Submitted for inclusion in the Summary from the April 2011 Creating Connections Conference to be published in *Human Systems*.

ATTACHMENT AND MENTALIZING AS CHANGE AGENTS IN PSYCHOTHERAPY

Jon G. Allen, Ph.D.
The Menninger Clinic

The field of psychotherapy is choking on acronyms: CBT, DBT, DIT, PE, EMDR, ADEP, RLX, MBCBT, TPP, TFP, IPT, EFT, and MBT—to pick a few. Three-letter acronyms seem most in vogue. Many of these acronyms are associated with yet others: EBT (evidence-based treatment) or EST (empirically supported treatment). Plainly, the crowning glory is to have an EBT for a diagnostic condition, also with an acronym (e.g., DBT for BPD, CBT for MDD, PE for OCD). But the proliferation of ESTs has led to a number of widely recognized problems. First, no therapist could master all the manualized ESTs, or even a sizeable subset. Second, the ESTs are developed for single disorders, and comorbidity is the rule. Third, most therapists are general practitioners who treat a wide variety of disorders, albeit somewhat restricted by scope of practice. Fourth, and most telling, the ESTs differ minimally from one another in effectiveness, notwithstanding all the research energy that has gone into qualifying them as ESTs and entering them into horse races with one another.

Jerome Frank was uncommonly prescient, proposing in *Persuasion and Healing* a half-century ago that the effectiveness of different psychotherapies was attributable more to what they had in common than to what was distinctive among them. Decades of subsequent research proved him right. Of course, patient characteristics—severity of illness most prominently—far outweigh the influence on treatment outcome of anything we clinicians do. But next in line come relationship factors, which include three that Rogers identified in *Client-Centered Therapy* over a half-century ago: empathy, positive regard, and congruence or authenticity. Concomitantly, the therapeutic alliance became the most extensively researched common factor. The alliance is composed of two basic facets: (a) a trusting relationship based characteristics such as Rogers identified and (b) collaborative work on agreed goals. These two facets are strongly interrelated, and the alliance also includes all-important efforts

to repair inevitable ruptures. For all the psychotherapy research field's investment in developing ESTs, these shared relationship factors account for substantially more outcome variance than the specific treatment methods.

Accordingly, with antipathy for acronyms and pique at the overwhelming proliferation of ESTs, while also longing for a three-letter acronym of my own despite myself, I have declared myself a practitioner of POT: Plain Old Therapy. POT capitalizes on our major source of influence, the relationship and alliance. But this tack begs the question: while we are relating and allying, *what are we doing?* Put otherwise, we have the relationship and the work, but what is the work? The various ESTs define the work, but there seems to be little distinctive in their benefits, and we need to figure out the nature of the essential work in the more generic or integrative psychotherapies, which I'm dubbing POT.

After declaring that we know that therapy works but we don't know why, Alan Kazdin made a compelling case that identifying *mechanisms of change* is the best way to move the field of psychotherapy forward. Common factors such as the relationship and alliance may point us in the direction of mechanisms of change, but we need more specificity. Moreover, developmental psychopathology also can point us toward mechanisms of change: if we know the mechanisms by which psychopathology develops, we might address our interventions to these developmental deficits. From this vantage point, I propose edging toward somewhat greater specificity by focusing on two common factors in psychotherapy relationships as promising domains of mechanisms of change: attachment and mentalizing.

In *Polarities of Experience*, Sidney Blatt synthesized evidence for two fundamental lines of development, relatedness and autonomy (self-definition). Ideally, these two lines are synergistic throughout development; development in each line enhances development in the other. Blatt's perspective maps neatly onto attachment categories: secure attachment reflects an optimal balance between relatedness (safe haven) and autonomy (secure base); anxious ambivalence emphasizes relatedness at the expense of autonomy; dismissing avoidance emphasizes autonomy at the expense of relatedness; and disorganization (or fearful attachment) exemplifies a conjoint failure of relatedness and autonomy. This developmental orientation, coupled with my interest in attachment trauma (i.e., childhood abuse and neglect) as a prominent contributor to developmental psychopathology has led me to focus on attachment as a fundamental common factor in psychotherapy and a candidate mechanism of change. The developmental benefits of attachment security and the costs of

insecurity have been amply demonstrated in developmental research, increasingly in longitudinal studies. Accordingly, with Blatt's argument for balancing relatedness and autonomy in mind, it makes sense to construe improvement in attachment security—and use of the therapeutic relationship to do so—as an overriding aim of psychotherapy.

But what is the means by which we foster attachment security in psychotherapy? In a word, mentalizing. Plainly, Rogers was on the right track in focusing on relationship conditions, and a trusting relationship is one facet of the needed therapeutic alliance. In the context of attachment relationships, we have construed mentalizing as a fundamental common factor in psychotherapy. By mentalizing, we refer to our natural human capacity to attend to mental states in self and others and to interpret actions in relation to our apprehension of mental states. We mentalize both explicitly (i.e., consciously, deliberatively, and reflectively, in narrative form) and implicitly (i.e., relatively intuitively and automatically, procedurally, at the level of emotional resonance). Spearheaded by Peter Fonagy and his colleagues in *Affect Regulation, Mentalization, and the Development of the Self,* the focus on mentalizing has enriched our understanding of the development of attachment security in a way that has relevance to psychotherapy. In short, parents' mentalizing in relation to their early attachment relationships is conducive to parents' mentalizing of their children, such that their children are likely to rely on them for emotional security. To use Fonagy's phrase, in times of distress, securely attached children anticipate that their parents will *hold their mind in mind*—or we might say, mentalize mindfully. Consequently, well mentalized, securely attached children learn to become better mentalizers (e.g., to be empathic in their interactions with other children). Conversely, trauma in attachment relationships—crucially, being left psychologically alone in states of unbearable emotional pain—stems from a failure of parents' mentalizing in relation to their own attachment history and then in relation to their children; this adverse intergenerational cascade leads to insecure attachment and compromised development of mentalizing in their children. In short, mentalizing begets mentalizing as well as secure attachment, and attachment security and mentalizing are synergistic throughout life. Conversely, nonmentalizing begets nonmentalizing, which is potentially synergistic with insecurity in attachment relationships throughout life.

Extrapolating liberally from child development to adult psychotherapy, attachment security and mentalizing capacity are the engines of emotion regulation, a fundamental concern of psychotherapy for a wide range of developmental psychopathology related to

anxiety, depression, and personality disturbance. Intuitively, without the benefit of attachment research, Rogers was on the right track. Empathy is a major facet of mentalizing and, coupled with positive regard and congruence (i.e., openness, honesty, and transparency in the therapist), empathy creates the healing relationship that Rogers envisioned. By virtue of the mentalizing and good will inherent in it, this Rogerian triad is conducive to secure attachment in parent-child relationships and in psychotherapy alike.

Disentangling secure attachment from mentalizing moves us toward somewhat greater specificity regarding the quality of a therapeutic relationship. Mentalizing is the psychological process through which the secure attachment is established and maintained and through which emotion regulation is achieved. Hence the overriding requirement in psychotherapy is to establish a mentalizing, emotionally attuned connection—in the spirit of Rogers. Concomitantly, mentalizing is the medium of the explicit psychotherapeutic work, which entails creating a psychological formulation, identifying goals, and engaging in intrapsychic and interpersonal understanding and problem solving. To a significant degree, from an attachment perspective, mentalizing activity will be devoted to exploring and potentially revising internal working models of relationships—in part on the basis of working models that are enacted in the patient-therapist relationship. But we should not put undue weight on interpretive work or verbal insight. Much of the benefit of psychotherapy rests in implicit, procedural learning, that is, nonconscious revision of internal working models—not by explicit understanding but rather by *doing*, that is, by relating in new ways to oneself and others.

Whatever the explicit formulation, goals, and treatment methods may be, the foundation for this work will be the cultivation of mentalizing and attachment security. These are means and ends. The goal is to promote the patients' greater skill (or more consistent application) of mentalizing, especially in problematic attachment relationships. To reiterate, psychotherapy parallels parenting and early development in this sense: mentalizing begets mentalizing. The psychotherapist, by adopting the *mentalizing stance* (a mindful, nonjudgmental curiosity about the patient's experience and the patient-therapist interactions) promotes the patients' mentalizing. In thinking about the core therapist skill, I have come to a humbling conclusion. Sarah Hrdy documented convincingly in *Mothers and Others* that our evolution as a human species was accelerated by communal childrearing, wherein mentalizing capacity was crucial to receiving care and sustenance not only from the

mother but also from other members of the community. Hence our mentalizing capacity takes pride of place in our human distinctness. From this evolutionary story, I infer that our skill as therapists (or as parents or romantic partners) comes down to this: *skill in being human.*

We make a small but important step toward specificity in mechanisms of change in moving from the venerable common factors of Rogerian facilitative conditions and therapeutic alliance to the developmental perspective of mentalizing in the context of a secure attachment relationship. This step is particularly valuable in making a relatively direct link between developmental psychopathology and psychotherapy. But moving from common factors to demonstrated mechanisms of change requires extensive programmatic research, as Alan Kazdin has explicated. Parent-infant and parent-child interventions intended to promote mentalizing and secure attachment come closest to experimental demonstrations of the therapeutic impact of these processes and relationships. But extant research makes a bare beginning on this long-term agenda of linking attachment theory and research to mechanisms of change. I am not in favor of aspiring to developing another brand name such AFT (Attachment-Focused Psychotherapy) as a candidate for yet another EST. Arietta Slade represents the current consensus in stating that attachment theory and research *enriches* and *informs* our conduct of psychotherapy rather than dictating our practice. Hence I will stick with POT. Yet, laced with attachment theory and a mentalizing focus, POT is neither entirely "plain" nor "old."

Conference Reflections

There is much fine writing on attachment in psychotherapy, starting with Bowlby's elegant exposition in *A Secure Base*. Yet the Creating Connections conference underscored for us all the need to make the findings of attachment research and related practice even more widely known to the clinical community. I also have a long-standing interest in patient education, and I have found the conference to be immediately applicable to this educational work. Space permits only a few examples. Dan Siegel's integration of the attachment and mindfulness literatures neatly complements our interest in mentalizing; patients are far more familiar with mindfulness than mentalizing. I find it helpful to add the ethos of mindfulness to mentalizing, that is, advocating that we be mindful of mind. I have started talking with patients about Phil Shaver and Mario Mikulincer's work on security priming and the

potential value of bringing to mind positive experiences in attachment relationships. In *The Search for the Secure Base,* Jeremy Holmes introduced the concept of an "internal secure base," which I have conceived as a secure attachment relationship with oneself. Security priming, that is, activating internal working models of attachment, is one way of enhancing the internal secure base and thus using relatedness to promote autonomy. I find it nothing short of astounding that Mario and Phil have found such widespread positive effects of *subliminal* security priming—perhaps as we are doing continually in psychotherapy when it is going well. I am especially partial to Mario's idea that, no matter how insecure one's attachment history may have been, everyone has "islands of security." This idea can be reassuring to patients, and I believe it must be true—otherwise our traumatized patients would not even be able to make a stab at psychotherapy with us. I cannot refrain from enthusiasm in informing patients of Jim Coan's compelling evidence that attachment relationships are the most efficient way to regulate stress; the finding that proximity to a secure attachment figure lessens the load on brain-based regulatory activity makes the point dramatically. Thus, while acknowledging that self-regulation (e.g., as taught in Dialectical Behavior Therapy) is worth mastering, I point out to patients that there is no substitute for proximity to someone with whom you are securely attached. In short, attach and give your brain a break! Jim Coan's findings bring me to one of the most important revelations to me as an individual therapist specializing in trauma: I find utterly persuasive Sue Johnson's conviction that we must help traumatized patients establish security in their key attachment relationships as directly as possible by means of couples and family therapy. Sue's work exemplifies creating connections where they are most needed. Establishing mentalizing in the context of attachment in individual therapy can be a bridge to other attachment relationships, but patients must not remain on the bridge.

References

Allen, J.G. (2013). *Restoring mentalizing in attachment relationships: Treating trauma with plain old therapy*. Washington, DC: American Psychiatric Publishing.

Allen, J.G., Fonagy, P., & Bateman, A.W. (2008). *Mentalizing in clinical practice*. Washington, DC: American Psychiatric Publishing.

Kazdin, A.E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3,* 1-27.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (Second ed.). New York: Oxford University Press.

Slade, A. (2008). The implications of attachment theory and research for adult psychotherapy: Research and clinical perspectives. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (Second Edition) (pp. 762-782). New York: Guilford.