

The psychodynamics of attachment in everyday life

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Abstract

The paper brings together research findings and basic theory to help therapists of any sort identify attachment dynamics between themselves and clients, and for understanding clients in their home contexts. The term “psychodynamic” is used in its original sense from its originator Edoardo Weiss (1950). The understanding of attachment dynamics created refers to everyday living and moment to moment changes in emotion and relating, between people in a variety of contexts (Heard and Lake, 1986, 1997). The ideal for therapists is knowing how to act in the moment. So that current thoughts and feelings can be reflected on with clients in sessions. Reflections outside of the session; or through supervision, are also useful applications of the understanding of attachment. This paper makes definitive statements about attachment processes so that it becomes possible to recognise the wider clinical picture involved. One that is heedful of a developmental view of relationship styles with respect to the impacts made on children, who I here cast as innocent parties who have received a negative learning experience. I have previously argued against the Freudian meanings of the term transference, and argued instead for the adoption of mis-empathy (Owen, 2006a, 2006b, 2007).

However, given that love, friendship and gaining co-operation are three of the most important and satisfying aspects of life – and that their frustrations and disappointments are the worst, I present some findings from attachment research in adults. First, I want to comment on the style of the presentation that I am using. In order to summarise a good deal of information into a small space I resort to bringing together a list of research findings to provide a scholarly overview of different aspects of the attachment processes. I translate such material into a form that I hope therapists will recognise and apply. However, the material to be considered is voluminous so I will only be presenting that which I think is most valuable towards the aim of helping clients stay in therapy and remain able to use it (Cassidy & Shaver, 1999, Johnson & Whiffen, 2003). My focus will be more on identifying how both

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parties contribute towards the therapeutic relationship. I have distilled developmental and social psychological empirical findings (Shaver & Mikulincer, 2002) to aid becoming able to recognise the immediate dynamic in the room. I urge an acute sensitivity to bodily gesture, facial expression, voice tone and the content of speech – all with respect to the emotions that therapists feel. The view taken is an integrative one and a further development of my interest in theoretical and practical integration (Owen, 2009, 2011). Through the sensitivity to how clients communicate verbally and non-verbally, and in relation to what therapists feel, it is hoped to communicate effectively with them, assertively and with tact, to make the therapeutic relationship a topic of discussion, to make it more secure, and so deliver the help that clients have come for.

For therapists, while it is the case that practice is not an intimate relationship for them, because they do not disclose verbally about the detail of their lives, it is the case that they self-disclose nonverbally and continually. What I am referring to is that our facial expressions, tone of voice, and whether we smile before we speak, for instance, or if the corners of our mouths might be turned down whilst we listen, are all powerful communications from us. Whilst I am not encouraging anything other than a warm, relaxed, fairly informal and caring stance for therapists, the blooming obvious requires some attention. *Non-verbally, clients read us while we read them.* There is a circular system of cause and effect in operation, as in all relationships, the contributions of one party lead to the contributions of the other. Yet there is something truly amazing in all relationships. The consciousness of other persons never appears “first hand” like our conscious experiences appear for us. Whilst I am not saying that all of the contents of our minds are transparent to us; what I am getting at is that we never get to experience anything as another feels it. We never have and we never will. Putting the two together then, we can only be intimate and close with people, to the extent that we communicate with them and come to know and trust that what they say concords, is congruent with, what we experience of them. In this context are considered the difficulties of the psychodynamics of two-person therapy relationships, with the focus mainly on the perspective of clients. The approach I take below is first to consider attachment dynamics as they appear generally in the everyday lives of clients (and ourselves). Only once this context is established will I consider therapy relationships.

Psychodynamics of attachment in everyday life

It was Edoardo Weiss in 1950 who first coined the term psychodynamics. This word is not the sole possession or capability of the psycho-analyst or the psychodynamic psychotherapist. All human beings to some degree, even if inaccurately, are being psychodynamic when they describe and explain the “manifestations and consequences of the interaction of mental forces within the human being”, (Weiss, 1950, p. 1). He was referring to conscious experiences that are “teleological” (p. 2) because they concern purposeful, aim-oriented behaviour. His opening words are: “Every human being is aware of inner driving forces whenever wishes, feelings, emotions impel him to act... he is also aware of opposing forces which restrain him from acting. When gratification is obtained through action, the driving force is felt to subside; but when action ... is checked by an interplay of emotions, either the initial psychological situation persists unaltered, or new ones arise which must be mastered”, (p. 1).

Psychodynamic is nothing other than being emotionally intelligent or psychologically-minded. It covers the connection between mental processes and the persons to whom they are directed. And so it is with attachment. There are three major types of attachment, *secure* plus two insecure types, *anxious ambivalent* and *avoidant*. (There is a fourth major type *disorganised* that occurs because of parenting and formative experiences that were traumatic, abusive or highly neglectful and disorganised – I won’t be commenting on this although it is highly relevant to practice, Richardson, 2008). The meaning of attachment is also closely related to the conscious experiences of love and its disappointment, intimacy and self-disclosure of all types, the desire to be close and connected with other people. This is why I am first attending to the signs of secure, anxious and avoidant attachment in everyday life. Being securely attached brings with it the promise of lasting satisfaction and indicates good mental health. Anxious and avoidant processes need identifying and rectifying.

So for the sake of readability I am not going to run through the background material blow by blow, but I am now going to state some identifying aspects of the secure, anxious and avoidant processes in everyday living. The paper closes with an overview of how to work with the two insecure styles or relating. The next three sections are thumbnail portraits of the secure, anxious ambivalent and avoidant styles of consciousness and their accompanying social worlds.

Empathy of the secure other seen from a secure perspective

Secure persons are those who can create a secure process between themselves and others most of the time, regardless of the problems and conflict that they may face. Its origins are in the context of childcare where the carers were there for the baby at the beginning of its personal history. What was provided were consistent, tender, responses and accurate empathy, so that infants could 'see themselves in the minds of their carers' and see that their needs and emotions were acceptable even when they were distressed. The carers were there for their children and effective in providing care and promoting safe exploration. They were successful in understanding their child and so nurturing an adult who can satisfy their own needs and be both autonomous and connected to others. Secure attachment is a most interesting process worthy of detailed consideration. In adulthood through, the message is that gregariousness is good and it's perfectly acceptable to be yourself, and be open about one's distress with others particularly those who mean something and with whom we are closest, and so make a life. Here are some key aspects (Lewis, Amini & Lannon, 2000, p 73-4, Shaver & Mikulincer, 2002, p 138).

- Secure persons can moderate their own distress. Are emotionally regulated: they soothe themselves when they are distressed and tend to the distress of others.
- Have an accurate, positive picture of the capabilities of others and are trusting generally.
- Have long-term relationships and friendships and maintain them. Shows love, trust, openness and sharing.
- Are generally trusting, relaxed, assertive, have good self esteem and are accurately empathic and insightful (AKA emotionally-intelligent, psychologically minded).
- Secure persons are loving and warm: they comfort others when they are distressed, facilitate others, accept and encourage them. They are intuitively helpful and know how to help others and may do so, even before needing to be asked.
- Have strong social and communication skills, are more relaxed and better adjusted to contexts even if they are ambivalent about them, as they can tolerate situations that are imperfect.
- Sets boundaries with others, is solid, reliable, calm, flexible and show creative problem-solving.

Empathy of the anxious ambivalent other seen from a secure perspective

Anxious ambivalent persons are those who create an anxious process between themselves and others most of the time, regardless of the interest, help and support that they may have. Technically, their attachment system is hyper-activated in that they have a hair trigger: They strongly want to go forward towards others - but are also quick to run away. In a moment, they can turn on the spot. They are confused in how they feel and appear confusing to others. They are clinging, needy and demanding when turning towards others and may be critical, angry, untrusting and rejecting. This is because the caring they received was inconsistent and their carers were unable to console their children on reunion after separation. The term “tangles” describes what anxiously-attached people do in therapy sessions and everyday life when they resist care. Past pain is close to the surface. The anxious self sees itself as insufficient in the eyes of others. Some key facets are (Shaver & Mikulincer, 2002, p 141):

- Anxious attachment centres on emotional dys-regulation, anxiety about the nature of close connections, mistrustful, ‘fussed up,’ worried or pre-occupied, paranoid even, about the current quality and the future of relationships and have low self-esteem and self-doubt particularly in the absence of current real deficits of these sorts.
- Accuses others of being out of reach or indifferent to their needs when they aren’t.
- Shows distress and anger on separation from others who are felt to be special and close. Clings, wants to be very close. Demanding or angry on reunion after separation.
- Can over-focus on a partner, idealises others, has anxiety about relating that eventually subside on contact. Has difficulty breaking up with partners or friends even though the relationship is really over.
- Tangles up attempts at receiving care and getting close to others, withdraws. Metaphorically ‘inspects the emotional bank account’. Persons in such a process can be hostile, threatening and manipulative as they respond to paranoid understanding of slights that are anxiety-ridden readings of the situation rather than factual one. May tell lies to test others. May create envy or jealousy to test whether self is cared for.

If all the above were present at one fell swoop then there are needs for clarity of the treatment and getting clients into positions where they can use what is going to be offered them as part

of the skill here is making sure that they will be able to tolerate the ambiguity and worry that having therapy may cause for them.

Empathy of the avoidant other seen from a secure perspective

Avoidant persons are those who create an avoidant process between themselves and others most of the time, regardless of the reaching out of others towards them. They are in denial and on the back foot, emotionally. Their attachment system is either weakly activated or easily deactivated. They reject, distance themselves, avoid, and move away from forms of love, connection and support. When under stress, they may temporarily become anxious ambivalent, whilst the stress is current. However, they only tolerate weak and superficial connections with others. This is due to receiving un-empathic, unresponsive, cold, neglectful, rigid and resentful parenting. The resulting indifference in the adult is the best way of maintaining a form of contact that is undemanding and has been generalised from its original source. Persons who habitually use the avoidant process, have their consciousness and emotions set low, as they feel little but are physiologically stressed. For them, their needs are unacceptable and they need to remain isolated because connection to others is fearful in itself: They have closeness anxiety rather than the expectation of feeling the warmth of human contact (Shaver & Mikulincer, 2002, p 143).

- Avoidant persons are commitment phobic and alienated from their own attachment and intimacy needs. Originally, this was a means for surviving harsh psychological environments. But commitment phobia has become generalised needlessly, to become excessive self-reliance. Accordingly, something inherent, the potential to enjoy the warmth of human contact is repressed and the effects are long-lasting.

- There is a lack of intimacy glue. Avoidant persons have valency of the sort that they only have the ability to connect with secure or anxious others but not with other avoidants as their abilities to form relationships are limited.

- Angry or anxious when others get too close or too intimate. Complains that “others expect too much” and belittles them for being needy when they are not.

- Can suddenly deactivate a connection, isolates self, and ‘goes elsewhere’ internally or externally. Or deactivates love and closeness through omission: There is a consistent lack of emotional intimacy, and there can be prickly criticism, and a lack of positive verbal and affectionate responses. Avoidant persons are continually stressed but passive, sometimes not

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expressing or even feeling the distress of isolation and ‘put their emotions in a box,’ metaphorically speaking.

- Appears blank: Little emotion expressed on separation and reunion.

- Sometimes when stressed, avoidant persons can appear as anxious-ambivalent and the repression of their own needs may be lifted for a while, as they truly express themselves – but this only happens temporarily.

- Show pseudo-closeness with people that are known for a long time. Otherwise can be critical and unfaithful with a partner. Have a poor expression of appreciation for friends, family and partner. Feel exposed and pull away after being emotionally intimate. They may mentally divorce a partner or close friend and give them the cold shoulder. Can be vague or secretive and lack self disclosure. Ends relationships but then idealises the ex-partner.

- Has desire for ideal partners and friends. Communicates through incongruous verbal and non-verbal ways. Does not care and invalidates others’ emotions to escape intimacy. Generally, unresponsive to others, cold, lacks appreciation and valuing, over-values thinking so appearing unemotional. Ignores reasonable requests and messages for contact.

If all of the above were present in one person, traditional psychiatry would want to use the term schizoid and expect the person to feel empty and depressed perhaps because connections are not getting made.

Empirical findings about attachment dynamics in therapy

The background information above was provided to create awareness of what is going on with the three major types of dynamic process. These can be seen in what clients bring to assessment, in what they discuss about their work and home life. The aim is now to focus on dynamics between secure therapists and secure, anxious or avoidant clients. After the above, I want to turn attention to therapy relationships and consider some empirical findings to focus on key processes and relate them to turning points in therapeutic relationships, to help identify contributions from our side and the clients’ side. The sum total of both contributions is a mutual creation. In doing this I refer to empirical findings by Una McCluskey in *Attachment therapy with adolescents and adults* (Heard, Lake & McCluskey, 2009, pp. 134-5) which is a re-working of the presentation within *To be met as a person* (McCluskey, 2005, pp. 81-2, 219-226). In her terminology, clients are cast as care-seekers, whilst therapists are care-givers. I re-present her findings in condensed form and refer the reader to her originals

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to get the full picture. There are identified nine major repeating patterns in a qualitative analysis of videotapes. The first three are secure and the remainder are insecure in various ways.

1 If therapist and client are both in role as care-seeker and care-giver, then a secure process is achieved through each meeting. The therapist takes the lead in empathising and verbalising the emotions and motivations of clients back to them and they confirm whether we have understood them. The mutual process is one of co-responsiveness as they are also open to what we say. They see that they are acceptable in our eyes and they re-evaluate the meanings they had in this new light.

2 Clients present a topic assertively but therapists comments are at first irrelevant as they haven't quite empathised what they are being told. But clients persist and then the penny drops and therapists tune in more accurately, so the remainder of the meeting become like item 1 above.

3 At first clients present in an anxious and disorganised way but therapists are able to catch all the contrary nuances and then secure process is achieved, like 1 above.

4 Clients start asking for help in a secure way but therapists persistently fail to tune in and divert onto irrelevancies without catching the client's point. There is no psychological contact but 'two conversations in the same room' metaphorically speaking. Clients psychologically withdraw towards the end of the session.

5 Clients are demanding but therapists are unable to soothe their emotions. Therefore, there is disagreement and the therapist has failed to empathise. Both persons cease to have psychological contact by the end of the session.

6 Clients present their topic securely but therapists are aloof throughout and under-responsive, so clients give up presenting during the session, somewhat like item 5 above.

7 Therapists miss their clients' expression of despair. There is some slight contact before mutual withdrawal, like 5 again.

8 Clients present a topic and are highly anxious and resistant in the manner of presentation. However, therapists miss the point entirely so clients resist more than previously and end the session distressed or dismissive towards therapists' failure to empathise and contain them, similar to item 5.

9 Clients present securely but end up resistant and withdrawn or dismissive because therapists have failed to empathise the original emotion presented at the start of the session, somewhat similar to 5.

What Heard, Lake and McCluskey conclude is that why therapists fail to respond is due to the effects of anxiety on their otherwise intact ability to empathise. The inhibition of responsiveness means that they are empathised as turning away, dismissing and uncaring. In some cases, two seconds of silence is read as dismissal. If one is subject to implied criticism or sarcasm, then any comments that defend, explain, or put the blame back onto clients, can then be read as a counter-attack even if they were meant as explanation. In this situation, clients might assert themselves and re-present their topic for attention. Or maybe, they withdraw that topic (to substitute it with a safer one). But they might ultimately cease to attend – either suddenly or just loses interest in attending, in the belief that this therapist does not understand them.

Discussion

One problem is that clients with different attachment styles read the same actions in different ways. For an avoidant client, merely mentioning that the sessions will have to come to an end (the therapist thinks it is the half-way point) is enough for avoidant clients to feel that they are being thrown out. So they don't come next week, even when they have explicitly agreed to phone and cancel - or when they have agreed to discuss complaints with you. This is what I mean about people reading each other. What I am referring to is how people empathise each other. In this case, a secure therapist had intended to help by paving the way towards a planned ending, and agree a final focus for the treatment; but the avoidant client drew the conclusion that nothing more could be done, that the therapist couldn't be bothered with them anymore, that we were bored with them perhaps, and therefore left in a huff and felt rejected. Clients do read the implications of what we say and do, and non-verbally, how we look to them, and sometimes draw conclusions that are wildly inaccurate with respect to what we really did say or do, and what we really did intend.

However, as there is a general reluctance for clients to express their fears and worries to us, and if there is no debriefing at the end of every session, to invite them to express any misgivings to us, then it means that we have not foreseen difficulties that we could expect. In order to meet those worries and fears pre-emptively, the therapeutic relationship has to be safe enough, with sufficient prompting for clients to mention things that they feel, but are

reluctant to tell us. Often their reluctance to speak up concerns the fear that we will feel criticised and that this will prejudice their care. Or, that the worries are too personal about how they see us and our abilities to help and understand them. From their perspective, they are left with the possibilities of denying the inadequacies they read in us; or hoping that we will improve in our care-giving; or continuing attending despite such hope; or valuing any small event that we have got right; or feeling hopeless and depressed and unable to improve the relationship (Heard, Lake and McCluskey, 2009, p. 139).

But without the possibility of open discussions with clients about their view of the help they are receiving, then we will never be able to find out what they do and don't like about our abilities and their sense of the usefulness (or not) of what we are doing with them. Without regular review sessions, particularly at assessment and definitely at every one of the first six meetings, then there is no way of making sure that the therapeutic relationship is strong enough to continue. This is one means of minimising early drop out and making sure that clients get what they deserve and came for in the first place. The therapeutic skill is a type of assertiveness in being able to comment with tact and subtlety, on the immediate nuances of what is happening for clients, as they present us their stories which are highly complex and might be distressing to hear. Like hairdressers, we could easily cut people when we get close to them. So the skill is to be to the point but in such a way that it doesn't hurt too much nor alienate them from attending.

How to work with attachment problems in the therapeutic relationship

The remainder of this paper focuses on the broad sweep of awareness and social skills required, once the basic forms of insecure attachment type have been noted in clients. (If on the other hand, readers are noting their capacity to be insecure in their homes lives and working lives, then I refer them to the many free resources on the internet so that they can test themselves and get an understanding of their own attachment style). The way that I am going to do this is to make appeal to the idea of emotional intelligence as supplied by Daniel Goleman (1995). However, I am going to take it a stage further into a means of working out how to react in a secure way. The therapeutic relationship, like any other, is the sum total of two (or more) persons. What oneself does, feels and says is only one half of the whole in individual therapy. I will arbitrarily start with what appears for a secure therapist in a sketch

of how to proceed, but it might be the case that therapists are heavily focused on what is happening for clients, which does not preclude what I am saying here. However, let's start with the most basic awareness of our emotions in relation to insecure clients.

The first step in being emotionally intelligent in a secure way is to become more aware of what oneself is already aware. To be open to the here and now relationship can get too caught up in a needy or hasty action rather than finding out what clients really do think about when they are properly engaged in therapy, collaboratively. The emotions we feel are the sum total of many factors. In the context of being a secure carer, the intellectual context described above translates into being a confident and interested therapist, who wants to know what is happening for his or her clients, and is neither closed off by their distress or overawed by its demands, or some other strong emotion about clients in total. The basic feeling-state of wanting to help, I suggest, is an openness and warmth addressed to the general public, a kindness or attitude of compassion, an attitude of tolerance and interest in the other's unique self. If there are strong emotions motivated by the non-verbal presence of the client and their manner, then these emotional forces that arise in us is our connection to specific clients and can be understood in our emotions, thoughts and physiological reactions concerning how it is to be a professional helper. This is a second step of understanding the psychological causes of the client on us. We are aware of the immediate situation, but that is not all.

Next, whilst still only focusing on self, the primary attitude towards clients is to be aware and to soothe-self, if necessary, whilst responding verbally. In the cases of insecure attachment which I will describe some more below, there is the case one's own distress can stop rational and caring action. If the empirical research of John Gottman is right, he has found that within couples with discord in their relationship then when people's heart rate goes above 100 bpm (especially men), then the ability to rationalise and empathise can be lost (Gottman & Silver, 1999, p 36). The final part of the therapists' response is to make assertive verbal communication that pre-empts problems, explores the clients view with their permission, and otherwise unceasingly works to promote the therapeutic encounter as a secure event and safe haven.

Let's look at the empathic relation towards clients some more, again entirely from a secure application of the intellectual content of what has been cited above – but now turned into

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emotional intelligence, as it can be operationalised. The first awareness that needs checking is our empathy of what is happening for clients. For it is only they who can confirm or deny whether we are understanding them properly. The reflection of thought and feeling is an absolute necessity to check whether our empathy of them is correct (Rogers, 1986). Secondly, the psychological motivations of their emotions, understanding, thoughts, intentions to act, the meaning of what they are describing, when they explain how their family bullied them as a child, is precisely sharing and checking the accuracy of our understanding of their attachment style and our reading of their relationships with their family, for instance. Another important topic to focus on and explore, is how they see us and how they view their side of the relationship with us, but I will say more on that score below. What also arises in our empathising of clients is an anticipatory empathy of what their further responses and intentions might be, and this too needs to be checked out with them. At a higher level, there is the checking of understandings about what they say and do in our relationship and finally leading into soothing and caring actions that they can do for themselves or in other ways where we can help them be self caring.

So the remarks above indicate the application of emotional intelligence in relation to how to work and promote a secure therapeutic process in which we are responsive. We lead in making it safe for clients to be emotionally present, and speak their problems and be autonomous. Our behaviour models how to relate securely and shows that it is good to speak about distress in a safe relationship and find that meanings do change, entirely spontaneously, or through the experience of being valued and treated as a worthy person whose emotions are valid, and in a number of other ways including the use of explicit techniques to change meaning. I would suggest that towards the end of every session that approximately five minutes is spent on rounding up what today's meeting has been like in a type of debriefing. The research on pre-empting dropout seems to support the effectiveness of monitoring the relationship, particularly during the first six sessions.

When working with anxious ambivalent clients the following point may arise. The general aim with anxious ambivalent clients is to pre-empt their protest behaviours, disappointment and anger, by speaking assertively, armed with the knowledge of their view of the world and how they might feel. They might tell you that you can't help them, or show displeasure at not being helped by others in their lives outside, or tell you directly that you are not helping them

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and that you are no good. The emotions that are likely to arise in meeting these persons are feeling overwhelmed, threatened, worried and anxious and over-helping and tangling clients up in return through feeling anxious. The formulation of their anxiety in relationships is that their current distress, when triggered, leads to poor thinking and ineffective problem-solving, which reminds them of their past distress, and that feeds their current distress. Accordingly, therapists should expect clinging and neediness, and excessive openness about problems with accompanying worry about the impact of these revelations. Contrary demands for help may be followed by rejection of oneself and criticism or lack of value to sessions which you thought went well. Unwarranted criticism and personal comments might arise including envy. At assessment there might be difficulties in getting in the room: wanting to know what will happen before attending, wanting to bring a partner into the first session or all subsequent sessions, or they are fearful and want to tell you everything at the first meeting.

Persons who are habitually avoidant present a completely different dynamic indeed, if they enter therapy at all. The overall aim with avoidant persons is to pre-empt their avoidance of attending and their avoidance of painful emotions and topics. The avoidant person won't know what to say when they attend or might be submissive and ask for your direction or what they may do is back out of the work in a variety of ways not being mentally present or not working in the session, or cancelling or not turning up at all. The formulation of their problems is that their safety procedure is deactivating their emotions and connection to others, in order to maintain their self-reliance and self-enclosure. Accordingly, they reject both threats and support, and have no access to personal resources for doing otherwise. The emotions that will arise for therapists are that they want their clients to hurry up for they are slow, untrusting, and poor at self-disclosing, nor emotionally literate or socially skilled either. The key to working with this type of relationship dynamic is to go at their pace and to focus on the expression of emotion and the impact that that has for them. They may admit feeling distressed for several days after a session and may ask to come once a fortnight rather than once a week. I have found that asking them how you can help them may not get an answer. So I would recommend not exceeding their capacity for distress and spend a good portion of the early sessions going over what it is like to attend, and to make how they experience attending, an agenda item for each of the first few sessions. I would also recommend explicitly discussing with them, what it is that they want to discuss and to maintain their attendance on a regular basis. The avoidant client will be avoidant everywhere and with

everybody. What they secure therapist models with them is the utility of taking the risk to speak out what it is they truly feel. This goes against their lifelong trend of not saying what has happened for them and what it feels like, but on the outside, as it were. They may provide excessively short answers to questions and need prompting to provide the amount of detail that is sufficient to discuss their experiences at length. It might be the case then that you hear things for the first time that have never been spoken about and have been locked away and forgotten. Avoidant persons are not demanding and are likely not to seek therapy and may see little or no value in human warmth and contact. Their attachment needs are repressed and forgotten and their lack of valued contact is something that you are indirectly working on rather than in the anxious ambivalent case where there is more friction and sparks are flying.

For me, the attachment literature is a treasure trove of material that can support the application of its findings in transforming the quality of people lives. Attachment style applies to us because at an experiential level, once we know how it feels to be secure, then our professional work also falls into place and makes sense in an unshakeable way.

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