ATTACHMENT
TRANSFERENCE AND COUNTER-TRANSFERENCE

Guy TONELLA,
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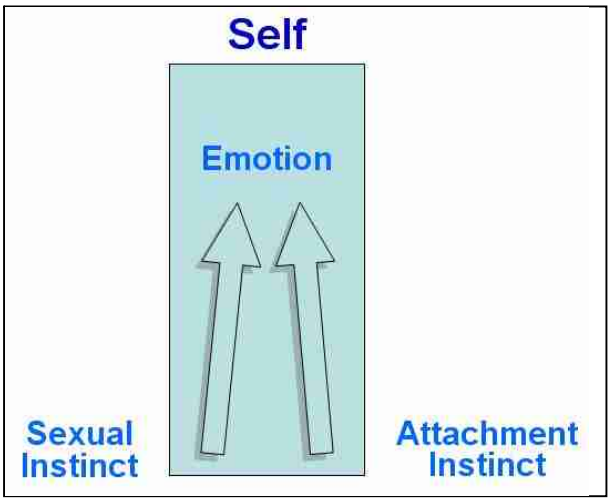
ATTACHMENT RELATION AND THERAPEUTIC RELATION

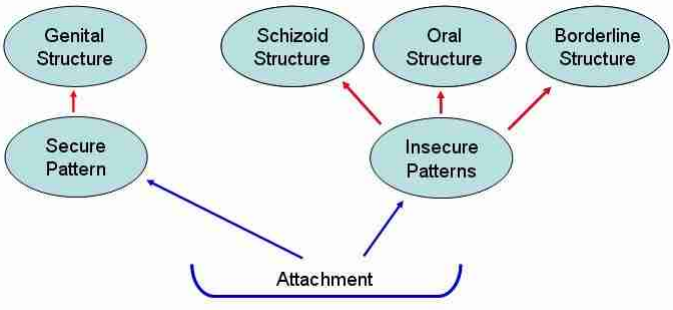
Following Freud and Reich, Lowen in 1958 places sexual instinct and sexuality at the core of bioenergetics practice. At the same time, Bowlby (1969) formulates his attachment theory.
Emotional expression then takes on two possible meanings: either it is a signal of sexual pleasure/displeasure (Lowen), or it is a safety/distress signal (Bowlby).



Today, both theories, of sexual instinct and of attachment instinct, are co-integrated in the bioenergetic approach. Each one is *a structuring force, present and active, at the beginning of life.*

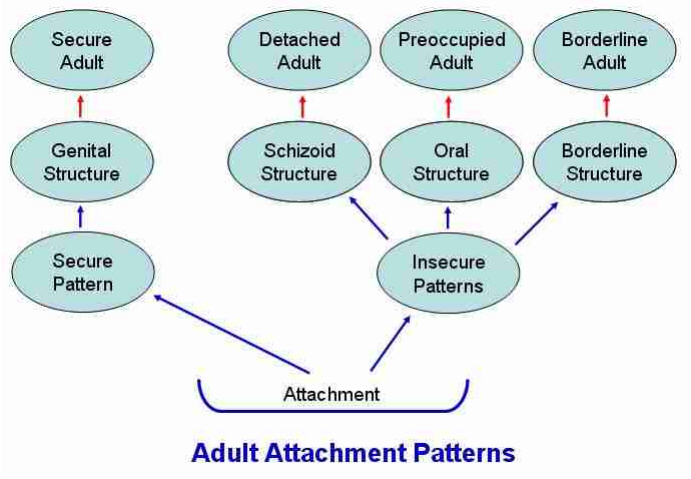
The theoreticians of attachment theory (Bowlby, Ainsworth, Main, as well as the work of Wolf, Emde, Anders, Sander, Cassidy, Stern, Fonagy and others) all contributed to show that the Self, as a subjective identity-in-development, cannot be built without bonding and that bonding is the work of both partners, by their *mutual attachment* and their *interactivity.* This is true for the elaboration of the bonds between mother and baby. This is true for the construction of the bonds between therapist and patient, Schore is demonstrating it actually on a neurobiological level.

What happens when these bonds of attachment do not fulfil their organizing and regulating function? The child experiences anxiety. Ainsworth (1978), Main and Solomon (1988) show that he attempts to protect himself against anxiety by adopting three main types of attachment strategies: he can become "*anxious-avoiding*", "*anxious-ambivalent*" or "*disorganized-disorientated*".



Attachment Patterns & Structures of the Self

We can establish bridges between these attachment strategies and our bioenergetic structures of personality: between the"*anxious-avoiding*" child and the "*schizoïd structure*", between the "*anxious-ambivalent*" child and the "*oral structure*", between the *"disorganized-disoriented*" child and the "*borderline personality*".



If the child or the adolescent does not have the possibility to evolve and build a pattern that is more secure, he then retains his infantile pattern. He becomes an adult that is "*detached*", an adult that is "*preoccupied*", or an adult that is "*disorganized-disoriented*".

This adult we meet in therapy will actualize, repeat, his attachment pattern with us. We can call it "transferential attachment pattern".

A CLINICAL VIGNETTE: RAFAEL

Rafaël is 28 years old when he begins his therapy. He is an accountant but only holds a temporary job. He feels lonely and has never been able to initiate a love relationship with a girl: this is what brings him to therapy. Courting a girl throws him into a state of intense panic: he feels suffocated, paralyzed, terrified, and his mind goes blank.

During the first year, the word "stress" will be the only word at his disposal to describe his inner state. Sometimes he is able to perceive a physical sensation, which he treats as "objective" evidence, or he may perceive a "physical emotion" (as he said), but he seems not having personal, subjective experiences.

He "manages his life" (his own words), he thinks about it in a rational way, he has little emotional life, no love relationship, just a program of activities he has prepared for himself.

He comes to therapy because his life is empty: devoid of sensations, devoid of feelings, devoid of meaning, and because he longs to love and be loved even though he does not know what love is nor how to attain it. He yearns for love and at the same time he feels scared.

Rafaël never felt loved by his parents who were exclusively preoccupied with their duties. He describes his mother as a cold, demanding, critical and excessively frustrating schoolmistress. Rafaël never experienced maternal empathy. He anticipates with terror any type of relationship, including with me, as an experience where he will be nonexistent, his Self being always negated by the other person. He describes his father as someone caught in his routine, without presence and submissive to his wife. He will tell me: "I was raised in a golden slum; I was fed and I was given a few toys so that I would shut up… but nobody loved me". His only living emotional bond was with his brother who was 2 years younger; but he was separated from him when he was sent to boarding school at age 7.

He then describes to me the efforts he made to escape from life. Between age 7 and 10, feeling empty, alone and without a life, he challenges himself by reducing his breathing to the minimum and by practicing being in apnoea for longer and longer periods of time. Then, he attempts to reduce the rhythm of his heartbeats, down from 50 to 40, then 30 and finally 19 heartbeats per minute. He brings himself to the verge of fainting, with vertigo and problems of vision. Between 12 and 18 years old, he tries to shorten his hours of sleep. Towards age 15 he sleeps a scant 2

hours per night, he gets used to it, but he has turned into a zombie. However, nobody notices anything over that 10 year period of time when he "went on strike" so to speak, from life. *He was out of touch, without anything showing on the outside, going through a long winter that had lasted for 28 years.*

I taught him to breathe, to move, to look at me, to allow himself to be looked at by me from an intimate distance, eye to eye. At first he was frozen, without any sensation or emotion, and I would sense tremendous terror in him. I would throw a cushion at him and we would play; he then started to have fun, to get involved in the relationship, to come out of non-existence and to feel the need to come and see me instead of coming (to therapy) because of a mentally planned program.
A mutual attachment relationship was now noticeable. I could sense the bond he was establishing with me in the way he looked at me and in the freedom with which he would tell me that he was starting to feel fear and that he had always missed physical contacts. I could sense the bond I was establishing with him when I would hold him in my arms, over and over again, his head in my hands, supporting it, gently rocking it, weighing to what extent he could surrender, attentive to his terror of losing his mind. He would eventually discover the sensation of physical warmth and the impression of safety under a blanket, sometimes curled up against me, a feeling of trust, because I am not asking for any personal benefit in return. He would eventually discover tenderness and the meaning of a life that is emerging for him.
It will take time, a lot of time, for his anger to manifest, for his needs, his desires and his own subjectivity to be asserted. We will both fight for this and he will hesitate for a long time before finally giving the full measure of his strength.
He experiences death anxieties, fear of falling into nothingness, terror of annihilation under the dark look of his mother, (a dark look he sometimes projects unto me), murderous rage towards this mother, and a hatred which he can only start to feel with much difficulty. All these emotions leave him on the brink of unbearable pain or detachment. But during all those moments when he would pull away into a kind of pre-mortem frozenness that would leave him voiceless, on his own initiative or on mine, he would find anew the path to my eyes or to my arms, he would listen to the images and the words I would summon up to give shape to what he was actually experiencing and in the naked truth of his distress would allow shivers and shaking and recover his true feelings.
Towards the end of the therapy, he will fall in love with his dance teacher, a woman 30 years older than he. He will himself wonder about this relationship, and will ask me one day if he hadn't found "something" of a maternal love in this relationship. I was careful then not to give any kind of interpretation; I just smiled at him, colluding with his thoughts. She, too, loves him. I believe she is the first woman in his life who really loved him, who showed it to him in a mutually shared, safe and tender bond that led to a nascent sexual desire devoid of anxiety, in an experience of mutually shared pleasure.

In terms of attachment theory, we can say that Rafaël was able to use me as a "safe base", dispelling his terror of the adult and developing a "sufficiently secure" Self so that he would believe in love and get rid of what used to inhibit his vital aggressive impulse as well as his sexual desire. The fact that we played a lot together did contribute to this by reviving dynamic patterns he had developed with his brother from whom he was separated and who subsequently fell into an apathetic depression from which he never recovered, apparently.

ATTACHMENT AND THERAPEUTIC PROCESS

Attachment theory highlights the fact that the etiology of pregenital structures is not of a sexual nature but more of a narcissistic deficit or traumatic nature. Sexual problems that derive from developmental deficit and trauma are the expression of a traumatic attachment pattern and not of a sexual conflict.

C*haracter analysis* is a method for analysing sexual conflicts and dissolving defensive reactions against sexual anxiety. But when the origin of the problem is not sexual (a sexual conflict) but relational (a developmental trauma) the therapeutic purpose is *to reinitiate bonds of attachment* and *functional motility*, that means to develop *a secure self in a secure attachment relationship*.

How?

That is what I experienced with Rafaël. For example, "throwing the cushion" in a playful mode has re-initialized his drive that had been turned off when he lost his brother as well as the few connection he had with him. In this sense, playing and experiencing pleasure is a therapeutic activity, including for an adult: it enables him to come out of the stillness and frozenness of his bodily functions. It re-energizes attachments and interactions.

The various "new" experiences of Rafaël, repeated in all kinds of variations and sources of shared pleasure between us, were substituted for the "old" experiences of robotization of the Self, of avoidance, of solitude. These old experiences had not disappeared from his memory. He felt the temptation sometimes to reproduce them when he went though phases of exhaustion or vulnerability. But the experience of understanding and being understood, getting involved again in a non-defensive, developing a creative and living form of attachment, taking initiative and deriving a feeling of joy from it, could now come back or be activated in a durable way.
These new patterns have contributed to the support of his initial expectation: that of being able to love and allow himself to be loved. This is what enabled Rafaël to fall in love, and what brought his therapy to a closure. He subsequently left his parent's house and moved into his own apartment. One day he phoned me to let me know that he now held a steady job after 11 years of holding a temporary job. Safety and love had done their work.

ATTACHMENT, TRANSFERENCE AND COUNTER-TRANSFERENCE

Working with character analysis on sexual conflicts is classically based on a **body-mind analytical process**: 1) working on one hand on the muscular tensions patterns and on the defensive psychic patterns (muscular and ego armours) resulting of prohibitions and guilty anxiety; 2) working on the other hand on the neurotic relational patterns as transference, repetition of infantile patterns (therapist is perceived as a parental figure).

Working with deficit and developmental trauma requests much more based on an **intersubjective system** where both patient and therapist are requested in a non verbal, preverbal level as Schore observed. The process is not so analytical in the sense of analyzing the bodily, verbal or transferential expressions of the patient. It is intersubjective in the sense of experiencing and

regulating the sensations, emotions, micro-mouvements, face or eyes expressions, needs of distance or closeness that take place in the patient-therapist system.

Therapist is no more somebody who knows, does a lecture (body lecture) and interprets, but he is somebody who experiences, regulates, feeds-back and contributes in a co-creative way to give a sense about what happens. Fonagy (1994, 2000), a psychoanalyst, has developed this intersubjective dimension in the therapeutic field: his conviction is that when the patient experiences that he is felt and thought by the therapist, he begins to feel and think by himself.

I remember my first session with **Rafaël**: he is seated in front of me, he looks at me without seeing me, immobile, frozen, hardly breathing, terrified, I guess. I look at him quietly, with affection. I ask him what is going on for him, but he does not hear me, or he cannot answer me. At the end of a long moment of silence, I say to him with kindness, but also with sadness: "I feel lonely … And you?" He looks at me, amazed, quiet, with some tears in his eyes. Then he says to me in a sad voice: "So do I …" He will reveal to me much later that he felt at the time that I was human, that I had access to feelings of loneliness, and that I could understand him. For sure, that feeling was not strange, my inner child had kept a memory which had found a companion in **Rafaël** and had signalled it to him.

That therapeutic attitude means sensorial, emotional, mental implication and proximity from the therapist, not distance, objectivity and neutrality. As the baby with his mother, the patient needs to feel real, true and affective presence from the therapist, just to experience and learn than this is possible and integrable today.

What is transference at that point? Transference is actualization of an insecure attachment pattern.

What we call usually transference can be present through body postures, emotional expressions in the face, in the eyes, subtle tremors or spastic micro-movements, superficial breathing, thoughts, images, dreams and fantasies. Therapist is unconsciously considered, through projections, as the real parent of the patient. Working on transference means to help the patient to make conscious these projections and to release or transform the body and mind mechanisms that produce that "repetition".

I would like to talk of another aspect of transference: when the patient doesn't consider you unconsciously as his real parent, but consider you unconsciously as the parent who was missing. This is a totally different relational situation. In that case:

- patient doesn't consider you as a parent who condemns his desires (sexual desires) but as an expected parent who can answer to his primary needs.
- patient doesn't hope to release some conflictive inhibition in his self ; he hopes to meet you as a real person for feeding his self.

This second aspect of transference is about attachment transference. I could say: patient doesn't expect to throw out his body and mind his repressive parent; he expects to put into himself (internalize) a secure, present, attentive, empathic parent he never had.

Now, clinically speaking, things are often complex. Sometimes, the first movement of the patient will be to actualize with you his kind of attachment pattern: *anxious-avoiding*", "*anxious-*

ambivalent" or *"disorganized-disoriented*". You will experience that he treats you as if you were his real parent: he is threatened or frozen or he doesn't ask you anything, any holding or handling, he protects you, adapts to you, etc.
In fact, he is not conscious of these attitudes: they are just body or interactive non conscious actualization because many times they are not mentally elaborated. They belong to the bodily self, they are presented, acted, shown. But no existing images, no existing words could comment it. Patient is doing from his procedimental memory, his limbic memory without knowing. There is no "transferential projection" on you; there is just a "transferential actualization".

I believe this is a specificity of attachment transference. Attachment transference is not located in the linguistic memory, in thoughts with representations and words, it is located in the bodily self and in the forms of interactions with others, including with therapist.

Therapist will have to discover and explore patient attachment and interactive pattern, which presents insecurity, distraught attitudes, terror to ask you something or to receive something from you, fear to be ignored or not understood, not to be regulated when what he feels is too much and when comes up terror to become crazy…

Therapist will have also to help the patent to discover the roots of his attachment transference in his inner states, without images or words. The therapist will have to sense, to feel, to discover it through his own body, his mirror neurons, his own limbic system, as resonances. This will be the beginning process to give a form and a name to those states or inner impressions and help the patient *to feel* that state and no longer *to be* that state.

Therapist will have to help the patient to understand how this attachment pattern has organized his future love and sexual relationships, for the best and for the worst. Once again, sexual problems can be consequences of insecure preverbal attachment, and body tensions related to those sexual problems are consequences of non regulation of preverbal emotional states.

What is counter-transference as this point? Counter transference is an insecure attachment pattern reaction of the therapist in response to the insecure attachment pattern of the patient

What I could observe from my own reactions, or supervising, is that we have a tendency at moments to verbally question to much the patient: "What is happening?" or "What do you fell?" This, for different reasons:

1) The insecurity, scared or frozen or depressive or in rage presence of the patient arouse our own insecurity and actualize our own insecure attachment pattern.
2) Patient is enabling to put words on his experience and that increases our own insecurity about not knowing what happens. So we ask again: "What happens?" or "What do you fell?"
3) We need intellectually to know what happens, to have verbal answers, because we need to control the process, just for controlling our own anxiety.

Sometimes, it is because in our own attachment pattern some sensations, emotions and movements towards the other were allowed and others no. So, unconsciously, we select and put

emphasis upon some sensory-emotional expressions of the patient, we allowed it, and we forget or don’t “see”, or focus on others.