

**A description of the process of working intersubjectively with an  
insecurely attached young adolescent: a case study**

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## Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **ABSTRACT**

The dissertation presents clinical case material from a psychodynamic therapy with a 12 year-old boy. He presents with minor conduct disturbance, difficulty in affective expression and withdrawal in the context of a dysfunctional family system. The case study research addresses the following aims. It uses information collected from initial interviews with the family and subsequent therapy and feedback sessions to explore the patient's attachment patterns. It explores the links between the patient's attachment style and his access to and expression of affect. It describes the impact on both attachment style and affective expression of a brief therapeutic intervention. The empirical description of these interactions is made possible by literature with a focus on attachment, affect regulation and intersubjectivity. The descriptions show how the therapist and child, through their ongoing self- and interactive regulation influence his access to broader affective expression and a more secure attachment style. Attachment theory provides a useful framework in which to examine and observe these therapeutic interactions because it uses accurate verbal and non-verbal behavioural indicators to track unconscious enactments between the patient and the therapist.

The therapy sessions were videotaped and transcribed over a 9 month period, and our interactions and conversation are analysed and evaluated in terms of hermeneutics. The dissertation finally discusses the strengths and weaknesses of the case study research and it offers recommendations on how future studies focusing on the therapeutic relationship could be improved.

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# CHAPTER ONE

## INTRODUCTION

This dissertation will present clinical case material from a short psychodynamic therapy with a 12 year old boy over a period of 9 months. The child presented at the Child Guidance Clinic as the identified patient. He presented with minor conduct disturbance (fire setting and cutting his pants with a pair of scissors) as well as with difficulty in affective expression and withdrawal. These behaviours have been linked to early attachment relationship difficulties, which result in problems of affect regulation (Bowlby, 1988; Fonagy & Target, 2006). Following the intake interview, subsequent history-taking interviews and assessment sessions with the child, it became apparent that he may be the symptom of a problematic family system and this impacted on his well-being. This was manifest in their dysfunctional and disorganised interactions that left all the members of the family dissatisfied. Problems within the family system included an absent father and emotionally over involved mother.

This finding left me with a challenge: how should I intervene when the child's current difficulties were being experienced in his continuing familial relational context? I contemplated whether the goal of therapy with this child should be to work with the family system with all its members, or to create a safe space with a focus on basic affect regulation to facilitate the development of a secure base of attachment, thereby changing his current experience. After consultation and discussion with my supervisor, and taking into account the family's unavailability for family work, I kept the child in therapy. I provided feedback to his parents concerning parenting skills and suggested that they be referred for marriage or relational counseling.

The descriptions of interactions with the child were made possible by literature with an emphasis on attachment (Bowlby, 1969; Bowlby, 1973; Bowlby, 1980; Bowlby, 1988; Fonagy, 2001), affect regulation (Schore, 1994) and intersubjectivity (Atwood & Stolorow, 1984; Stolorow, Atwood, & Brandchaft, 1994). One of the things addressed in this framework is failure of affect regulation, which is precipitated by an insecure attachment style that often results in a lack of control over affects and is expressed as acting out behaviours. According to Fonagy (2001), the regulation of emotions depends on an

understanding of internal experience, which is most likely to arise in the context of an early caregiving relationship. Negative affectivity may be mediated by the absence of a core capacity to appropriately regulate negative emotions. This may be the result of frightened-frightening attachment experiences in early childhood. The descriptions show how the therapist and child, through their ongoing self- and interactive regulation influenced his access to broader affective expression and a more secure attachment style.

This dissertation has four aims. Firstly, it uses information collected from initial interviews with the family and subsequent therapy and feedback sessions to begin to map the patient's pattern of attachments from infancy. Secondly, the dissertation will explore the links between the patient's attachment style and his access to and expression of affect. Thirdly, the dissertation will describe the impact (if any) on both attachment style and affective expression of a brief therapeutic intervention.

Finally, the research addresses the following question: In the absence of a primary secure attachment relationship, how will the patient and therapist intersubjectively regulate emotions in an attempt to develop a more secure attachment pattern?

## **CHAPTER TWO**

### **LITERATURE REVIEW**

The last three decades has added new lenses with which to view the child. They were made possible by literature with an emphasis on attachment (Bowlby, 1969; Bowlby, 1973; Bowlby, 1980; Bowlby, 1988; Fonagy, 2001), affect regulation (Schore, 1994) and intersubjectivity (Atwood & Stolorow, 1984; Stolorow, Atwood, & Brandchaft, 1994), which has provided a securely empirical base for the explorations of development and treatment by psychoanalytic theorists. The literature review will focus on these bodies of knowledge.

#### **1. Attachment**

Bowlby's (1969, 1973, 1980) attachment theory is one of the most influential theories of development. Bowlby integrated principles from diverse scientific disciplines to explain affectional bonding between infants and their caregivers and the long-term effects of early attachment experiences on personality development, interpersonal functioning, and psychopathology. He developed an ethological theory concerning the regulatory functions and consequences of maintaining proximity to caregivers. He argued that infants are born with a repertoire of behaviours (attachment behaviours) aimed at seeking and maintaining proximity to supportive others (attachment figures). In his view, proximity seeking is an inborn affect-regulation device (primary attachment strategy) designed to protect an individual from physical and psychological threats as well as to alleviate distress (Bowlby, 1969, 1973, 1980). He thus conceptualised human motivation in terms of behavioural systems and noted that attachment-related behaviour in infancy, for example, clinging, smiling, crying, monitoring caregivers, and developing a preference for a few reliable caregivers or attachment figures is part of a functional biological system that increases the likelihood of protection from dangers, comfort during times of stress, and social learning. Modern attachment theory (Fonagy, 2001) also states that the primary survival gain of attachment lies in eliciting a protective caregiver and in the experience of psychological containment of aversive affect states required for the development of a coherent self. Bowlby (1988) claimed that successful accomplishment of these affect-regulation functions results in a sense of attachment security, that is, a sense that the world is a safe place, that one can rely on protective others, and that one can therefore confidently explore the environment and

engage effectively with other people. According to Fonagy and Target (2006) brain development itself is facilitated or inhibited by early psychosocial experience. Secure attachment ensures optimal development of brain processes that support social thinking patterns for collaboration and co-operation with others. Early childhood experiences lay down biological pathways (brain pathways) thereby ‘hard wiring’ patterns of social interaction later in life (Fonagy & Target, 2006).

Central to attachment theory (Bowlby, 1988) is the notion that children will feel secure in their relationship with their attachment figure to the extent that the attachment figure provides consistent, warm, and sensitive care (attachment-figure availability). When this happens, children learn to use the attachment figure as a secure base. They are willing to turn to the attachment figure in times of need, and if the attachment figure is available and responsive, they are able to be comforted by the attachment figure in a way that allows them to feel better and to return to other activities. As a result, positive expectations about others’ availability and positive views of self as competent and valued are formed, and major affect-regulation strategies are organised around these positive beliefs. The secure base hypothesis (Bowlby, 1973) also suggests that when there is a lack of consistent, sensitive care, children will feel anxious or insecure in their relationship with their attachment figure and consequently be unable to use the attachment figure as a secure base. When attachment figures are unavailable or unresponsive to the child’s needs, proximity seeking fails to relieve distress, and a sense of attachment security is not attained. As a result, negative representations of self and others are formed, and strategies of affect regulation other than proximity seeking are developed (secondary attachment strategies). In other words, attachment figure availability is one of the main sources of variation in strategies of affect regulation. Bowlby (1988) assumes that the attachment system is active over the entire lifespan and is manifested in thoughts and behaviours related to support seeking.

Empirical support for Bowlby’s (1969, 1973, 1980) theory was provided by Ainsworth, Blehar, Waters and Wall (1978), who document different patterns or styles of secure base use among children and their parents. According to Mikulincer, Shaver and Pereg (2003), most empirical tests of these theoretical ideas have focused on a person’s attachment style,” the systemic pattern of relational expectations, emotions, and behaviour that results from internalisation of a particular history of attachment experiences and consequent reliance on a particular attachment-related strategy of affect regulation” (p. 79). These patterns termed

securely attached, anxiously attached avoidant (or dismissing), anxiously attached ambivalent (or resistant) and disorganised (or disoriented), were shown to correlate with observed maternal behaviour toward children in the home thereby supporting the role of parent-child relationship in the development of attachment patterns.

Bowlby (1973) argues that the 'internal working model' of the infant is a representational model of the self. He suggests that "each individual builds working models of the world, and of himself in it, with the aid of which he perceives events, forecasts the future, and constructs his plans" (p. 236). A key feature of this model is the notion of "who these attachment figures are, where they may be found, and how they may be expected to respond" and "how acceptable or unacceptable he himself is in the eyes of his attachment figures." (Bowlby, 1973, p. 236). Therefore in this model the child's feelings of acceptance or rejection by the attachment figure determine his or her working model of him/herself. Fonagy (2001) states that the central feature of the internal working model concerns the expected availability of the attachment figure. The key feature of this is how acceptable or unacceptable the child feels in the eye of the attachment figure. A child whose internal working model of the caregiver is focused on rejection is expected to develop a complementary working model of the self as unlovable, unworthy and flawed. These models of the attachment figure and the self are transactional, interactive models representing self-other relationships (Fonagy, 2001). This transactional model further describes the intersubjective relationship between infant and child. In this relationship the child sees the parent thinking about his/her needs and responds, modelling connections with thoughts, feelings, moods and desires. The child internalises this model and makes interpretations for him/herself and so develops a theory of mind. In the attachment relationship between the parent and child the parent responds to the child and teaches the child about regulating his/her emotions by modelling it either by soothing an over-stimulated or overwhelmed child or by stimulating an under-responsive child. The child internalises this pattern of affect regulation and learns to regulate him/herself.

Sroufe (1996) reconceptualised attachment theory in terms of affect regulation. He argues that the relationship between and infant and caregiver not only implies an "affective bond" but is in fact "the apex of dyadic emotional regulation, a culmination of all development in the first year and a harbinger of the self-regulation that is to come" (Sroufe, 1996, p.172). Fonagy (2001) suggests differential patterns of attachment which result in the access an individual has to particular types of thoughts, feelings and memories. Those with secure

attachment histories learn in their attachment relationship to regulate their emotions and have good access to thoughts and feelings experienced in the attachment relationship. Those with insecure attachment histories either ‘down-regulate’ which means they avoid emotionally charged systems, or ‘up-regulate’ and become increasingly emotionally disorganised when aroused and have limited access to attachment related thoughts and feelings (Fonagy, 2001). Bowlby (1988) believes that attachment insecurity, although originally an adaptive set of strategies designed to manage distress, increases vulnerability to psychopathology and can help identify specific types of difficulties that may arise.

According to Mikulincer, Orbach and Iavnieli (1998), securely attached individuals have adopted adaptive ways of regulating affect. Secure persons attempt to manage distress by enacting effective coping responses, coordinating attachment with other behavioural systems, and acknowledging the impinging distress without being overwhelmed by it. In this way, secure persons develop more flexible and well adjusted views of the world and the self and more reality-tuned coping plans compared to insecure persons. Insecure attachment seems to be a risk factor that hinders well being and leads people to adopt maladaptive ways of coping (Bowlby, 1988). Avoidant infants adopt a “flight” response in dealing with the caregiver’s unavailability. This group place distance between themselves and the caregiver. On the other hand, anxious-ambivalent infants anxiously approach the caregiver and “fight” for his or her love.

The flight response of avoidant persons has two basic facets (Mikulincer, Orbach, & Iavnieli, 1998; Wei, Vogel, Ku, & Zakalik, 2005). First, defensive attempts are made to deactivate the attachment system in order to avoid any potential conflict with distressing attachment figures. Bowlby (1969) indicates that this response leads to what is called detachment and to cognitive and behavioural distancing from attachment cues in particular and from distress-related cues in general. Second, compulsive attempts are made to attain self-reliance and autonomy as a means of compensating for the reluctance to depend on others. Avoidant persons tend to dismiss the importance of close relationships, to minimise emotional involvement with and dependence on others, to deny attachment needs, and to pursue autonomy and control (Sable, 1983). According to Bowlby (1988), avoidant persons’ tendency to detach themselves from distressing attachment figures may then be generalised to behavioural and cognitive attempts to distance themselves from any internal and external source of distress. Moreover, their compulsive pursuit of self-reliance may lead them to

suppress or dismiss bad self-attributes as a way of preventing the recognition that their own self is a source of distress. Avoidant persons are prone to deny any personal weakness, to suppress bad thoughts and emotions, to inhibit the overt display of pain and distress, and to rely on repressive-dissociative mechanisms (Muller, 2009; Mikulincer, Orbach, & Iavnieli, 1998; Mikulincer, 1995; Mikulincer & Orbach, 1995).

The way anxious-ambivalent persons cope with their basic insecurity implies a hyperactivation of the attachment system (Mikulincer, Orbach, & Iavnieli, 1998). They attempt to minimise distance from distressing attachment figures and maximise the secure base these figures can provide. This is a fight response by which people attempt to win others' love by means of clinging, hypervigilant, and controlling responses. This strategy creates an excessive and anxious focus on attachment and distress-related cues (Wei, Vogel, Ku, & Zabalik, 2005). Their tendency to minimise distance from distressing attachment figures may be generalised to behavioural and cognitive attempts to minimise distance from other distress-related cues (Bowlby, 1988). These persons tend to approach distress in a hypervigilant way, to overemphasise bad self-traits and memories, to exacerbate negative affect, and to allow distress to spread to other life areas (Mikulincer, Orbach, & Iavnieli, 1998; Mikulincer, 1995; Mikulincer & Orbach, 1995).

## **2. Attachment and therapy**

Bowlby (1980) states that attachment is of long duration, often persisting throughout the life cycle both intrapsychically and externally. The dynamics involved in the formation, maintenance, renewal, disruption, and loss of attachment relationships highlight fundamental similarities and differences between early attachment relationships and the patient-therapist relationship. Although the median length of psychotherapy is 5-6 sessions (Farber, Lippert & Nevas, 1995), many therapies, particularly those conducted within a psychodynamic framework, continue for many years. Meetings between the patient and therapist do, however, eventually come to an end. Some patients, especially those with insecure attachment styles, may use their awareness of the eventual conclusion of treatment as a means of limiting the influence of the attachment relationship and maintaining a sense of independence. They defend against feelings of attachment and assert that there is no point in investing emotionally in a relationship that is going to cease. The deactivating strategies of avoidant attached patients may delay the development of attachment. Due to their discomfort

with dependence and intimacy, avoidant patients will be prone to distancing and distrust in early therapeutic encounters and their physical defensive maneuvers will give therapists the impression that attachment development is absent (Obegi, 2008; Parish & Eagle, 2003). Avoidant patients may thus take longer to develop an attachment to the therapist and the expression of attachment markers (affect) may be subtle or subdued (Obegi, 2008). However, Bowlby's (1988) statement regarding the duration of attachment alternatively indicates that once an attachment relationship is established, it remains operative even in the physical absence of the attachment figure. In essence, the therapist may continue to be used by patients as attachment objects long past the point of formal termination.

According to Obegi (2008) as well as Parish and Eagle (2003), regarding the issue of time, variability in treatments, in addition to differences in attachment styles prevent generalisable estimates for the development of attachment security. Treatments vary in their session frequency, session duration, and length. Since interpersonal contact is necessary for attachment security to form, therapeutic dyads that have lengthier or more frequent contact are expected to steadily advance attachment security, whereas shorter therapies may cap the growth of attachment security. An open question is thus whether brief therapies that mobilise strong affects accelerate the development of attachment security.

Bowlby (1988) indicates that the behaviour of the therapist is a significant factor to the therapeutic relationship:

“Even so, a patient's way of construing his relationship with his therapist is not determined solely by the patient's history: it is determined no less by the way the therapist treats him. Thus the therapist must strive always to be aware of the nature of his own contribution to the relationship which, among other influences, is likely to reflect in one way or another what he experienced himself during his own childhood” (p. 141).

Behaviours that correlate with stronger expressions of affect and attachment markers, for example warmth, are consistent with characteristics of a security-enhancing attachment figure. It thus seems likely that the length of therapy will turn on, in part, the ability of therapists to provide a security-enhancing climate that is adapted to individual differences in attachment styles (Obegi, 2008; Parish & Eagle, 2003).

### **3. Affect regulation**

Recent neuroscientific findings provide information indicating that interactional patterns between infants and caregivers create lasting neural changes in the brain's networks, resulting in lasting attachment styles, affect regulation patterns and modulatory emotional set points that last from infancy to adulthood (Schore, 1994; Schore, 2005; Schore, 2008). Schore (1994) proposes that attachment communications are critical to the development of structural right brain neurobiological systems involved processing of emotion, modulation of stress, self-regulation and thereby the functional origins of the bodily-based self.

According to Schore (1994), the main task of the first year of life is the creation of a secure attachment bond in emotional communication between the infant and the primary caregiver. For successful communication to take place, the caregiver must be psychobiologically attuned to the dynamic shifts in the infant's bodily-based internal states of central and autonomic arousal. During the affective communications fixed in mutual gaze episodes the psychobiologically attuned sensitive caregiver assesses non-verbal expressions of the infant's arousal and then regulates these affective states, both positive and negative. The attachment relationship mediates the dyadic regulation of emotion. In this process, the more the caregiver unconditionally tunes her activity level to the infant during periods of social engagement, the more she allows him to recover quietly in periods of disengagement. Also, the more she attends to his cues for re-engagement, the more synchronised their interaction (Schore, 1994; Schore, 2000; Schore, 2005; Schore, 2008). In episodes of affect synchronicity, the caregiver and infant are in affective resonance, and as such, an intensification of vitality affects and a positive state occurs (Schore, 2008). In moments of interactive repair the "good enough" caregiver who has misattuned, can regulate the infant's negative state by accurately re-attuning in a timely manner. The regulatory processes of affect synchronicity that create states of positive arousal and interactive repair, which adjust states of negative arousal are the fundamental building blocks of attachment and its associated emotions and resilience in the face of stress (Schore, 1994; Schore, 2000; Schore, 2008). Innately regulated by the attunement between the right hemispheres of both caregiver and infant, the caregiver's self-states are conveyed to the infant's through numerous nonverbal communications. According to Schore (2005), emotion is initially regulated by others but over the course of infancy it becomes increasingly self-regulated as a result of neurophysiological development. The following adaptive capacities are essential to self-

regulation: “the ability to flexibly regulate psychobiological states of emotions through interactions with other humans, interactive regulation in interconnected contexts, and without other humans, autoregulation in autonomous contexts” (Schoore, 2005, p. 209).

A child’s capacity to regulate his or her affect is dependent on an attuned and empathic caregiver. When a primary caregiver is emotionally unavailable or when the child is subjected repeatedly to inconsistent responses because of parental misattunement, the child is likely to manifest abnormalities in affect development and affect regulation as well as an insecure attachment style (Beebe & Lachmann, 2002; Stern, 1985). Caregiver sensitive responsiveness is defined by the attachment figure’s success in fitting their own response patterns to those of their children in ways that are mutually satisfying. Sensitivity and responsiveness of the primary caregiver to the child’s emotional states is a major determinant of the way the child learns to regulate distressing affects and to relate to other people (Beebe & Lachmann, 2002; Bretherton, 1985; Goldberg, MacKay-Soronko, & Rochester, 1994). Reckling and Buirski (1996) link failures in physiological self-regulation to psychological deficits, particularly in recognition of moods, that stem from early attachment problems. Insensitive primary caregivers impede an infant’s ability to modulate affective expression and arousal (Susman-Stillman, Kalkoske, Egeland, & Waldman, 1996).

Schoore (2005) posits that the early-maturing right brain seems to be involved in implicit emotional learning that precedes verbal development. The right hemisphere has been connected to early implicit information processing and to emotional memories and experiences that underline the self-schema and the individual’s sense of self. Schoore (1994; 2005) describes how the emotion processing limbic circuits of the infant’s developing right brain, which are dominant for the emotional sense of self, are influenced by intrinsic intersubjective affective interactions rooted in the attachment relationship with the primary caregiver. Implicit processing triggers the quick and automatic handling of nonverbal affective cues in infancy, and “is repetitive, automatic, provides quick categorization and decision-making, and operates outside the realm of focal attention and verbalized experience” (Lyons-Ruth, 1999, p. 576). Schoore (2008) describes how prosodic vocalizations, coordinated visual eye-to-eye messages and tactile and body gestures, serve as channels of communicative signals in the proto-dialogues between infant and caregiver, which stimulate instant emotional effects. Bowlby (1969) also describes facial expression, posture and vocal tone as the critical means of attachment communication between the emerging self and the

primary object. The dyadic implicit processing of these non-verbal attachment communications are the creation of the operations of the infant's right hemisphere interacting with the caregiver's right hemisphere. Attachment experiences are thus imprinted in an internal working model that encodes strategies of affect regulation, which act at implicit non-conscious levels (Schore, 2005).

Schore (2005) indicates that these particular implicit right brain operations are crucial for adaptive interpersonal functioning and are specifically activated in the therapeutic alliance. The ability to receive and process implicit communications is "optimized when the clinician is in a state of right brain receptivity" (Schore, 2005, p. 842). The right hemisphere is involved in recognizing other people's emotional expressions and is assisted by internally generated bodily sensations interpreted by the right brain. The clinician's right brain thus allows the clinician to know the patient in the most immediate and direct way. Schore (2005) concludes that the intersubjective field contains within it not only an emotional exchange but a bodily one as well. Implicit right brain-to-right brain intersubjective transactions lie at the core of the therapeutic relationship and are called "moments of meeting" (Schore, 2005).

Ginot (2007) asserts that the implicit relational knowledge that is part of the shared relationship culminates in an enactment that by its enmeshed nature allows the therapist's unmediated experience of the patient's stable relational patterns. Enactments provide the most significant and direct ways for both patient and therapist to connect with what needs to be known, recognised and integrated as part of a developing sense of self. Enactments add to an intersubjective mode of empathy based on an unconscious experience that directly connects with the patient's dissociated emotions, defenses and attachment patterns (Ginot, 2007). Emotional links and sensory responses to others are activated through communicated gestures, vocal tones, postures, and facial expressions, creating an intuitive or an implicit knowledge of them, which can be viewed as an expanded notion of empathy (Ginot, 2007). According to Schore (2008), many features of social interaction are nonverbal, consisting of subtle variations of facial expression that set the tone for the content of the interaction. Body postures and movement patterns of the therapist could also reveal emotions such as disapproval, support, humour, and fear. Tone and volume of voice, patterns and speed of verbal communication, and eye contact further include elements of unconscious communication and add to the unconscious establishment of a safe, healing environment. Fonagy (2001) views the therapist's concern with the patient's shifting mental states as

essential to the patient's capacity to develop a similar concern. In relationally-oriented therapeutic contexts that promote intersubjective communication and interactive regulation, deficits in internal working models of the self and the world are gradually repaired.

Restoring into consciousness and re-assessment of internal working models is the fundamental task of psychotherapy (Bowlby, 1988). Importantly, the therapeutic impact of this lies in the extent to which the therapist is attuned to the patient's affective states and developmental longings.

#### **4. Intersubjectivity**

According to Buirski and Hagland (2001), a central organising concept of intersubjective theory is that our experience of ourselves is essential to how we operate in the world. Our subjective experience is all that one might be aware of at any given moment as well as much of what is out of awareness. Over time, the complex interlinking of individual abilities and temperament, relational configurations with caregivers during infancy and childhood, and the kind or cruel realities of one's life circumstances meet to form patterns. These patterns of experiencing oneself and the world describe our subjective, personal reality and become structured as our organisation of experience. In the therapeutic setting, we attempt to understand these patterns in the context of a relationship that becomes a new lived experience and the basis of new organising patterns (Buirski & Hagland, 2001).

Buirski and Hagland (2001) postulate that subjectivity consists of organising principles developed out of lived emotional experiences with childhood caregivers. The context for the creation of the organisation of experience is the intersubjective field of early childhood, primarily the subjectivity of the caregivers as they learn to understand and respond to the unique temperament and personality of their child. An important factor in the quality of that early relational context is the capacity of the caregivers to appreciate and respond in soothing and affirming ways to the emotional life of the child. Therefore, a child's experience of being understood or not, particularly when he or she contends with intense affects, is the intersubjective context (lived experience) out of which subjectivity develops. There is no subjectivity without intersubjectivity. The key elements of the intersubjective field as it contributes to positive and stable subjectivity are those experiences that affirm, regulate, and integrate affect for both members of the dyad (Buirski & Hagland, 2001).

Buirski and Hagland (2001) state that human subjectivity becomes organised into patterns based on repeated emotional experience within the child-caregiver dyad. Such patterns are the foundation on which the coherence and continuity of experience depend. Stolorow, Atwood and Branchaft (1994) posit that it is an important source of human motivation in that “the need to maintain the organisation of experience is a central motive in the patterning of human actions” (p. 35). Infants require sensitive care by caregivers who take pleasure in their health, comfort, and well being. Ideally, a system develops in which both infant and caregiver expects that the needs of the child will be met in ways that are satisfying to both. However, whatever quality of care is given, the developing child organises those patterns of experiences into expectations for the future. Without generating expectancies, experience is random and unmanageable, and every new circumstance would require new learning. Part of human adaptation involves the ability to organise experience into meaningful patterns. These patterns or organisations of experience contribute to the essence of subjectivity and the sense of a cohesive self (Buirski & Hagland, 2001).

According to Stolorow, Branchaft and Atwood (1987) as well as Stolorow and Atwood (1992), the selfobject provides a self-delineation and differentiation function for the child when the caregiver is able to accurately perceive and respond to the child’s affective world. Positive experiences of attunement to the child’s shifting affect states lead to the structuralisation of the self. Non-attunement leads to disavowal and dissociation of affect from this structuralisation. A mediating factor is the attuned responsiveness of the selfobject to the painful internal world of the child (Stolorow & Atwood, 1992). The selfobject thus has an important role to play in regulating the affective experience of the child.

When the caregiver fails to attune to the painful internal world of the child, there is a breakdown in the caregiver’s role of regulating the child’s internal world. The caregiver no longer provides the function of containing, holding, reflecting, and validating the child’s internal experience. According to Stolorow and Atwood (1992), “painful or frightening affect becomes traumatic, we contend, when the requisite attuned responsiveness that the child needs from the surround to assist in its tolerance, containment, modulation, and alleviation is absent” (p. 53). The child is in a sense abandoned and has to regulate his or her own internal world but still attempts to maintain his or her needed selfobject tie to the caregiver. Stolorow, Branchaft and Atwood (1987) indicate that this involves the child having “to serve significant selfobject functions for his or her parents” (p. 91). The child may

come to view aspects of his or her own internal affective world as damaging to the parents. This perception would result in the child developing a harsh internal voice, and his or her need to grow and develop may become a source of conflict and guilt. Under these circumstances, defenses employed to assist with this can be seen as adaptive, as they are attempts to manage unbearable, frightening internal experiences. Defenses are expressed, out of awareness, in the unconscious organising principles and show the patient's attempts to organise experience and create meanings.

Within the paradigm of interacting subjectivities, transference is co-constructed through the interchange of differently organised subjectivities of patient and therapist (Buirski & Hagland, 2001; Stolorow, Brandchaft, & Atwood, 1987; Stolorow, Atwood, & Brandchaft, 1994). The therapeutic context will determine which unconscious organising principles will be induced and how the experience will be internally organised by the patient. The organisation of the therapeutic experience for both patient and therapist will be shown in the patterns and themes, verbal and non-verbal, which characterise personal and intersubjective reality (Stolorow, Atwood, & Brandchaft, 1994). Buirski and Hagland (2001) propose that self-regulation refers to a person's capacity to regulate or control internal states, such as affectivity, arousal or responsiveness. Interactive or mutual regulation refers to the extent that each person influences the other. Significantly, the way that a person self-regulates will impact the other, which will have a reciprocal impact on the experience of self.

The intersubjective field encompasses selfobject experiences and the repetitive dimensions from past interactive experiences (Stolorow, Brandchaft, & Atwood, 1987; Stolorow, 1995). Transference describes the shifting needs and fears of the patient in mutual relationship with the therapist's own organising principles. Atwood and Stolorow (1984) indicate how the therapist's own unconscious organising principles may occasionally alter the patient's subjective meaning. On other occasions, the therapist's organising principles will be in close concert with the patient's own organising principles. This juxtaposition in ways of experiencing the other is inevitable and reflects the interaction of two differently organised subjectivities. The therapist must develop a means of reflective self-awareness and the ability to de-centre from his or her own organising principles (Atwood & Stolorow, 1984).

The intersubjective field includes selfobject experiences and the repetitive dimensions from past interactive experiences (Stolorow, Atwood, & Brandchaft, 1994). The organisation of

the transference serves a number of functions for the patient, which includes maintaining the self and defensively warding off repetition of experience that is deemed to be too painful or dangerous to the self (Atwood & Stolorow, 1984). The process of therapeutic action varies depending on whether the selfobject or conflictual, resistive, and repetitive dimensions of the transference are at the centre of the therapeutic relationship (Stolorow, Brandchaft, & Atwood, 1987; Stolorow, Atwood, & Brandchaft, 1994). When the selfobject dimension of the transference is at the forefront, it leads to the restoration and maintenance of self-experience. When the patient however perceives and experiences the therapist as a source of painful affect states then this dimension of the transference is in the background. When the therapist is viewed as the source of pain, it can serve the function of maintaining the patient's experience of self. Interpretation of the resistance dimension leads to transformation of structures of subjectivity. Interpretation should only take place within the context of 'good enough' affective attunement that leads to re-establishing the selfobject attachment at the centre of the therapeutic relationship (Stolorow, Brandchaft, & Atwood, 1987; Stolorow, Atwood, & Brandchaft, 1994). Integration of affect via affective attunement is central to the transformation of structures of subjectivity (Buirski & Hagland, 2001).

According to Buirski and Hagland (2001), the empathic-introspective stance includes the therapist's empathic inquiry both into the patient's subjective world and into his or her own. Empathic inquiry includes grasping a full range of contextual elements such as the emotional, historical, behavioural, and cognitive aspects of the patient's unfolding experience. Affect attunement refers to the therapist's abilities to recognize and respond meaningfully to various qualities of the patient's subjectivity. Affect attunement and empathic inquiry are two-person processes. They occur in the therapeutic dyad, which is the intersubjective field formed from the subjectivities of patient and therapist. Buirski and Hagland (2001) indicate that when referring to the empathic-introspective stance, empathic listening is considered to be a bridge to the subjectivity of the patient. The affectively attuned responses of the therapist based on his or her empathic understanding make possible a unique kind of subjective experience for the patient, which includes feeling known and understood as well as providing the basis for a new organisation of experience. Listening to the patient, understanding the context of the patient's life experience, and reflecting that understanding to the patient represent the fundamental aspects of empathic inquiry (Buirski & Hagland, 2001).

In this chapter, I have outlined the theoretical constructs that will be used to analyse the case material that follows. These theoretical constructs also support the methodology described in the following chapter.

## **CHAPTER THREE**

### **METHODOLOGY**

In this section I will describe the methodological approach that has been utilised for this study, namely, a clinical case study within an intersubjective paradigm. This section will include a description of the context of the study; a discussion of the case study method; a discussion of the key views of intersubjectivity theory and its relevance to this case study. I will also discuss the analysis of material and the protection of the confidentiality of the subjects of this case study.

#### **1. Context of study**

The case material upon which this paper is based consists of psychodynamic therapy undertaken during Clinical Psychology Master's training at the University of Cape Town's (UCT) Child Guidance Clinic. The Child Guidance Clinic provides academic training for Clinical Psychology Master's students and offers a psychological service and support at reduced rates for residents in Cape Town. Students are trained in adult and child psychotherapy, and a large focus of the training is on the assessment and diagnosis of child patients and appropriate interventions. Child patients are referred for treatment by schools, general practitioners and family members in Cape Town. The subject of this case study was assigned to me for assessment and treatment.

#### **2. The case study method**

According to Kazdin (1992), there has traditionally been a lack of consensus between the practitioners of case study method and empirical researchers in the domain of clinical psychology. This lack of agreement results from the traditional experimental methods of investigation and evaluation of variables that contribute to behavior. Traditional experimental methods attempt to test hypotheses through controlled conditions, carefully obtained objective measures of functioning, and scientific rigor (Bromley, 1986; Kazdin, 1992).

Kazdin (1992) indicates that the variables controlled in traditional experimental research tend to be exaggerated in the case study method. This amplification of detail by means of detailed description provides the opportunity for intensive study of the subject within a particular context. Within clinical psychology, this context usually refers to the treatment situation (Kazdin, 1992). The case study method attempts to show how and why a subject behaved in a given situation and inferences are drawn about factors arising from the past or the present that are likely to account for the current behaviour. The concentrated study of the subject, particularly of unique and/or complex problems and processes, may lead to hypotheses about causes of behaviour or treatment effects. In this way, the case study method complements traditional experimental methodology. Atwood and Stolorow (1993) as well as Kazdin (1992) however caution that the results yielded by the case study method are merely suggestive and cannot be viewed as the definitive explanation for any particular phenomenon. Donmoyer (2000) argues that even statistically significant findings from large sample groups cannot be universally applied to all individuals; it rather requires the knowledge of the individual clinician to determine the applicability of any finding on any one individual in particular. Generalisability is not the aim of this research. Rather it is to understand this particular unique patient and to illustrate relevant attachment, affect regulation, and intersubjectivity literature with case material.

Donmoyer (2000) as well as Terre Blanche and Durrheim (1999) state that case study method can also lead to scientific discovery and provide rich information as well as a deeper understanding of a phenomenon. Case studies have the advantage of allowing new ideas and hypotheses to emerge from careful and detailed observation. This is most notably seen in the field of psychoanalysis, where psychoanalytic knowledge has been advanced through the intensive study of the individual (Atwood & Stolorow, 1984; Atwood & Stolorow, 1993; Kazdin, 1992; Stolorow, Atwood, & Brandchaft, 1994).

The case study method thus includes certain important features. It focuses on a particular pattern of behaviour within specific circumstances over a limited time-period; it aims to provide a discriminatory but detailed description that captures the distinctive characteristics of the subject and his or her context, including an analysis of the implications of these observations and finally, it uses a theoretical framework that influences the organisation and interpretation of the data obtained (Bromley, 1986; Donmoyer, 2000; Kazdin, 1992; Yin, 1994).

### **3. Gathering data**

The psychodynamic therapy sessions described in this analysis were carried out at the Child Guidance Clinic. Sessions were videotaped and session notes were kept to further document the process. Session notes were used as a guide to issues, complications and features of importance to be discussed in supervision. Supervision was provided by an allocated senior psychologist who guided me to expand my reflective awareness and explore both transference and counter transference issues that emerged from the case material in order to increase my therapeutic understanding.

According to Goldberg (1988), the therapist is the instrument who gathers the data by means of subjective evaluations or interpretations. These evaluations and interpretations are dependent on the researcher's chosen theoretical perspective. Whether descriptions of behaviour can however be removed from the theoretical lens through which they are viewed raises the question of whether psychoanalysis can be considered a science. Goldberg (1988) contends that a specific set of principles should be applied to a case. These principles rest on the basic principle of hermeneutics. The researcher is thus required to be aware of his or her own theoretical perspectives as they influence the investigation. The theoretical perspectives that the researcher brings to the investigation "influences the dialogue with the patient, and what the patient offers us, in turn, influences us" (Goldberg, 1988, p. 54). It is therefore crucial that therapists continually attempt to expand their reflective awareness of their own unconscious organising principles, especially those influenced by theory, so that the impact of those principles on the therapeutic process can be recognised and itself become a focus of therapeutic investigation (Stolorow, Atwood, & Brandchaft, 1994). Within an intersubjective paradigm, the researcher is therefore always included in the description of what is being observed (Atwood & Stolorow, 1984). The intersubjective approach emphasises the therapist-patient system of mutual interaction in which each participant is affecting and interpreting the other's experience. This view has implications for the knowledge generated in a psychoanalytic case study:

"The varied patterns of meaning that emerge in psychoanalytic research are brought to light within a specific psychological field located at the point of intersection of two subjectivities. Because the dimensions and boundaries of this field are intersubjective in nature, the interpretive conclusions of every case study must, in a very profound

sense, be understood as relative to the intersubjective context of their origin” (Atwood & Stolorow, 1984, p.6).

Atwood and Stolorow (1984) state that psychoanalytic case studies are always interpretive procedures and that the validity of their results can only be evaluated in terms of hermeneutics.

According to Atwood and Stolorow (1984), Buirski and Hagland (2001) as well as Stolorow, Atwood and Brandchaft (1994), the hermeneutic circle indicates how a phenomenon can only be understood in terms of how the parts of it make up the whole and knowledge of the whole is made up by the study of the parts. The subject and the researcher together comprise the dialogue that makes up the whole or, in other words, the intersubjective field. The intersubjective field is the space where both partners’ subjectivities composed of their respective organising principles and patterns of self-regulation meet and construct a dialogue together. Taking the risk of testing our organising principles in dialogue with a subject makes possible a new meaning or organising principle, a future form of experience that could emerge only through the dialogue (Atwood & Stolorow, 1993; Stolorow, Atwood & Brandchaft, 1994). The interpretation and meaning derived from the particular data described in this case study will essentially be a subjective account. The processes of structure formation and therapeutic action described in this case study will be a unique phenomenon arising out of a specific intersubjective field to which both partners will contribute their distinct self-regulatory patterns.

#### **4. Analysis**

Within this case study, data will be derived from close interaction with the subject of the research paper. This method may be considered most appropriate for the purpose of understanding his internal world as this should enable an empathic immersion into his perspective to a greater degree than standardised measurements would allow. Inclusion of the intersubjective field should also establish the particular context in which the material will arise.

The process to be adopted in the analysis of the material will include a thorough examination of the recorded therapy sessions and the written notes made in order to document the psychodynamic processes involved. Furthermore, information collected from interviews with

the family and subsequent therapy and feedback sessions will be used to establish a baseline pattern of attachment and affect regulation against which therapeutic impact and change can be measured.

The recorded therapy sessions and accompanying written notes as well as additional information obtained from the family were processed using an adaptation of the interpretive approach outlined by Terre Blanche and Durrheim (1999). The first step in the analysis procedure referred to familiarisation and immersion (Terre Blanche & Durrheim, 1999) during which time each therapy session was watched and the accompanying written notes were read numerous times in order to gain a preliminary understanding of the meaning of the case material. The notes and additional information from the family were then used, based on the findings in the literature, in considering all the sessions as a whole. This was done in an attempt to arrive at a detailed understanding of the factors that influenced the patients' and therapist's attachment and affect regulation processes. The second stage in the analysis procedure involved deducing themes (Terre Blanche & Durrheim, 1999) from the text. This involved a top-down approach using ready-made categories or themes and looking for instances that fit those categories or themes best. During the activity of developing themes, case material from each therapy session was marked off as being instances of, or relevant to, one or more of the themes. This facilitated the third phase in the analysis procedure during which the case material was coded (Terre Blanche & Durrheim, 1999). Verbal and non-verbal information or case material was coded using different coloured pens to highlight relevant pieces of the text by virtue of their containing material or information that pertained to the themes under consideration. The content of the text referred to events occurring during therapy sessions and were labelled with more than one code if it referred to more than one theme. Once the case material or information was organised in this manner, the various themes could be elaborated on by finding or tracking repetitions of patterns of attachment and affect regulation. These patterns or regularities of the way patient and therapist responded during therapy sessions in different situations and at different times provided the basis or framework against which therapeutic change or impact could be measured.

In this way, a hermeneutic spiral was created in that a continuous back and forth process was established between the literature and the case material or information whereby different parts of the case material or information were interpreted then related to the totality of the text and then re-evaluated accordingly (Atwood & Stolorow, 1993). Through this process, a deeper understanding of the factors that influenced the patient's attachment and affect

regulation process was created as the hermeneutic spiral developed (Terre Blanche & Durrheim, 1999). This formed part of the final stage of the analysis procedure, which involved interpreting and checking (Terre Blanche & Durrheim, 1999) and it yielded the results that are described in Chapter Five of this paper. During this final stage in the analysis procedure, theoretical insight was also required that offered further understanding and clarity regarding the interactions within the therapy relationship and aspects of the patient's and therapist's behavioural attachment and affect.

More specifically, analysis of the material primarily involved tracking a range of affect representations in therapy sessions (self- and mutual regulation patterns). Firstly, his attachment to the therapeutic process was monitored along with his and my reactions to cancellations. For example, how did we both react to breaks in treatment and to subsequent resumptions of therapy sessions? Were cancellations evocative of feelings of anger, anxiety or disappointment? Did we both look forward with pleasure to resuming sessions (i.e., reuniting) and did he display proximity seeking behaviour once sessions had resumed?

Secondly, emerging themes were tracked and attempts made to recognise their relationship to representations of attachment and affect representations within the co-constructed therapeutic relationship. Here, the patient's comfort with the intimacy of the therapy sessions was monitored through uninhibited and genuine displays of affect like crying, warm greetings and mutual laughter.

Thirdly, I obtained feedback from parents about the development of interactional change (attachment style), symptom reduction and improvement in overall behavioural and emotional functioning.

Finally, feedback from the patient regarding the creation of new expectations and organisations of experience were used. For example, did he use the safety of sessions to explore painful feelings, events and alternative ways of feeling and acting?

For the purposes of this research paper, secure attachment can be operationalised as representational systems where the attachment figure is seen as accessible and responsive when needed (Bowlby, 1988). As the therapist, I wanted to attempt to provide a secure base by offering an attachment experience that balanced closeness and autonomy and included

positive expectations about availability and sensitive responding. The goal of the therapy was to assist in the patient's progress towards a more secure base. The goal of the research was to track as closely as possible shifts in attachment in relation to self- and mutual regulation, particularly of affect.

## **5. Ethics**

Detailed monitoring of the way in which the student psychologist in training therapeutically and administratively manages the case is guaranteed by the allocation of senior psychologists to supervise the student psychologist. These supervisors provide support and training to the student psychologist and ensure that professional standards, ethical considerations and the patient's best interests are maintained.

The parents of the subject were asked to sign a form granting permission for material emerging during therapy to be used for research purposes. It was explained to the parents that the Child Guidance Clinic is a training institution attached to the University of Cape Town and is also involved in research work. Parents agreed to such use of the material and signed the form. Each time I met with the family, I informed them that our therapy sessions were being recorded. I asked for permission for my supervisor to watch the recordings in order to help me formulate an understanding of the case. I considered whether to ask the family directly if I could use the material emerging from therapy sessions for a research project. In discussion with my supervisor, it was decided that the issues it would raise would disrupt the therapeutic process. On balance, the decision to accept patient consent at face value was considered to be the more ethical practice (Bollas & Sundelson, 1995; Gabbard, 2000). To protect the identities of family members thereby ensuring their confidentiality and anonymity, names and demographical details have been altered.

## **CHAPTER FOUR**

### **HISTORY-TAKING INTERVIEWS**

This section will describe my meeting with John and his parents. I will then describe the parents' history as it was revealed during the therapy. I will describe collateral information, the assessment results and present my diagnosis. I will also present my intervention plan.

#### **1. Referral and first meeting**

The referral for an assessment was initiated by John's mother (Marge, 42) who stated that John was assessed and diagnosed with AD/HD in 2006. The referral card also stated that his "mother wants him re-assessed as he is doing strange things, cutting his school pants and set something alight in bathroom".

Present at the first history-taking interview were John (12) and his parents Marge (42) and Jack (41). My initial impression of John was that he was a slightly built and quiet child who showed little emotional expression. He was also well groomed, soft spoken and displayed some mild anxiety (restlessness and fidgeting) during the interview situation. My first impression of Marge was that she appeared anxious and over protective of John. My first impression of Jack was that he appeared anxious and detached from John and Marge.

During the first half of the interview, the parents, especially Marge, described John's difficulties while John explored the therapy room for a while and then played passively on the floor lining up the clinic's plastic soldiers and animals as though they were commencing combat. During the family interview, John was listening to the conversation taking place between his parents and me. I attempted to draw John into the conversation but he remained quiet and seemed to play happily on his own. Not once during the history-taking interview did Marge or Jack attempt to monitor John's play.

When the parents were asked to describe the history of their relationship, both parties became reluctant to continue the conversation in front of John. I felt anxious and thought that it would be inappropriate to continue with this line of questioning at that stage. This was confirmed by supervising staff observing the interview and it was decided that I should

continue with this specific topic without John in the therapy room. There were no objections from John or his parents when presented with this proposal. This turned the conversation to their relationship and it was revealed that Jack had suffered from a mental disorder/psychiatric illness and had engaged in numerous extra-marital affairs.

After the initial hour session, I spent time with John for half an hour. He was polite and compliant and appeared to “meet” me on my terms. John’s affect appeared restricted and he answered my questions and gave an account of his interests in a soft monotone. He seemed very solitary and displayed poor eye contact. He however explored the therapy room with interest. As a joining exercise, we played football together. He described everything at home and school as being “fine”.

Overall, there appeared to be two ways in which to describe the presenting problem. The first was a description of John’s minor conduct disturbance as well as his difficulty in affective expression and withdrawal, and the second concerned him being a symptom of a problematic family system that may have impacted on his well-being. I needed to try and understand from John’s perspective how all this impacted on him and what his difficulties were.

Collateral information obtained from a visit to John’s school revealed that he was a happy social child with no obvious problems. No evidence of AD/HD was observed. His Grade Seven teacher indicated that John was well behaved in the classroom setting and performed his duties as a prefect adequately.

## **2. Diagnosis**

From the history-taking interview and psychological assessments, the following provisional diagnosis was made (using the *Diagnostic and statistical manual of mental disorders*): On Axis I, Parent-Child Relational problem and Partner Relational problem. I was not certain that a diagnosis of Conduct Disorder was appropriate as the fire setting incident was an isolated occurrence and he did not meet the full criteria for the disorder. His teacher also had not experienced such behaviours at school. Furthermore, behaviours associated with Conduct Disorder did not emerge during the assessments or therapy. I was however aware that John could possibly be experiencing symptoms of depression but as these were not overt, no diagnosis of depression was made. No diagnoses were made on Axis II and Axis III. On

Axis IV, a diagnosis of Problems with primary support group was made, with specific reference to threat of parental separation, parental overprotection, inadequate discipline, and divorce, re-marriage of a parent and mental health problems of a parent.

### **3. Family history**

The following will describe the patient's and parents' history as it was revealed during the course of therapy together. During the initial history-taking sessions, I elicited information from each of the parents separately in order to gain an honest and accurate account of their extended and nuclear family functioning. This course of action was decided upon in conjunction with my supervisor as there seemed to be some hesitancy by both parents to openly discuss their marital and familial history in each other's presence during the initial intake interview.

During the subsequent history-taking session with Marge, I experienced her as anxious, compliant and wanting to divulge the information in the shortest space of time. Marge indicated that she was worried about John and wanted therapy to start as soon as possible. This rigid expectation influenced her self-regulation, as well as our interactive regulation.

Marge was born in Plettenberg Bay; the first of three children. Not much information was elicited about Marge's early childhood and adolescence. She spoke about her childhood and adolescent life only in general terms. Marge reported that her parents were never married. She had two sisters and a brother. Marge's mother was described as an alcoholic who was emotionally absent from the family. According to Marge, her mother seldom displayed physical affection towards her children. Her father was described as having numerous extra-marital affairs and he thus seldom spent time with the family. She indicated that he would drift in and out of their lives. According to Marge, her father also never provided financial security for the family. Marge said that she thus took on the role of playing surrogate mother to her younger siblings and they had to take care of themselves from a young age. Marge stated that she and her siblings continue to share a 'close' relationship. Marge's mother died of cancer in 2004 and her father died in 2000.

During the subsequent history taking session with Jack, I experienced him as defended, hostile and irritable. These experiences and expectations also influenced his and my self-

regulation, as well as our interactive regulation. He openly challenged me by stating that John was supposed to be the focus of clinical attention rather than him. In line with Jack's mental configurations, I believe I was experienced as critical, demanding and invasive as he possibly had similar experiences with other mental health professionals when he was hospitalised.

Jack was born in Cape Town. Not much information was elicited regarding Jack's early childhood and adolescence. He also described his childhood and adolescent life only in broad terms. Jack reported that his parents were happily married and shared a 'close' relationship. Jack's father was described as being strict but loving. His father often used corporal punishment as a disciplinary measure. Jack indicated that his father drank alcohol over the weekends but was adamant that he did not abuse alcohol. Jack's father died in 2000. He was hijacked and shot to death. According to Jack, he currently shares a 'close' relationship with his mother and siblings.

Jack reported that he was diagnosed with "schizophrenia" in 1988. He was hospitalised twice in 1991 and 2006 for relapses. He however presented no overt symptoms of Schizophrenia during interviews. There was no access to further collateral, which may have provided a more definitive diagnosis. He further reported that he is currently not using any medication. According to Jack, there is no reported psychiatric history in his parents' family of origin. According to Marge, when Jack was hospitalised for two months in 2006, she and John only visited him once together at the hospital. John was extremely upset and did not want to go back to visit his father. Marge had to comfort John continuously and became even more protective of him. Marge reflected that she and John became extremely 'close' during this period. Also during this period, Marge went for psychotherapy due to emotional strain and for a bout of insomnia, which lasted approximately three months. Marge suggested that during all the difficult times she paid lots of attention to John. According to Marge, he was her "pillar of strength".

Marge indicated that John has certain chores to complete such as washing dishes and cleaning his room in the afternoon, as well as a curfew that he must adhere to. John seldom completes his chores. He also does not adhere to the curfew when Jack is at work. When Jack is at home then he will be home promptly at the allotted time.

Parents responded positively to the pregnancy. The pregnancy was planned although Marge felt that she was not ready to have children. Jack started drinking alcohol after John was born. Marge stated that there were no prior pregnancies, miscarriages and abortions. There were also no reported complications with regards to the pregnancy, including no maternal alcohol and drug use. Marge indicated that she was unable to give normal birth due to a narrow birth canal. Her private doctor issued a letter stating that she required a caesarean section. The public hospital where she gave birth did not accept this letter and insisted that she give normal birth. She was thus in labour for 28 hours before having an emergency caesarean section. In 1996, whilst living in Plettenberg Bay without Jack, John was left with a day mother while Marge worked. John became attached to the day mother. The day mother subsequently moved to another city and John is left with a new day mother. Marge was not comfortable with the new day mother because she was younger than the first day mother. Marge would phone her approximately five times a day to check on John.

In 1997, Marge and John moved to Cape Town to be with Jack. In the same year Marge and Jack were married but got divorced in 1998. Marge found this relocation difficult due to a loss of her social support system. John went to crèche at one year and three months of age as Marge attempts to find employment. It was difficult for her to leave him at crèche. According to Marge, John cried for approximately one week. Marge was not comfortable with John attending crèche at such a young age.

Marge also reported that during this period that she approached Jack's mother to baby-sit John. Jack's mother did not however want to take care of him when Marge started a new job nor when she wanted to pursue leisure activities at that time. Jack's mother and sister labelled John as being naughty. Marge thus left John with neighbours whom she hardly knew. At present, John is not allowed to enter his paternal grandmother's bedroom because he leaves the room in a mess. According to Marge, he has also stolen items from the bedroom. John does however not obey the no-entry rule. He continues to enter the bedroom and play with his paternal grandmother's possessions.

Both parents posit that the current nuclear family is composed of Marge, Jack and John. At present close relatives include Jack's mother and sister who live in Cape Town. Marge's relatives, which include two younger sisters and Jack's other remaining relatives, including an older brother and younger sister, live in Plettenberg Bay. According to both parents, the

family currently lives in a two bedroom flat. John has his own room and parents share a room. According to Jack, John sleeps with Marge in parents' bed when he works nightshift. John also wants Marge to sleep next to him even when Jack is at home.

Marge reported that she and John share a 'close' relationship. She said there is a high degree of physical contact between them such as frequent hugging and kissing. Jack and John do not share a 'close' relationship. John does not show physical affection towards his father such as hugging and kissing. Jack also shows minimal physical affection towards John. John does not directly ask him for items that he needs or wants. Jack also added that John seldom speaks to him unless he is spoken to.

Parents stated that they tended to be critical of each other's styles of discipline in John's presence. Marge suggested that she is a permissive parent. She is warm and caring but lax in discipline. Marge indicated that Jack is an authoritarian. Jack agreed that he uses corporal punishment as a disciplinary measure. Marge posited that John tends to push boundaries with her but not with his father. According to Marge, when there is a disagreement between them as parents, Jack will sometimes withdraw and not speak to her for approximately one week.

Marge stated that John was two years old when Jack moved out in 1999 to live with another partner. In the same year, Jack and his new partner had a child together. Marge indicated that her brother was stabbed to death by his friend in 1999. This event occurred three weeks after Jack had left the family unit. John witnessed Marge's extreme grief reaction and became upset (crying and screaming). Marge stated that a neighbour had to take John to her home for the remainder of the afternoon.

Before Jack's separation from the family unit, John and Jack would spend a lot of time together. Marge reported that John was upset (crying) when Jack left. During that time John walked around the house as though looking for something or somebody. He missed his father terribly while he was away. During Jack's absence, John was able to spend every second weekend with him. Marge remembered that John would either be excited or subdued after returning from weekends with his father. John never shared with his mother the reasons for his excitement nor subdued mood. Jack stated that when John spent weekends with him they would play in the park, go to shopping centres and have picnics. Jack returned to the family unit in 2004. John was extremely happy when his father returned to the family unit.

However, in 2005, 2007 and 2008, Jack engaged in numerous extra-marital affairs and increased alcohol use, which placed strain on the relationship.

In 2009, an area of conflict developed concerning Jack's other children. John's half brother (10) and half sister (8) are left with them by Jack's ex-wife at extremely short notice. Jack always allowed this to happen until Marge argued with him for not consulting with her first. Jack also gives his two other children more attention and physical affection. Jack makes no secret about John's half-brother being his favourite. Marge believes that John is jealous of his father's close relationship with his half brother.

Mo suggested that, at present, the daily routines of the family are consistent. Mo reported that the family has only recently engaged in leisure activities (going to the park and shopping centre together).

#### **4. Intervention plan**

In light of John's behavioural difficulties and his parents' relationship difficulties, it appeared that John and his parents required their own interventions. John seemed to be significantly traumatised by his father's mental disorder, parental conflict and the constant threat of parental separation, as well as overburdened by his enmeshed relationship with his mother.

After discussions with my supervisor it was decided that John would attend long-term individual psychotherapy in order to assess his emotional functioning; to help integrate affect associated with the mentioned traumatic experiences; provide him with the experience of a consistent, supportive relationship with a male adult figure as well as enable him to begin to acknowledge and express painful feelings, which may have resulted from his experiences in a disorganised family system. It was the view of the clinical team that the family unit was not available for intervention as a family.

I was working from an attachment perspective and the aims of therapy were to provide John with a secure base from which to explore the various unhappy and painful aspects of his family life, past and present, many of which he found difficult to think about. With a trusted companion to provide support, encouragement, empathy and guidance, the therapeutic intervention also revolved around helping John understand his and his parents' interactive experiences.

It was also decided to work with the parents by providing them with information and support with regards to parenting skills with a particular focus on disciplinary measures, boundary setting, becoming organised as a family, responsibility, communication and sibling rivalry. A further possible intervention focused on the possible assessment and referral of the parents to FAMSA for couple relational counselling. These decisions related to the traumatic events they as a couple and family had been through, and how it continued to affect relationships within the family in a powerful manner. The aim would be to improve both the couple dyad and family system as a whole by exploring and attempting to shift their interactional experiences.

## **CHAPTER FIVE**

### **CASE ANALYSIS**

Chapter Two outlined the concepts of attachment, affect regulation and intersubjectivity, particularly referring to how these three salient dimensions of relatedness are developed from infancy and subsequently experienced in the therapeutic relationship. Here, it was noted that intersubjective communication and interactive or mutual regulation between therapist and patient, as well as the extent to which the therapist is attuned to the patient's affective states may gradually repair internal working models of self-other relationships thereby creating a more secure attachment style (Bowlby, 1988; Fonagy, 2001).

In this chapter, clinical material is presented to elucidate the application of these theoretical concepts. In line with intersubjectivity epistemology, the focus will be on the themes and patterns that emerged within the intersubjective field. There are two levels of description that elucidate the theoretical concepts. These include:

1. Tracking themes and patterns of self- and mutual regulation and the co-construction of the relationship between the two of us in the therapy room.
2. Description of the impact on both attachment style and affective expression.

The abovementioned levels of description are not separate, as both the therapist's and patient's self- and mutual regulation influenced the way the therapy unfolded and thus how a more secure attachment was formed.

The analysis that follows suggests that failure to regulate affect and its connection to earlier attachment relationships is linked to the unfulfilled need for self-other representations of a particular kind. The data was analysed using attachment and affect regulation theory to establish examples of verbal and non-verbal attachment and affect regulation patterns in order to answer the research question regarding the link between the patient's primary insecure attachment relationship and his access to and expression of affect in the co-constructed therapeutic relationship.

In this analysis, I will describe with illustrations from case material, examples of attachment patterns and patterns or representations of affect within the therapeutic relationship as they

unfolded in the course of a brief therapeutic intervention. Beebe and Lachmann (2002) indicate that the most exceptional contribution of infant research to psychoanalysis is found in evidence that the basic processes of interaction at the non-verbal level remain very similar across the life span. The implications of this for the therapeutic process are significant.

Beebe and Lachmann state that “self-regulation refers to self-comfort and the capacity to regulate one’s states of arousal and organise one’s behaviour in predictable ways” (2002, p. 124). This capacity is evident in both verbal and non-verbal interactions. Usually non-verbal behaviours function in the background but they can be noted by the therapist and influence his or her responses. The non-verbal patterns reflect the patient’s adaptive efforts to engage with the other while attempting to maintain a comfortable level of arousal (Beebe & Lachmann, 2002).

In this chapter, I will describe how the non-verbal attachment patterns and patterns of affect regulation contributed to and ultimately impacted the co-constructed therapeutic relationship. The attachment relationship refers to the needed function of the therapist to provide regulatory experiences that help induce, restore and maintain the patient’s self-experience. In the beginning and middle phases of therapy, the patient’s withdrawal or avoidance indicated that I was not experienced as an attachment figure (Bowlby, 1988; Fonagy, 2001). These patterns may have been repeating behaviour rooted in his relational experiences at home, especially with his father. I was experienced as misattuned to his self-state, which in turn left me preoccupied with my own self-regulation. This was most evident in the shifts and changes in non-verbal behaviour, such as gaze, flow of dialogue, posture, self-and object-touching, and physical orientation.

## **Patterns or representations of affect**

### **1. Negative/hostile affect**

Negative or hostile affect was most evident with John during the initial phases of therapy. He used it in his relationships when he is emotionally aroused (anxious) or upset. Examples that John used in therapy sessions to illustrate his negative or hostile affect will follow.

In a discussion with his parents regarding the reason for referral during the intake interview, which included his acting out behaviours or minor conduct disturbance (fire setting incident and pants cutting), he appeared uncomfortable while sitting in between them and showed non-verbal expressions of shame, including tilting his head downwards towards the floor and slumping his shoulders. As the conversation continued with regards to his acting out behaviours, he seemed to become even more uncomfortable and bent over forwards almost curling up into a ball in an apparent effort to hide or protect himself. These non-verbal expressions may have reflected emotions such as shame or guilt. The child may come to view aspects of his or her own internal affective world as damaging to the parents. This perception would result in the child developing a harsh internal voice, and his or her need to grow and develop may become a source of conflict and guilt. Under these circumstances, defenses employed to assist with this can be seen as adaptive, as they are attempts to manage unbearable, frightening internal experiences. Defenses are expressed, out of awareness, in the unconscious organising principles and show the patient's attempts to organise experience and create meanings (Stolorow, Brandchaft & Atwood, 1987).

On another occasion, John was hitting the punch bag in the therapy room. He was hitting it extremely hard as though he was attempting to regulate his affect by displacing his anger. This prompted me to interpret the hitting. I indicated that he seemed angry and I asked whether he was hitting someone in particular. John reacted with a loud "no", a verbal expression of disapproval accompanied by non-verbal expressions, which included a rigid body posture, clenched fists and a sharp angry look towards me.

On another occasion, Jack and I discussed his use of corporal punishment on John and the fact that he explicitly promotes his other son as his favourite child. It was noticeable from the recorded footage that John was listening to the conversation. As we spoke, he put the boxing gloves on and sat quietly, softly hitting himself in the face whilst looking at himself in the mirror. This may have been an implicit and non-verbal communication of anger, sadness and self punishment. The more we spoke about this topic, the more active he became, such as doing bunny hops and backward rolls across the room. These may have been attempts on his part to regulate uncomfortable feelings through hyperactivity. When the topic of discussion changed to something less threatening, John's activity level dropped and he went to sit by the chess set. As soon as the topic of discussion reverted back to threatening content, which included talking about marital discord and Jack's previous psychological problems, John put

the boxing gloves on again and brought the soft toy snake closer. At one point, he pretended to fight with the snake and at another he pretended that the snake was strangling him. After that, he placed the snake on the floor and hit it numerous times with the boxing gloves before going back to punching himself softly on the chin again. These acts appeared to be indirect, non-verbal expressions or signs of distress or worry in response to the threatening nature of the content that was discussed.

In a later interaction between John and me, as we were drawing on the board in the therapy room, he appeared to be comfortable to stand close to me as long as we were standing side-by-side. As soon as I turned towards him in an attempt to initiate face-to-face conversation, he openly refused this effort at establishing intimacy by slowly moving away from me thus indicating physical avoidance through his defensive body positioning and movement pattern. This may have reflected a negative or hostile reaction in a pre-emptive attempt to deactivate the attachment.

Also in a later session, after administering the TAT, I commented on how difficult it must be to for him to verbalise his feelings. When he did not answer or respond, I felt that I needed to soothe him by again explaining confidentiality issues and indicating that the therapeutic space is a safe place to express negative emotions and experiences. After I told him this, his lips began to move as though he was talking softly to himself. Perhaps it was his attempt at silently telling me what he found too difficult or could not expressly verbalise. This focus on the difficult and uncomfortable emotions may have been too much because he shut down completely as evidenced by his use of physical avoidance, such as turning his entire body away from me and folding his arms across his chest. This may also have been a non-verbal acknowledgement of his distress. I attempted to re-engage him by verbalising for him what he might be feeling. This notion of affect labelling (putting feelings into words) was an attempt to manage his negative emotional experiences (Bowlby, 1988). The accuracy of my comments seemed to resonate with him and his body language opened up as he turned to face me. I further tried to get him involved in the process by asking him to show me where on his body the “bad” feelings were located. He was able to show me and even told me that his stomach was in knots.

Without taking his current anxiety into account, I mistakenly thought by getting him to draw what he was feeling on the board would possibly make it easier for him to acknowledge

difficult emotions in an indirect and less threatening way. John however displayed a negative or hostile affective expression at this suggestion. He compliantly went and sat at the drawing board but showed an overt display of hostility by not attempting to draw on the board. He also showed his disapproval through physical avoidance (turning his body away from me and moving further away from me when I attempted to approach him) and by verbally asking me to stay on the other side of the room. When the caregiver fails to attune to the painful internal world of the child, there is a breakdown in the caregiver's role of regulating the child's internal world. The caregiver no longer provides the function of containing, holding, reflecting, and validating the child's internal experience. The child is in a sense abandoned and has to regulate his or her own internal world but still attempts to maintain his or her needed selfobject tie to the caregiver (Stolorow & Atwood, 1992).

It must be noted that throughout the therapy, John never displayed intense displays of negative affect, such as sadness (crying) or explicit expressions of rage. According to Bowlby (1988), avoidant persons' tendency to detach themselves from distressing attachment figures may then be generalised to behavioural and cognitive attempts to distance themselves from any internal and external source of distress. Moreover, their compulsive pursuit of self-reliance may lead them to suppress or dismiss bad self-attributes as a way of preventing the recognition that their own self is a source of distress. Avoidant persons are prone to deny any personal weakness, to suppress bad thoughts and emotions, to inhibit the overt display of pain and distress, and to rely on repressive-dissociative mechanisms (Muller, 2009; Mikulincer, Orbach, & Iavnieli, 1998; Mikulincer, 1995; Mikulincer & Orbach, 1995).

During the final phase of therapy (last three sessions), John did not display any negative or hostile affect. These sessions were mostly characterised by displays of positive affect.

## **2. Strong displays of positive affect**

John's strong displays of positive affect were most evident whilst building rapport and joining with him during the early phases of therapy but also included times when therapy appeared to be non-threatening and non-invasive in the middle and latter phases.

In an attempt to join or build rapport with John, I attempted to use an activity (chess) that he was competent in during certain therapy sessions. The use of this activity was also an

attempt on my part to alleviate his and my anxiety in the room. When I presented the chess set for the first time as part of a therapy session, his face first showed an expression of interest and then joy when he realised what it was that I had brought with me. He interacted in a spontaneous, warm, friendly and positive manner while explaining the rules of the game to me. We both got caught up in the game and it felt easier for me to bond with him in this manner without intruding on his intrapsychic experiences. I felt that in previous sessions, I was progressing too fast in response to the pressure placed on me to move along with the therapy by his parents. This was my deliberate attempt to slow the therapeutic process down, present myself as less threatening and thus build rapport and provide a secure base from which an attachment relationship could develop. According to Atwood and Stolorow (1984), the therapist must develop a means of reflective self-awareness and the ability to de-centre from his or her own organising principles.

When he beat me in four moves, John and I displayed a strong display of positive affect (mutual laughter). He immediately initiated conversation and asked in a warm, friendly and positive manner if I wanted to learn the move. Once the session was over, in the waiting room, John told his mother that I almost beat him during one of the chess games. As he recounted this experience to her, his facial expression showed genuine surprise. It appeared that a secure attachment relationship was developing as we were both able to self and mutually regulate this experience within the intersubjective field. According to Stolorow, Branchaft and Atwood (1987) as well as Stolorow and Atwood (1992), the selfobject provides a self-delineation and differentiation function for the child when the caregiver is able to accurately perceive and respond to the child's affective world. Positive experiences of attunement to the child's shifting affect states lead to the structuralisation of the self. Non-attunement leads to disavowal and dissociation of affect from this structuralisation.

On another occasion John's mother and I were discussing the possibility of me visiting his school to observe and obtain collateral information from his teacher regarding his behavioural and emotional functioning, relational functioning with teachers and peers, memory functions and possible Attention-Deficit/Hyperactivity symptoms. I told him in a joking manner that he did not have to worry as I would not speak to him while I was there. He engaged in mutual laughter with his mother and I. This may have illustrated attuned responsiveness of the selfobjects (mother and I) to his possible anxiety of having me there in an attempt to regulate this negative affective experience (Stolorow and Atwood, 1992).

It was discussed with John that we would engage in a chess and soccer competition in a later therapy session. This was my attempt at providing him with a positive alternative experience with an adult male figure, an experience that he was lacking at home. When the aforementioned session arrived and John walked into the room, he demonstrated genuine and strong displays of affect, which included interest, excitement and joy at the prospect of the competition. During both activities, he interacted in a warm, friendly and positive manner as evidenced by his constant smiles and attempts to converse with me in a spontaneous manner. He also showed strong affective expressions of joy when scoring a goal and disappointment when missing a penalty kick. John may have felt secure in his relationship with me to the extent that I provided consistent, warm and sensitive interactions. As a result, he may have developed positive expectations of my availability and positive views of self as competent and valued, and those major affect-regulation strategies were formed and organised around these positive beliefs.

### **3. Object-focused hand movements and body-focused activity**

According to Freedman, O'Hanlon, Oltman and Witkin (1972), one major class of hand movements is the object-focused movements. Their defining characteristic is the close link to the spoken word. There are a variety of object-focused movements, which emphasise and punctuate, qualify, and illustrate the spoken message. Object-focused movements are single acts and are phased into the rhythm and content of what is said.

On the other hand, Freedman, O'Hanlon, Oltman and Witkin (1972) state that body-focused activity bears no apparent relation to speech. These movements involve continuous rubbing, stroking, or scratching by the hands of some part of the body or other object surface. While object-focused movements seem to function as part of the verbalising and symbolising process, the central function of body-focused activity appears to be self-regulation.

During the course of therapy, John displayed difficulties in verbalising his thoughts and feelings. Due to his limited verbal capacity in this regard, the motor or non-verbal rather than the verbal channel of communication became the significant vehicle for representation of self conflict. He was more likely to use gestures in the description of threatening external events or inner feelings and he frequently employed pointing or groping movements when words seemed unavailable. The demand to encode or represent negative internal experiences may

have induced a state of muscle tension that found its expression in motor activity (Freedman, O'Hanlon, Oltman, & Witkin, 1972).

When I spoke with John's parents regarding his acting out behaviours or when John and I conversed about the same topic and other difficult topics primarily regarding the relationship with his father, his body-focused activity increased and involved either hand-to-hand movements (clasping his hands together and the wringing of his hands) or the exploration of the body or other object surface. It appeared that during the stressful encounter, these movements were indicators of attempts to regulate negative internalised experiences, which he carried with him from the home situation to the therapeutic situation. The prevalence of the body-focused activity thus usually occurred when the therapy process was experienced by John as threatening, stressful or disorganised. His particular vulnerability to stress experiences and to anxiety arousal can be traced to limitations in symbolic organisation and transformational capacity of negative internal emotional states or affects.

Based on John's history, it is hypothesised that he is an individual who may be more prone to feeling shame or to feeling blamed by an unseen "other". In the communicative therapeutic setting, such experiences appear to lead to greater object need (object dependence). His persistent body touching in the therapeutic setting may be regarded both as an indicator of negative object experiences and as the internalisation of such experiences. As an indicator of negative object experiences, his body touching probably stems from the parent-child interaction (Freedman, O'Hanlon, Oltman, & Witkin, 1972). The fact that these movements may have been initiated by an unavailable or rejecting caregiver makes the observations relevant to his history of separation and abandonment issues. Such means of self-regulation of affect is a frequent phenomenon in response to conditions of selfobject misattunement. According to Schore (2002), the physiological dysregulation that results from relational trauma are often accompanied by deficiencies in the provision of selfobject experiences of affect synchronicity and interactive repair. Instead of optimal dyadic contexts of right-brain-to-right-brain intersubjectivity, he may have been exposed to severe breaks in intersubjectivity, which may produce 'dead spots' in his subjective experience. These experiences negatively impact the experience-dependant maturation of the right hemisphere, which is dominant for subjective emotional experiences and affect regulation (Schore, 1994). Schore (2002) posits that the coping deficits in right-hemispheric self-regulation are evident in a limited capacity to modulate the intensity and duration of affects, particularly

biologically primitive affects like shame, rage, excitement, and hopelessness. Under stress, such individuals experience diffuse, undifferentiated, chaotic states accompanied by overwhelming somatic and visceral sensations. This poor capacity for mentalisation leads to a restricted ability to reflect upon his emotional states. When it occurs in the communicative therapeutic setting, it often takes place together with reduced vocalisation, pausing, and gaze aversion and avoidance, all signs of withdrawal from the object (Freedman, O'Hanlon, Oltman, & Witkin, 1972). John's increased body-focused activity in the absence of an injuring selfobject appeared specifically in phases where he responded as if he were faced with an unavailable or rejecting selfobject even though he was in a warm receptive environment.

#### **4. Silences during sessions**

During the intake interview, I asked John how he felt about his parents arguing in relation to child-rearing practices. He was unable or unwilling to answer the question due to his anxiety and retreated back to rummaging through the cupboards in search of toys to play with. I indicated to him that it was okay and that we could get back to that topic at a later stage.

On another occasion, after he completed the Kinetic Family Drawing (KFD), I asked him about the picture (who was represented in the drawing and what they were doing). When I asked him why he drew himself on the other side of the page separated from his parents, he lapsed into silence. Even after attempts at probing further and then attempting to interpret the possible permutations of the drawing on his behalf, he remained silent and withdrew into himself.

In a later therapy session, I inquired about what it was like for him to attend sessions at the Child Guidance Clinic. John again reverted to silence, avoided eye contact and body-focused activity increased. I commented that it might be difficult for him to come to sessions. Without looking at me, he simply agreed with a nod of his head and did not attempt to add anything else. I was at a loss for words and also lapsed into silence. The counter-transference here can be seen as a tendency to engage in mutual avoidance, which provides relief for both the therapist and the patient (Muller, 2009).

Similar silences accompanied by negative or hostile expressions of affect were observed numerous times over the course of therapy when I probed around the possible reasons for cutting his pants around the crotch area.

John's silences were also most evident when therapy sessions were non-directive or unstructured. He may have thus been uncertain as to how to use the therapeutic space therefore not knowing what was expected of him. To regulate his anxiety arousal during these situations, he frequently resorted to individual activity, such as building puzzles possibly to deactivate the uncomfortable attachment situation.

John's silences at different times during sessions and my lapses into silence in response to his silences possibly reflect efforts at self- and mutual regulation in an attempt at modulating emotional equilibrium when experiencing stressed mutual interactions (Beebe & Lachmann, 2002; Buirski & Hagland, 2001).

## **Patterns of attachment**

### **1. Detachment**

Detachment patterns that were tracked throughout the therapeutic process included John's vocal expression and prosody, facial expression, and behavioural organisation. These patterns of detachment seemed to be his strategy to deactivate the attachment. Deactivation, a central defensive characteristic of avoidant/dismissing attachment has as its goal to shift the individual's attention away from those feelings, situations, or memories that arouse the attachment system. It enables the person to diminish, minimise, or devalue the importance of attachment stimuli (Muller, 2009). According to Muller (2009), the avoidant/dismissing individual's tendency to direct attention away from attachment-related stimuli breaks down under increased cognitive overload.

As part of the joining process or rapport building with John during the intake interview, I attempted to include him in the conversation with his parents and I. I asked him innocuous questions, such as what books he likes to read and what games he likes to play.

In the session, I asked him about his three wishes. As soon as I posed the question, John averted his gaze and gave me only two wishes in a soft monotone. He could not present a third wish even after efforts at probing.

In another early therapy session, John and I were conversing about his selection into the Maths Enrichment Programme for learners who excel at mathematics at school. Despite all my endeavours at praise and showing interest in this achievement, he would only answer my questions in a monotone, avoided making eye contact, and presented as passive and withdrawn with no attempts to venture any further information of his own volition. I witnessed similar behaviours of discomfort in the same session when talking about the girls in his class and what they were like.

On all of these occasions, his replies were delivered in a restricted, almost expressionless tone (lack of intonation change) and were low in volume. He displayed an impassive facial expression and looked withdrawn (restricted affect), which may have functioned to reduce interest in me and the activity. Eye contact was poor, which may have reflected his anxiety or anger. His behavioural organisation comprised of a passive attachment in which he appeared withdrawn and uninvolved, and rarely initiated behaviours or emotions as well as conversation. It was as though he placed an unseen barrier between us attempting to maintain some distance between us. My countertransference was a combination of feelings that included awkwardness, and a sense of emasculation and incompetence as a therapist. However, regardless of my counter-transference feelings, I surprisingly always seemed to maintain an empathic-introspective stance towards him and felt the need to play the role of big brother in order to protect him. In treatment, I attempted this by making empathic statements recognising how difficult or painful a particular situation must have been for him.

The flight response of dismissing/avoidant persons has two basic facets (Mikulincer, Orbach, & Iavnieli, 1998; Wei, Vogel, Ku, & Zakalik, 2005). First, defensive attempts are made to deactivate the attachment system in order to avoid any potential conflict with distressing attachment figures. Bowlby (1969) indicates that this response leads to what is called detachment and to cognitive and behavioural distancing from attachment cues in particular and from distress-related cues in general. Second, compulsive attempts are made to attain self-reliance and autonomy as a means of compensating for the reluctance to depend on others. Avoidant persons tend to dismiss the importance of close relationships, to minimise

emotional involvement with and dependence on others, to deny attachment needs, and to pursue autonomy and control.

In early and middle sessions of therapy when we chatted about non-threatening subject matter, such as soccer, cartoons, chess (also while playing chess), and school, John would display mild forms of detachment. During these times, he would occasionally look at me and fleetingly respond to my voice with interest (smile) with only subtle evasion of eye contact. His eyes would sometimes drift just out of a direct line of gaze so that he appeared available but consistently eluded contact. This may have reflected pseudo-pleasure or the impression of boredom.

John displayed more positive active attachment behaviours during the final phase of therapy (last three sessions), which included initiating behaviours and conversations in a higher volume accompanied by more intonation changes, improved eye contact, and a broader range of affective expression (not limited to passive and withdrawn facial expressions).

Interestingly, these positive active attachment behaviours and affective expressions were also observed once during the third session of therapy when we engaged in an activity together in which we used the drawing board to establish his attachment affiliations. He appeared relaxed and possibly enjoyed the structure and non-threatening emotive content that the activity provided.

## **2. Proximity-seeking behaviour**

Proximity-seeking behaviours in the context of this dissertation refer to John's initiatives to increase physical proximity and attempts to make contact with me in a verbal and/or non-verbal manner.

His proximity-seeking behaviour in the beginning and middle phases of therapy were fleeting or non-existent, possibly due to his attachment style and accompanying anxiety. The following examples will attempt to illustrate this. In an early session, he found a pair of boxing gloves and struggled to put them on. He did not ask me to help him. I offered to help him put the boxing gloves on but he quickly declined my effort at proximity-seeking and moved away from me. The punching bag was in the room but it was not yet hung up on the

chain. He made no effort to ask me to put it up for him so I offered. I also prompted him to help me put it up, which he did.

The secure base hypothesis (Bowlby, 1973) suggests that when there is a lack of consistent, sensitive care, children will feel anxious or insecure in their relationship with their attachment figure and consequently be unable to use the attachment figure as a secure base. When attachment figures are unavailable or unresponsive to the child's needs, proximity seeking fails to relieve distress, and a sense of attachment security is not attained. As a result, negative representations of self and others are formed, and strategies of affect regulation other than proximity seeking are developed (secondary attachment strategies). In other words, attachment figure availability is one of the main sources of variation in strategies of affect regulation.

In another session, John went to play with the puzzles as soon as he entered the room. He engaged in this solitary activity without any attempt at initiating contact and it appeared as though he was seeking to decrease physical proximity from me. I felt awkward about his avoidance and did not know if I should approach him and intrude on his effort at affect regulation. I sat in silence for a while and watched him build puzzles with my hand over my mouth, which was my attempt at self-regulation. I eventually tried to seek proximity by joining him on the carpet and endeavoured to initiate contact with him by commenting on his play. The proximity-seeking behaviour on my part might have been an attempt to fulfill an unconscious and expressed wish to have his parents, especially his father do the same at home. He seemed to relax after a while.

An example of slight proximity-seeking in an early session occurred when we were playing a game of chess. When we had completed the game, he did not ask to play again, but instead he remained seated opposite me and simultaneously referenced me and the chess set as if to implicitly indicate that he wanted resume a new game. Also during this same period of playing chess, he beat me easily and immediately initiated contact by asking me if I wanted to learn the move. He went on to explain and show me how he did it and instructed me to try it under his direction. Interestingly, I also observed him mirroring my body positioning while we were playing (resting cheek on arm). This may have been a subliminal or implicit attempt to join with or attach to me. After the game, John maintained proximity by helping me pack the chess pieces away and handing me the box.

In a later session, another attempt on his behalf at proximity-seeking was evidenced when I forgot to provide water in the therapy room. He asked for water and I had to leave the room to go and pour him some water in the kitchen. I indicated to him that I would not be long and that he could wait for me in the room. Instead of waiting for me in the therapy room, John followed me to the kitchen thus maintaining his proximity and initiated verbal contact by asking for a full glass.

During the final phase of therapy, when John and his family arrived for their sessions, he was eager to go directly with me to the therapy room without me having to ask him to come with me. He began to initiate contact in the corridor in the form of conversation by first greeting me and then asking me how I was. In relation to John, positive expectations about others' availability and positive views of self as competent and valued are formed, and major affect-regulation strategies are organised around these positive beliefs.

Central to attachment theory (Bowlby, 1988) is the notion that children will feel secure in their relationship with their attachment figure to the extent that the attachment figure provides consistent, warm, and sensitive care (attachment-figure availability). When this happens, children learn to use the attachment figure as a secure base in that they are willing to turn to the attachment figure in times of need. If the attachment figure is available and responsive, they are able to be comforted by the attachment figure in a way that allows them to feel better and to return to other activities.

### **3. Exploration**

Exploration in the context of this paper refers firstly to John's comfort with physically exploring the therapy room. It secondly refers to how he uses the therapeutic relationship for exploration of past or current negative emotional or painful feelings and experiences related to his presenting problems.

With regard to his physical exploration of the room, from the first session to the last session, he always waited for me to give him permission to explore the room. Once permission was granted, he would freely explore the cupboards in search of toys to play with. It also appeared that he would explore the room more when anxious, that is, continuously searching

for something to play with rather than settling down with a specifically chosen toy to play with. Such exploration may have been an attempt at regulating his arousal levels.

The initial phases of therapy were smooth and superficial with little or no exploration of problem acting out behaviours and past painful emotional experiences as I was attempting to build rapport with him in an effort to gently activate his attachment system. At this stage of therapy, I was seeking to adjust to him as an individual through expressions of empathy, activity level, the pace of the work, affect, and emotional depth (Dolan, Arnkoff, & Glass, 1993). In the middle phases I began to inquire directly about his relationship with his father, the separations from his father, and the incident of pants cutting. Congruent with Muller (2009), I inadvertently utilised an approach that contradicted his avoidant defensive strategy in an attempt to activate the attachment system. This approach attempted to turn John's attention toward attachment-related experiences and challenged defensive avoidance. The directive nature of these sessions may have encompassed too much anxiety for him and were ultimately not productive. He displayed significantly increased non-verbal negative or hostile affect. My attempts to take him further in describing and feeling emotions resulted in John becoming less engaged. Even when I expressed warmth towards him, it led to distance and coldness on his part. I thus decided to take a less directive approach and hopefully a less threatening one at other times by indirectly exploring those past painful feelings and experiences. For example, I tentatively broached these subjects during activities, such as cards, chess and soccer. He was able to explore these issues with less distress as the activities may have acted as a buffer, which aided him to physically regulate the negative emotions that he was experiencing. These sessions may have been associated with a deeper and smoother experience for both of us as we both left the room at the end of sessions feeling less distressed. The abovementioned examples illustrate how I intersubjectively attempted to shift my own activity levels in order to effect change in John's activity and arousal levels.

#### **4. Separations and reunions**

There were many separations throughout the therapeutic process, which involved numerous cancellations by the family, vacations, and two missed appointments by him. I observed no reactions to these separations. I obtained feedback from Marge specifically regarding his reactions to these separations and she reported that she witnessed no visible reactions from him and it appeared to her that it was all the same to him whether he attended therapy or not.

There were also no reports of him looking forward with pleasure to resuming sessions. Marge further reported that when she asked him what took place in therapy sessions, John would casually remark that he could not remember. Sable (1983) also indicated that whenever there is an interruption in treatment, avoidant persons are prone to going blank, unable to think clearly, and blot out their feelings. When I asked him how he felt about coming to therapy after one of our longer separations (one month), he stated that he did not know why he had to be there. Farber, Lippert and Nevas (1995) indicate that persons with an anxious-avoidant attachment pattern usually question the usefulness of continuing therapy after returning from a separation. Although there were no visible reactions to disruptions in the therapeutic process, Bowlby (1980) posited that patients often exhibit implicit negative affect following separations, including feelings of anger, distance, distrust, and abandonment. When separations are repeated or prolonged and when it is compounded by factors such as threats of abandonment and unreliable caretaking, defensive processes may lead an individual to develop a protective shell and present a false self (Winnicott, 1965) to the world. His attachment behaviour to me may have become deactivated during separations due to the impact of life experiences in between sessions, which may have caused painful feelings and troublesome behaviour to proceed from anger, through despair and leading to a relatively detached or aloof attitude when he returned to therapy.

However, when I asked him in a later session closer to the end of therapy what it was like for him to come to sessions, he answered that it was “nice”. I then asked him if he felt like we were doing something constructive in the therapy and he replied in the affirmative. I also asked what it was that he enjoyed about the sessions and he said “we do fun things”. He also answered “yes” when I asked him if he felt more comfortable with me after our period of time together. Although he could not articulate his trust of and attachment to me, it appeared that he was beginning to trust and feel closer to me. This was evidenced by his open and relaxed body position as well as the warm, friendly and positive manner in which he answered my questions.

## **5. Attachment bond**

I felt sparks of an attachment bond developing during the middle phases of therapy, particularly when we engaged in our games of chess. My counter-transference reflected a

positive personal feeling between us, which was further evidenced by his positive affect and pleasure whilst engrossed in this activity.

In the final phase of therapy, I found myself excited at the prospect of seeing him again. In these therapy sessions it felt as though we were connecting. It did not seem like that barrier was between us anymore and I felt more at ease and less awkward in his presence. This was evidenced by his warm and friendly interactions, positive affective expressions, proximity-seeking behaviours, and most importantly, despite his lack of verbal ability to articulate his feelings, his openness to exploring past emotional or painful feelings and experiences related to his presenting problem. This indicated to me that John was possibly developing a growing and trusting relationship whereby he began to experience genuine pleasure in our relationship. The affectively attuned responses of the therapist based on his or her empathic understanding make possible a unique kind of subjective experience for the patient, which includes feeling known and understood as well as providing the basis for a new organisation of experience (Buirski & Hagland, 2001).

This perceived attachment bond may have been fostered by our dissimilar attachment tendencies on the preoccupied-dismissing dimension. According to Muller (2009), in such dyads, the therapist's natural style makes it more likely that he or she will take an interpersonal stance that runs counter to what the patient pulls for, consequently disconfirming patient expectations and perceptions.

## CHAPTER SIX

### CONCLUSION

The case study suggested that from an intersubjective point of view (Atwood & Stolorow, 1984; Buirski & Hagland, 2001, Stolorow, 1995; Stolorow, Brandchaft, & Atwood, 1987; Stolorow & Atwood, 1992), there was a reciprocal interaction between patient and therapist and a consequent pattern of relating that may have served as a new relational paradigm to help build healthier internal structures, thus attempting to modify an insecure attachment style. Bowlby (1980) states that attachment is of long duration, often persisting throughout the life cycle both intrapsychically and externally. The dynamics involved in the formation, maintenance, renewal, disruption, and loss of attachment relationships highlight fundamental similarities and differences between early attachment relationships and the patient-therapist relationship. Based on observations of caregiver-infant interactions, Stern (1985) and Beebe and Lachmann (2002) examined the pre-verbal, pre-symbolic interactions in the therapeutic process. This was important particularly with a patient who had difficulty verbalising and elaborating on his affective states, thoughts and life experiences. Thus non-verbal markers, such as body language, space, eye contact, and tone of voice became important signifiers in the therapeutic treatment, and in close observation of countertransference responses provided a key to unverballed enactments between patient and therapist. From a relational perspective, it was important for me as the therapist to be aware not only of my subjective responses to the patient (countertransference), but also of the patient's perception of his subjectivity towards me. Even with patients who are withdrawn, there is a basis of truth in their observations of and ways of relating to the therapist. Frequently, however, these observations and ways of relating will be communicated non-verbally and indirectly, and consequently, the therapist needs to be attuned to complex array of signals from the patient. I needed to be open to and curious about the patient's relational perceptions and observations about me and to make these relational dynamics conscious and to verbalise them within the treatment.

Ginot (2007) describes an unconscious enactment between therapist and patient in which the patient repeats past interactions with family, projecting fear, expectations and disappointment onto the therapist. These enactments, as also observed in this dissertation, are an attempt to repeat, in order to understand and resolve, problematic relationships in the patient's family.

Attachment theory provides a useful framework in which to examine and observe these therapeutic interactions because it uses accurate behavioural indicators. This analysis demonstrates the usefulness of the concepts of mutual and self-regulation as key aspects of the attachment system in clinical work.

In summary, the therapeutic situation can be seen as an arena in which earlier attachment templates were played out via verbal or non-verbal means in a safe environment, where there was an opportunity for more successful attachment styles and broader affective expression to evolve in John. This was achieved in therapy because an emotionally responsive other was available when the patient was anxious and stressed. The therapist was able to provide, to a large extent, appropriate caring and sympathetic responsiveness, which may have served to reduce the patient's distress. The patient's anxiety reduction reinforced the therapist's dependable availability and comfort, which then increased attachment security in the patient. It was an important reciprocal feedback system leading to a new pattern of interacting. It was this new positive pattern of interacting that became habituated as well as generalised and internalised as an "internal working model" of attachment. The therapeutic relationship in itself, as a provider of safety and security and as a change agent, played a central role in the therapeutic process and outcome, and will hopefully be a catalyst for other developmental achievements in the future. Feedback from John's parents, as the therapeutic process neared termination, indicated that the parent-child relationship had improved significantly. Such a transformational organisation in John's mental life may be credited to both the role of therapy as well as to the parallel process of fostering the increased role of actual parental involvement.

One advantage of thinking about therapy in terms of attachment is that attachment theory emphasises the emotional intensity and importance of the patient-therapist relationship, which may contribute to the efficacy of therapeutic treatment. For example, Schore (2005, p. 850) proposes that psychotherapy works precisely because it is "an attachment relationship capable of regulating neurophysiology and altering underlying neural structure." His model resembles other recent models of therapeutic change, which have in common the observation that therapy alters implicit or procedural memories of attachment, the non-verbal knowledge of how to have a close relationship (Fonagy, 2001; Lyons-Ruth, 1999; Stern, 1985). Problems that began in very early relational experiences are addressed in a new, therapeutic relationship that, in some aspects, replicates the central emotional bonds of early childhood,

and that is experienced as vitally important to the patient. In the language of attachment theory, the “internal working models” of attachment change through their activation and transformation in the therapy relationship. This can happen with or without accompanying insight on the part of the patient. Such changes in turn contribute to changes not only in a person’s way of relating to others but also in psychological functions that develop in the context of attachment relationships, for example, the regulation of affect and the capacity to reflect on the mental states of oneself and others (Parish & Eagle, 2003).

According to Bowlby (1980) and Sroufe (1996), early experiences are significant because defensive exclusion and detachment may begin in early childhood. How therapists apply this and other concepts, such as the particular focus on issues arising during therapy is largely determined by the theoretical framework. The attitudes and values of the therapist also affect his or her techniques of treatment (Sable, 1983). A therapist guided by attachment theory, therefore, conceptualises personality development in terms of real life experiences, particularly those of separation or loss that may have been, or are now painful, frightening, or unhappy. These are not perceived as the product of fantasy, oedipal, or aggressive conflict as found in traditional psychoanalytic analysis, but rather as reflecting actual situations within the family of origin or with those to whom the patient has emotional ties.

According to Farber, Lippert and Nevas (1995), the nature of the therapeutic situation, particularly the anxiety evoked, makes it ripe for the emergence of a patient’s attachment patterns. In the initial therapy sessions, John came into an unfamiliar place to meet with an unknown therapist, and likely experienced a decrease in felt security. Based on his attachment history, he expected and possibly attempted to extort certain reactions from the therapist. It appeared that John employed behaviours derived from his internal working models of attachment to deal with the feelings of anxiety, distress and disequilibrium stimulated by therapy as well as by factors outside of the therapeutic situation. By being aware of his reactions to a lack of felt security, for example, understanding his expectations of attachment figures under these circumstances, I attempted to help him explore how this aspect of personality affects other relationships, including the therapeutic relationship, and ways of being in the world. In this way, the attachment model lends itself to enriching the therapist’s understanding of the adolescent patient’s internal world and the people in it, the patient’s external world (outside the therapeutic setting), and importantly, the ways in which early attachment relationships affect the current nature of the patient-therapist relationship.

Consistent with Bowlby's (1988) notion of attachment theory, the emphasis of such treatment should focus on the relational nature of the patient. Issues of the patient's past and current sense of safety and vulnerability, and how or even whether the therapist is represented and symbolically evoked between sessions are especially important. Therapists should be particularly attentive to the ways in which separations and reunions are experienced by the patient in the current treatment, moments of silence at beginnings and endings of sessions, vacations, and missed appointments. Moreover, the therapist's awareness of the patient's attachment style can be used to point out and explore patterns that arise around anxious and fearful moments resulting from these internal models, especially when dealing with more articulate adolescents (Faber, Lippert, & Nevas, 1995).

The strength of this dissertation lies in its presentation of a rich description of the literature and clinical material (Donmoyer, 2000). However, using a single patient in order to illustrate the literature provides a limited range of behaviour and experience to describe the aspects of the literature that I have presented. Future studies with more than one patient's therapy material and of therapies of a longer duration would provide a wider and richer illustration of the presented literature. Future studies that also include a formal measure of patient attachment to therapist may tap an aspect of the psychotherapy relationship, which more clearly emphasizes the development of the psychotherapeutic secure base for patients with previous attachment insecurities. If attachment theory is to be applied more fully to psychotherapy, the process of therapeutic change will need more attention from theorists. The ideas of Mikulincer, Shaver and Pereg (2003), among others (Obegi, 2008; Parish & Eagle, 2003), offer fertile ground for this work.

Much of the meaning and satisfaction that we find in our daily lives stems from the security and closeness of our relationships with others. Feelings of joy, sadness, anxiety, or anger reflect what is happening with these attachments. It is thus hoped that we, in our therapeutic work, can help our patients improve their ability to make and maintain creative and secure bonds with others.

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