my studies, and I am very grateful that Airport Marina Counseling Service is considering allowing me to collect some data for my research.

I am conducting a qualitative study in regard to attachment patterns as they are manifested in the therapeutic relationship, both in the transference, and in the relationship separate from the transference. In my preliminary review of the attachment literature as it relates to the clinical setting, I have found much in the way of discussion of how attachment theory can be applied to clinical work, and even research exploring the relationship between the patient's attachment patterns and the quality of the therapeutic alliance, but I have not located anything which is descriptive of the ways the patient's attachment patterns are manifested in the therapeutic relationship.

In my research, I am going to attempt to identify, classify and categorize patient's behaviors, thoughts and feelings upon separation and reunion with their therapist (a la Mary Ainsworth's Strange Situation research with infants and caregivers.) My thought was that this could be valuable information to gather in regard to giving therapists and their patients insight into the patient's early (and consequently ongoing) attachment patterns.

My data collection would consist of asking up to 10 therapist/interns to audio record the first session with a patient upon return from the winter holiday break. I would also ask those same therapists/interns to fill out a brief demographic questionnaire and a brief (no more than 10 item) scale regarding their patients' utilization of therapy. All necessary measures would be taken to follow informed consent and human subjects' guidelines.

As this data is to be collected immediately after the winter break, I would need to know which interns and patients would be participating by mid November, in order to allow enough time to complete the informed consent process. I would imagine that supervisors and their interns would therefore need to be discussing this amongst themselves and then with their patients during the month of October. If it would be helpful, I would be more than happy to come and speak with the supervisors at any time to answer any questions regarding my request.

Again, I am very appreciative of your willingness to consider my proposal and my hope it that this research will prove to be a useful experience for all involved.

Sincerely,

Penelope J. Katz, LCSW
4900 Overland Avenue, #296
Culver City, CA 90230
310-415-2091

Appendix B.

Patients' Informed Consent

CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

INFORMED CONSENT FORM

I, _____, hereby willingly consent to participate in Attachment in the Therapeutic Relationship: An Exploratory Study of Patients' Response upon Reunion Following a Holiday Break, a research project of Judith Schore, Ph.D. (Principal Investigator) and Penelope J. Katz, LCSW (Investigator) of CICSW.

I understand the procedures as follows:

1. An audio recording will be made of my first session with my therapist following the winter holiday break.
2. My therapist will fill out 2 brief questionnaires to provide some general demographic information and information regarding my participation in therapy. The questionnaires will not ask for any information about the specific content of therapy sessions.
3. I am aware that there is minimal potential risk for emotional discomfort involved in participating in this study. However, if this should happen I will be able to contact the researcher who will make provisions for me to receive professional help for a reasonable and limited time.
4. I understand that this study may be published and that confidentiality will be maintained and that my anonymity will be protected.
5. I have been informed that a therapy session will be taped for the purposes of data analysis for this study. I have also been advised that my name will not appear on the tape and at the completion of the study the tape will be destroyed. I realize that I will not be identified in any publication or presentation of information gathered as a part of this study.
6. I understand that I may refuse to answer any questions, and that I may withdraw from the study at any time.

Signature_____ Date_____

Appendix C.

Therapists' Informed Consent

CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

INFORMED CONSENT FORM

I, _____, hereby willingly consent to participate in Attachment in the Therapeutic Relationship: An Exploratory Study of Patients' Response upon Reunion Following a Holiday Break, a research project of Judith Schore, Ph.D. (Principal Investigator) and Penelope J. Katz, LCSW (Investigator) of CICSW.

I understand the procedures as follows:

1. An audio recording will be made of the first session with a patient following the winter holiday break.
2. I will fill out 2 brief questionnaires to provide some general demographic information and information regarding my patient's participation in therapy. The questionnaires will not ask for any information about the specific content of therapy sessions.
3. I am aware that there is minimal potential risk for emotional discomfort involved in participating in this study. However, if this should happen I will be able to contact the researcher who will make provisions for me to receive professional help for a reasonable and limited time.
4. I understand that this study may be published and that confidentiality will be maintained and that my anonymity will be protected.
5. I have been informed that a therapy session will be taped for the purposes of data analysis. I have also been advised that my name will not appear on the tape and at the completion of the study the tape will be destroyed. I realize that I will not be identified in any publication or presentation of information gathered as a part of this study.
6. I understand that I may refuse to answer any questions, and that I may withdraw from the study at any time.

Signature_____ Date_____

Appendix D.

Demographic Questionnaire

DEMOGRAPHIC QUESTIONNAIRE

Please answer the following questions about your patient to the best of your ability. You may decline to answer any question if you have concerns that to do so could potentially put you patient at risk.

1. What is your patient's date of birth? _____

2. What is your patient's gender? _____

3. What is your patient's ethnicity? _____

4. What is the highest level of education your patient has completed? _____

5. What is your patient's current employment situation? _____

6. How long has your patient been at Airport Marina Counseling Service? _____

7. When did you begin counseling with your patient? _____

8. Is there an anticipated end date to the counseling with your patient? Yes_____No_____

9. If so, what is the anticipated end date? _____

10. Has your patient had any prior counseling? Yes_____No_____

11. If so, please list when and for what length of time. _____

_____

_____

_____

Appendix E.

Clinician Ratings

CLINICIAN RATINGS

1. How frequently does this patient show up for scheduled appointments?
A) Always shows up for scheduled appointments.
B) Usually shows up for scheduled appointments.
C) Shows up about half of the time for scheduled appointments.
D) Usually misses appointments.
E) Always misses appointments.

2. How often is this patient on time for scheduled appointments?
A) Always on time.
B) Usually on-time.
C) More than 10 minutes late about half of the time.
D) Usually more than 10 minutes late.
E) Always more than 10 minutes late.

3. How often does this patient request more than originally scheduled by calling or requesting additional appointments?
A) Always requests more than originally scheduled.
B) Usually requests more than originally scheduled.
C) Requests more than originally scheduled about half of the time.
D) Usually does not request more than originally scheduled
E) Never requests more than originally scheduled.

4. How often does this patient seek out help by doing things such as asking for your opinion and/or support?
A) Always seeks out help.
B) Usually seeks out help.
C) Seeks out help about half of the time.
D) Usually rejects help.
E) Always rejects out help.

5. How often does this patient talk about significant problems?
A) Always talks about significant problems.
B) Usually talks about significant problems.
C) Talks about significant problems about half of the time.
D) Usually doesn't talk about significant problems.
E) Never talks about significant problems.

6. How often does this patient acknowledge feelings of distress or anger?
A) Always acknowledges feelings of distress or anger.
B) Usually acknowledges feelings of distress or anger.
C) Acknowledges feelings of distress or anger about half of the time.
D) Usually does not acknowledge feelings of distress or anger.
E) Never acknowledges feelings of distress or anger.

7. How well does this patient utilize treatment?

A) Very poorly.
B) Usually poorly.
C) Neither poorly nor well.
D) Usually well.
E) Very well.

8. How much has this patient benefited from treatment?

A) Not at all.
B) Not very much.
C) Somewhat.
D) Quite a bit.
E) Very Much.

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