Editor’s Note: David Wallin, PhD, is a clinical psychologist in private practice in Albany and Mill Valley, California. Dr. Wallin has been practicing, teaching and writing about psychotherapy for nearly three decades. His most recent book, Attachment in Psychotherapy (©2007, The Guilford Press), has been translated into nine languages. He is also co-author (with Stephen Goldbart, PhD) of Mapping the Terrain of the Heart: Passion, Tenderness, and The Capacity to Love (©1996, Jason Aronson). He has lectured on attachment and psychotherapy in Australia, Europe, Canada, and throughout the United States. Dr. Wallin presented the Anne and Ramon Alonso Plenary Address at the AGPA Annual Meeting in New Orleans in February 2013. He will be presenting the Special Institute: The Therapist as a New Attachment Figure: How Our History Affects Our Efforts to “Raise” Secure Patients at the 2015 AGPA Annual Meeting in San Francisco, California.

HF: Your book, Attachment in Psychotherapy, weaves together many different themes and theories, including attachment theory, as well as neuroscience, mindfulness, trauma theory, and relational psychoanalysis. The book provides a synthesis of attachment research and the clinical research you refer to as relational or intersubjective. Can you speak about how you see these two fields being integrated?

DW: Thinking about the biography of my book, I’d say my interest in attachment theory sprang from my passion for relational or intersubjectivity theory. In the early 1990s, my own very problematic experience as a patient in classical psychoanalysis woke me up to the craziness of what’s been called “one-person psychology.” This is the idea that what shapes us in childhood and psychotherapy is primarily, if not exclusively, what goes on in our own head—our internal fantasies, drives, impulses—rather than the actualities of what we experience with our parents and our therapists. Happily for me, my discontent with my analysis coincided in time with what’s come to be called the “relational turn” in psychoanalysis.

So just as my personal experience was informing me about the shortcomings of a one-person psychology, through the theoretical writings of people like Stephen Mitchell, Lew Aron, Darlene Ehrenberg, and Jessica Benjamin, the field was beginning to elaborate the clinical implications of a two-person psychology. Clinically, this meant that the experiences of therapist and patient alike are co-created, with each partner in the therapeutic couple constantly influencing and being influenced by the other. The result was a very useful re-thinking and humanizing of analytic concepts like transference, countertransference, resistance, and so on. What was missing in this re-thinking was a developmental and diagnostic framework. Then serendipitously, I happened to sublet space in my office to Nancy Kaplan, whose work on attachment is pretty well known. I’d had an instinct that attachment theory and research were important, so in response to my invitation, Nancy gave me a small library of articles and book chapters about attachment, which turned out to be rather mind-blowing because they began to fill in the missing developmental and diagnostic dimensions of the relational/intersubjective clinical approach about which I’d become so passionate. What’s key in the overlap between attachment and intersubjectivity theories is their shared insight that, whether we’re looking at development in childhood or psychotherapy, the relationship is always where the action is.
HF: So you stress the importance of the relationship, both in attachment terms and in terms of the clinical innovations associated with intersubjectivity theory. Can you give us some sense of how these ways of thinking might enhance our efforts to help our patients?

DW: Attachment research and intersubjectivity theory make separate but interweaving contributions to clinical effectiveness. Attachment researchers illuminate how our experiences in our earliest relationships are internalized as mental representations and rules for processing information, which determine not only how we tend to relate as adults, but also what we know and how we can know. In other words, formative attachment experiences exert a profound influence on our behavior, as well as on the freedom and flexibility with which we can feel, think, sense, and desire. The research identifies particular attachment patterns in infancy that tend to be relatively stable over the lifespan. Recognizing these relational/cognitive/emotional patterns in ourselves and our patients can be very helpful, suggesting important hypotheses and informing our interventions. Attachment research contributes a great deal to our understanding of the key ingredients of the most developmentally facilitative parent-child relationships—and, by implication, the most developmentally facilitative therapist-patient relationships. Helpful as they are, these ideas about attachment patterns and developmentally facilitative relationships are also somewhat general and theoretical. By contrast, the contributions of intersubjectivity theory encourage a focus on the unique and specific influences exerted by a particular therapist and a particular patient as they relate to each other. It turns out that recognizing and making sense of these mutual influences largely depends on our ability to be attuned to the nonverbal dimension of experience in the therapeutic relationship as attachment research also highlights the centrality of nonverbal experience.

HF: Nonverbal experience in childhood and therapy is clearly one of the main themes in your work. Can you elaborate?

DW: Let me start with the rationale for a focus on what I call the nonverbal subtext of the therapeutic conversation. There is a lot of stability between the attachment patterns we display at 12 months and what the longitudinal studies tell us about attachment patterns at age 19 or 26 (the maximum age on which the current studies have reported). Whether the attachment pattern is secure, avoidant, ambivalent (aka, anxious), or disorganized, this pattern in infancy is likely to endure into at least early adulthood. This means that many of the most significant and lasting lessons about how to relate to oneself and others were learned prior to the acquisition of language. The core of the self is established in the preverbal phase of development. There are neurobiological and defensive barriers as well to the linguistic recall of formative experience. So if we’re to access the core of our patient’s experience, we need to get beneath or beyond their words. My shorthand here is that what human beings are unable (or unwilling) to put into words, they tend to evoke in others, enact with others, or embody. Accordingly, as therapists we need to attend to our countertransference in the broadest sense, to the enactments of transference-countertransference configurations that play out as we relate to our patients, and to the language of emotion and the body. Another way to say this is that therapists need to be translators of the language of the wordless world, just as the parents of infants are translators. Parents read the mind of their children through the translation of the child’s nonverbal cues and signals. Therapists, too, need to translate nonverbal communication into words that convey the internal states of their patients and themselves. We need to recognize and make sense of what is evoked in us, what we enact, and what is expressed somatically. Paying attention to nonverbal communication, and especially to the nature of our participation in enactments, is also vital to evaluating our efforts to provide a healing attachment relationship for the patient.
HF: The therapist’s deliberate effort to provide a relationship that is in a sense an improvement over the patient’s original attachment relationships is a key theme. This ties in with the ideas in your book about scaffolding and upgrading the dialogue in the therapy. How do these concepts relate to the therapist/patient interaction?

DW: Part of the yield of attachment research lies in its specifying the features of the most developmentally facilitative relationships in childhood. Given the oft-cited symmetry between what we provide as good parents and good therapists, this research provides useful guidelines for clinicians attempting to facilitate the psychological development of their patients. We should try to generate a relationship that: a) maximizes room for the patient’s thoughts and feelings; b) recognizes and repairs disruptions; c) facilitates a dialogue that is gradually upgraded to higher and higher levels of complexity and awareness; and d) actively engages and struggles with the patient. With regard to upgrading the dialogue, the therapist’s role is, in part, to support the patient’s emerging or nascent capacities to think more freely, to feel more fully, to be more present to experience, and so on. This support, also known as “scaffolding,” is what allows us to upgrade the quality of communication in the relationship. Good therapists are like good parents, who both model new capacities for the child (before kids can speak we “put words into their mouths”) and provide opportunities for children to exercise their own emerging abilities (“use your words”). Often this means that the therapist must go first. For example, with patients who can’t access and articulate their feelings, the therapist may well need to lead by showing some emotion.

HF: Being able to respond emotionally to the patient and to reflect on our own emotion and theirs is an important feature of this work. You note that it often requires that therapists have considerable experience as patients themselves. Will you say more about that?

DW: I’ll frame my answer by saying that it’s great to have the orienting guidelines that attachment research provides us. But what is key is our ability (or lack of it) to implement these guidelines. Usually our own attachment patterning imposes constraints here. As therapists, we usually come to this work by dint of our own (usually less-than-optimal) attachment history. Such a history invariably imposes significant limits on our capacity to provide a secure attachment relationship for others, including our patients. Being a patient in psychotherapy is probably the single most important route to the kind of knowledge, integration, and secure-enough attachment experience that can allow us to recognize and deal with these limits and constraints. Being a patient also allows us to know firsthand how one person can help another to tolerate and understand the difficult feelings that can keep people stuck. Ideally, the therapist in therapy (or perhaps in a good marriage) will experience a new attachment relationship that is healing. This is a relationship in which old patterns come to life and are modified in the context of new experiences. Of course, this hinges on the therapist and the therapist’s therapist working together to deconstruct the attachment patterns of the past and to co-create new, more adaptive attachment patterns in the present.

HF: You say that enactments arise where the attachment patterns of the therapist and patient interlock. Put a little differently, enactments are where transference and countertransference meet. You write that the therapist’s awareness of her/his part in any given enactment is necessary prior to clarifying the patient’s contribution. Isn’t this where enactments come into play?

DW: The first thing I’d say is this, along with the centrality of the relationship and of nonverbal experience, my book highlights the importance of the stance of the self toward experience. I highlight two particular stances toward experience—one that is reflective and that attachment researchers call a mentalizing stance, and the other which is a mindful stance. A reflective stance allows us to make sense of experience while a mindful stance, which is a present-centered and accepting stance, allows us to make room for experience. As therapists working with enactments,
we need to make room for emotionally salient experience before we can usefully make sense of it. This means that ideally we begin with a stance of mindfulness.

My recommendation is that therapists start with attention to their own participation in enactments by stopping the action in their own mind in order to ask the simple question, “What is it that I’m actually doing with this patient?” It could be that I’m making a joke, or bending over backwards to show that I understand, or maybe I’m making an interpretation or being unusually quiet. Having identified in a facts-of-the-case kind of way what I’m doing, I try and make sense of my conduct with two additional questions: “What might be the implicit relational meanings of what I’m doing?” and “What might be my motivations for doing what I’m doing?” This kind of internal inquiry usually generates a whole menu of ideas and possible interventions. What’s important to remember is that the relationship of therapist and patient is a dynamic system, meaning that whatever I’m doing, with its accompanying meanings and motivations, is almost always meaningfully related to the patient’s conduct in the enactment.

There are multiple advantages to working with enactments in this way. It brings to light what patients and therapists are unable to verbalize. In this way it generates the maximally inclusive and potentially integrative dialogue that’s a big part of the relationship we’re trying to create with and for our patients. Accessing what’s unspoken or unspeakable, and hence enacted, is also a route to dissociated experience in the patient, as well as in the therapist. Focusing on our role in enactments can also generate awareness of the ways in which our own attachment patterns are functioning as constraints on the healing potential of the therapeutic relationship.

**HF:** It is often said that in individual therapy patients come to talk about their issues and in group therapy they come in to live them. Your approach to individual therapy, using attachment theory and intersubjectivity, really seems to negate that dichotomy.

**DW:** I completely agree with you. When I do therapy with an individual, living experience in the therapeutic relationship versus talking about experience is not really either/or but both/and. Or put a little differently, it’s the lived experience that can be talked about, which is the primary therapeutic intervention. Ideally, that conversation accesses more and more experience that can thus be the route by which previously dissociated experience can now begin to be integrated. Experience that can be talked about is easier to bear—one is not alone with it—which makes that experience easier to recognize and claim as one’s own, thus to integrate.

**HF:** Throughout your book, you use the two-person therapy frame in your discussion. How might this be used within a therapy group, given that there are multiple sources of interlocking transference and countertransference enactments at play at any given time?

**DW:** Most of what I’ve said and written applies not only to individual therapy but also to group therapy. Principally, what I have in mind here is the centrality of the relationships in both forms of treatment of nonverbal experience and of mindfulness and mentalizing. I agree with you that given the multiplicity of enactments unfolding in group therapy, the task is bound to be more complex in that modality. You have to be thinking about the enactments in the therapist’s relationships in the group, as well as the enactments playing out between group members. Still, the same questions and concepts can be of use in either setting. The key here is, as always, the impact of the therapist’s own attachment history and patterning on her or his efforts to be of help. Depending on the nature of the therapist’s experience in the family group (and not just with the primary attachment figures), there may be particular patterns and pitfalls that can influence the therapist’s conduct in the setting of the therapy group.