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DMM news

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The international association for the study of attachment

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SPECIAL CONFERENCE ISSUE

Benvenuti in Italia!

Andrea Landini

We didn't even have a name when IASA began 18 months ago in Newcastle, UK. But we had people. More than 50 enthusiastic people from 22 countries accepted P.O. Svanberg's invitation to come to Newcastle to create our organization.

Today IASA exists! We are a group with a purpose and members and a big, resounding name, 'The International Association for the Study of Attachment'. Our newsletter, the DMM News, is sent to more than 3500 professionals in 40 countries. Nearly 200 of them came to Bertinoro, Italy for our FIRST biennial conference.

Bertinoro, on the hills of Romagna, has been a special place for us for a long time. We have gathered here for Advanced Clinical Seminars, for basic courses, and to develop new assessments. It felt very natural to choose Bertinoro for our first conference. It felt like coming home. The spectacular location, a castle on a mountain top, just added to the excitement of coming here.

Our goals were to establish our identity, to get to know each other and to work. We accomplished this and more! We barely fit in the meeting rooms, spilling out into the halls and courtyards. We had such outstanding speakers that many of us wanted to attend more than one session at a time. We filled the castle, the whole village of Bertinoro, and even the nunnery (!) with our work and ideas. Many new friendships were begun during the warm, sunny days of autumn in Italy.

The conference brought IASA's main issues into focus: precise observational assessments for research and treatment; early intervention and prevention of developmental risk; the study of challenging mental and psychosomatic disorders; the forensic application of the DMM for child protection and placement, and criminal issues. The most impressive feature was how research and intervention were never too far apart. That's how we want it.

This issue of DMM News recalls the conference and we hope to share some of the excitement of being there. We hope you'll want to come to the next. The location for 2010 will be announced in our next issue!

Until then, we wish you memories of strozzapreti (strangled priests!) and Sangiovese.

Benvenuti in Italia! Come again, stay long!

Andrea Landini, Conference Coordinator and IASA Founding and Board Member

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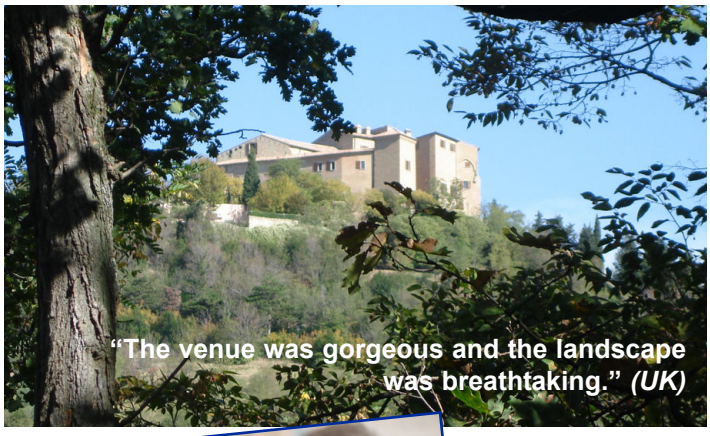


"The venue was gorgeous and the landscape was breathtaking." *(UK)*

"Good speakers, varied mix of workshops on interesting subjects & a great mix of people present to talk with." *(UK)*

"It was a great atmosphere of participation and unity." *(Italy)*

What I Want to Know: Mysteries, Paradoxes, & Urgent Issues

This conference reflects a turning point in the development of the Dynamic-Maturational Model (DMM) of attachment and adaptation. Since the early 1980's, first working under Mary Ainsworth and now with colleagues from many countries, I have been applying attachment thinking to troubled children and adults. In that process, I have developed both an observational/analytical way of working and an expanded model of how early exposure to unprotected and un- comforted danger can lead to maladaptive behavior that is resistant to change, i.e., that can leave individuals vulnerable to dysfunction and psychopathology.

What We Have Accomplished

The crucial components of the DMM are its (a) developmental framework, (b) the description of interpersonal self-protective strategies (fig.1), and integration of behavior with both (c) the underlying neurology of information processing (fig. 2) and also (d) the wider context in which behavior is adaptive or maladaptive (fig. 3).

Figure 1. Self-protective strategies in adulthood

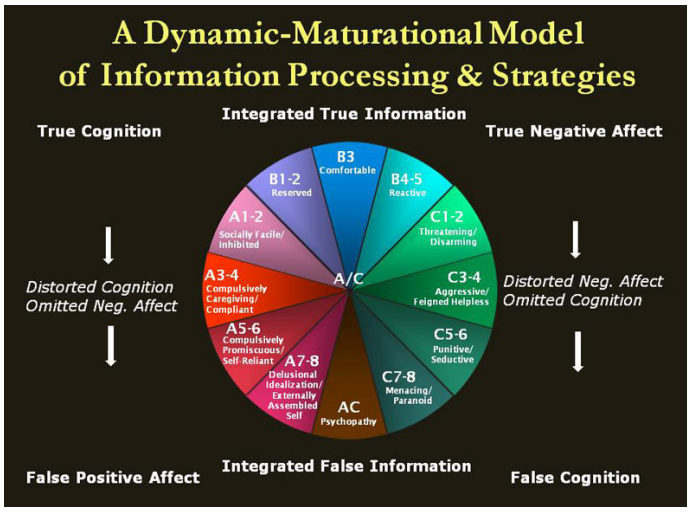


Figure 2. Representational systems

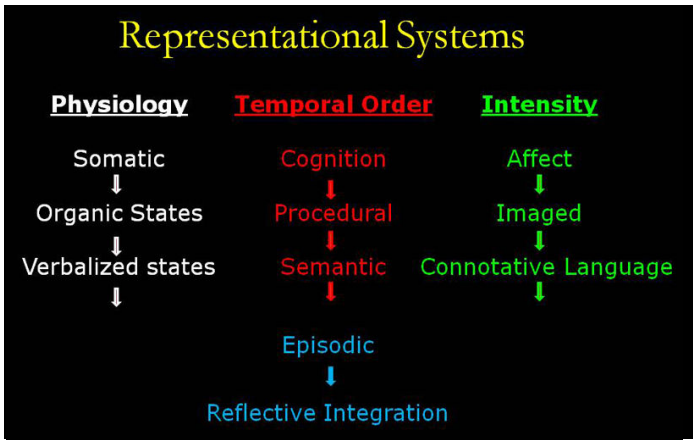
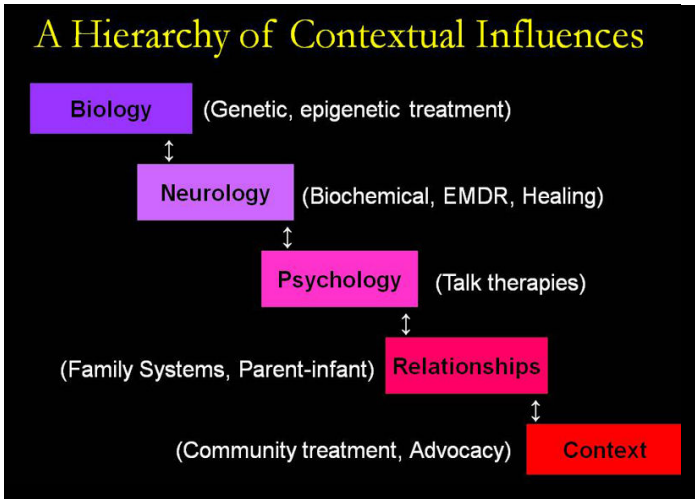


Figure 3. A hierarchy of interactive contextual influences



Now, with these at least sketched out, my burning questions become:

Why, when people really want to change, is it often so very difficult to do that?

Why, when professionals want so much to assist this change, is there so little evidence that they are successful?

Behind these two questions lies the central one:

How can we help people to change in ways that will reduce their suffering, promote adaptive behavior, and enable them to establish satisfying relationships with other people?

An Agenda for the Future

The problem

Why, after a century of effort from brilliant minds (e.g., Freud and Skinner early on, Bowlby and Bateson by mid-century) and from thousands of dedicated professionals, and with more than 1000 published treatments, do we not know how to offer treatments that are suited to individuals and that can ameliorate their psychological suffering? Indeed, the prevalence of many disorders (e.g., depression, ADHD, autism) is increasing. Furthermore, there is emerging evidence that treatment can harmful. Evidence of harm creates an urgent issue: *Will we systematically assess the possibility of harm and, when we find we have unintentionally done harm, how will we explain it and what will we do about it?*

The effectiveness of treatment

A wide body of literature indicates that about roughly a third of patients drop out before completing treatment and that, of the remaining two-thirds, treatment is effective in about 65% of cases. This drops to 50% within one year after the completion of treatment. On the other hand, being on the waiting list for psychological treatment is 50% effective, giving psychological treatment at most a 15% advantage over non-treatment. Further, in spite of therapist's often fervent belief in their form of treatment, no approach to treatment has been found to be more effective than the others.

A smaller body of evidence indicates that psychological treatment is sometimes harmful on average in about 15% of cases.

(Continued Next Page)

This suggests that (a) assessment of negative effects should become part of all treatment efficacy studies, (b) knowing the cause and course of dysfunction might improve how we select treatments and (c) a crucial issue might be fitting treatments to individuals' self-protective strategies.

The DMM as a basis for developing an integrative and comprehensive theory of treatment

The DMM offers several advantages as the basis for generating a comprehensive theory of treatment. First, it is drawn from all the major theories of human development and psychological treatment. Second, the DMM reflects a way of generating information based on observation, empirical tests, and clinical relevance. Third, it is the only approach to defining dysfunction that began with the study of infant development and individual differences in infants' development, then progressed forward systematically toward adulthood. At each age, the DMM accounts for a layered hierarchy of systemic influences and transactional processes: genetic and epigenetic, biological and maturational, dyadic, familial, contextual (school, neighborhood), and cultural influences. That is, the DMM addresses individual's adaptation in the light of the complex array of contexts in which the individual functions. Finally, the DMM has formal assessments across the lifespan that assess both information processing biases and self-protective strategies.

These advantages enable the DMM to frame psychological 'disorder', not as discrete entities, e.g., DSM or ICD diagnoses, but rather as strategically organized psychological processes that enable individuals to be safer in dangerous contexts. Danger and reproduction are the critical issues to survival. Maladaptive behavior almost always implies that the individual feels endangered or endangers others (particularly partners and children) and, in most serious cases of maladaptation, leads to sexual problems. The DMM proposes two basic psychological processes (cognition and affect) that are used differentially by people whose experience with danger differs. This can provide an explanation for why individuals with the same symptoms sometimes respond differently to the same treatment (specifically, they differ in their reliance on cognition or affect to dispose their behavior). More importantly, it provides a rationale for testing the effects of treatments on psychological processing by asking how the treatments change cognitive and affective representations. This, in turn, could become the basis for selecting treatments tied to individuals' mental processing.

DMM theory of development has already changed our understanding of many problems and disorders: (1) maternal sensitivity to their babies and mothers' prior exposure to danger, (2) child maltreatment, (3) foster care, (4) adoption, (5) post-natal depression, (6) conversion disorders, (7) ADHD & autism, (8) eating disorders, (9) PTSD, (10) psychoses, (11) psychosomatic disorders, (12) sexual dysfunction, (13 severe criminality. Some of these findings are in published studies, some are in studies under review or in process, and some are clusters of case studies, but all change our understanding of the nature of the dysfunctions. Moreover, they apply one theory to a variety of problems.

Having a single and comprehensive theory of maladaptation and treatment could reduce both the confusion among competing treatments and the suffering of people who come to us bearing shattered dreams and seeking hope.

"My compliments. It's complex to organize an international conference, especially the first. I think it succeeded very well. I really liked the Round Tables (especially the Courts) which were very stimulating, seeing the styles and the cultures of reference emerge." *(Italy)*

"The highlight was meeting people sharing views on children's development in high risk environments. The conference site (culture, & environment) was just marvelous." *(Russia)*

"The conference was a wonderful experience. In Bertinoro I asked questions, got answers and shared learning that I never expected and a sense of camaraderie that I rarely experience here in the States. Others understood. It was enlightening to talk with people from different backgrounds and I appreciate these professional connections and look forward to maintaining them to the next conference. I am so glad I went." *(USA)*

"The residence allowed time to focus on attachment issues without the distracting 'office'. The parallel sessions worked well so that I could attend the talks most relevant to me. The setting was so good; you should hold it there each time; I just love Italy." *(Ireland)*

"I liked the diversity and opportunity to meet and learn from colleagues from such varied backgrounds and cultures, the excitement and pride at being a part of IASA and the first conference, the opportunity to hear presentations of research which is groundbreaking and gives hope and inspiration for the future, and I valued the opportunity to meet with like-minded professionals " *(UK)*

"Thank you for a fantastic conference! The talks, the surroundings, the food and all the wonderful people from around the world, working and thinking similar to me and my colleagues. The DMM is meaningful in my clinical work and just what I missed in my training. The plenary talks were worth the trip alone!" *(Norway)*

Coming to Bertinoro


Donatella Landi

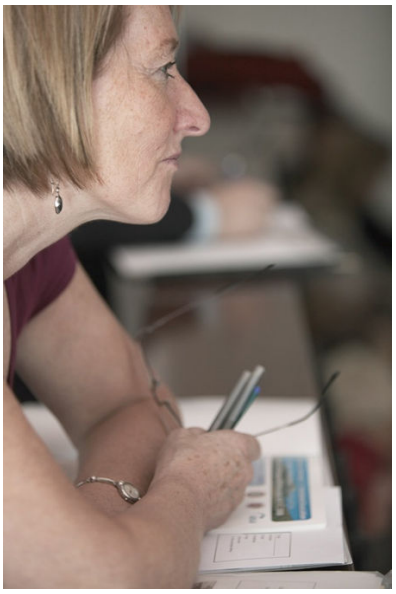
My journey to Italy began eight years ago, when I picked up a book: *The Organisation of Attachment: Maturation, Culture, and Context* by Patricia Crittenden. Here was a fresh framing of Bowlby's inspirational ideas and their crucial contribution to thinking about psychological reality. Like Bowlby, Crittenden placed relationships and relatedness as central to human living and emotional well-being.

In that book, familiar attachment ideas were extended in a language that felt robust and challenging. Was attachment theory an ethnocentric, western theory not yet universally established? Why was the dyad still seen in isolation? Why were crucial variables like context and culture still too neglected?

Here was a courageous researcher, like an explorer, not discouraged by 'the thick forest and the treacherous terrain.' Further, I discovered that Crittenden had substantiated her queries by extensively expanding the coding methods that I was familiar with so as to create an extremely detailed, sophisticated new model across the life cycle. Her hypotheses about adaptation were gaining empirical, systematic support that was filtering through a network of researchers and field workers she had established as she taught her model, shared observations, and attended to discrepancy as the pointer to thoughtfulness and change.

With my enthusiastic colleagues at the Attachment Journal, we decided to go to the first IASA Conference. Bertinoro is a gem, perched between the Appennines and the sea like an eagle's nest. In fact, beauty abounded at every turn, in the steep winding roads leading up to the Castle and in the proud solidity of the ancient Rocca in the far view.

The conference, having been oversubscribed, took possession of the place, with participants lodged all around the hill. For some, this meant their accommodation was rather austere, but the gentle hospitality and the exquisite cuisine were a pleasurable reward. A dreamy atmosphere set in when evening came. We turned into holiday makers, with the bonus of meeting across the table in a restaurant, or over a drink in a bar, someone who had great stories to tell or could tackle important questions, bringing the flavour of different places, languages, styles, to a shared set of concerns, interests, and passions.


"The emotional proximity among the professionals who use the DMM." *(Greece)*

The realisation grew, within this community, that something important is evolving and involving a vast range of professionals and field workers: psychologists, researchers, social workers, psychotherapists, child psychiatrists, health visitors, from all over the world. Most have accessed, via the DMM, a more rewarding way to work, a more accurate style of observation, and a more inclusive and respectful way to approach their 'subjects': mothers, children, families.

Information obtained from exploring and comparing outcomes of research carried out across a variety of cultures and societies was prominent in this first gathering of DMM researchers and clinicians.


"There were so many people from different countries with one common aim: supporting the chance to grow up with good mental health." *(Luxemburg)*

Can assessment of attachment offer a perspective on subtle, unconscious phenomena and then open up new ways to understand the impact of large scale events on societies? Rifkat Muhamadrahimov's research in Russia suggests the possibility. Can a whole nation be threatened and progressively healed by applying to its suffering the understandings of attachment theory? Mary Courchene reported on the abuse suffered by Canada's First Nation People across generations and talked about the regeneration that is taking place. Observational assessment was used as a tool to measure needs, a non-intrusive way to monitor internal states and gain information on which to set up intervention. Such a tool is particularly precious when aiming at the very early stages of development; Bente Nilsen demonstrated how the CARE-Index could reveal unspoken distress and guide caring professionals who sought to heal the wounds of parents' past endangerment.

As a psychotherapist, I found the reports on the use of AAI in the context of assessment pre- and post-therapy and for research exploring therapist's mental states regarding attachment challenging and engaging. The therapists' study provoked reflection, particularly around the dynamics induced in the therapeutic dyad by the matching - or mismatching - of patient's and therapist's attachment strategies. Furio Lambruschi also reported, unsurprisingly, that therapists generally present aspects of unresolved trauma and loss, just like their clients. Could this inform how therapists are trained?

I asked my roommate, a child psychiatrist who had trained extensively with Crittenden, what she most valued. She answered that what the DMM has brings to her practice is an understanding that all behaviour has a meaning and a function, even when it appears disorganised. The client's strategies will have been adaptive at some point in their main caregiving relationships and thinking about that relationship helps her in assessing the patient's difficulties and forming a therapeutic formulation. I think this is exactly what Bowlby himself would have wished to hear.

Donatella Landi, Attachment Journal, The Bowlby Centre, London

Does Attachment Shape A Mother's Brain? Exploring the Neurobiology of Attachment

Lane Strathearn

Background

Infant cues, such as smiling or crying facial expressions, are powerful motivators of human parental behavior, and activate dopamine-associated brain reward circuits in mothers (Figure 1) (Strathearn, Li, Fonagy, & Montegue, 2008)). Likewise, animal studies have demonstrated that the brain hormone oxytocin plays a critical role in the establishment of responsive maternal behavior.

From the Dynamic-Maturational Model of Attachment (DMM), a mother's own attachment experiences may predict the quality of care-giving she offers to her child. This study explored whether a mother's attachment strategy, using the DMM, could predict the extent of brain reward circuit activation and peripheral oxytocin response to her own infant's cues.

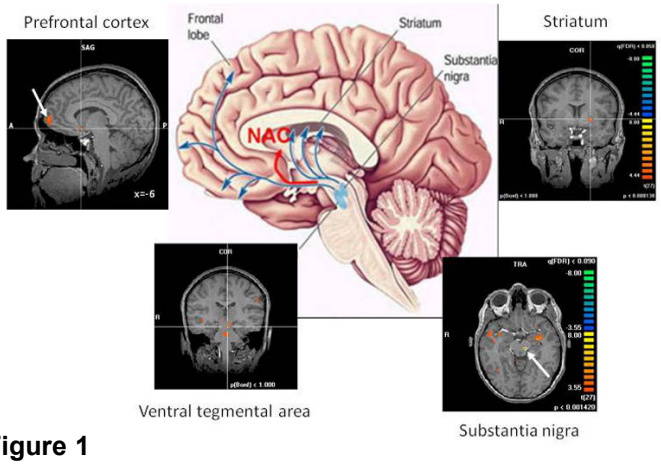


Figure 1

Hypotheses

It was hypothesized that mothers whose AAIs were classified as Type A would show preferential activation of nigrostriatal dopamine pathways, associated with action contingencies or "cognition", whereas Type B mothers would show greater relative activation of mesocorticolimbic pathways involved in reward and affective information processing (Figures 2 and 3). Furthermore, it was predicted that Type B mothers would show a greater oxytocin response when interacting with their infant during free play, and that these responses would be correlated with brain activation patterns.

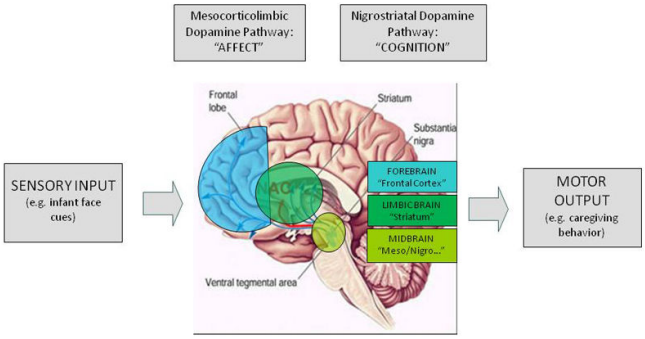


Figure 2

Method

Sample: First-time mothers with Type B attachment (n=15), determined prior to the infant's birth using the Adult Attachment Interview, were compared to mothers with Type A attachment (n=15). Groups did not differ on self-report measures of socioeconomic status, adult/infant temperament, breastfeeding, depression or parenting stress.

Procedure: Serum oxytocin was sampled from mothers before, during and after focused playful interaction with their 7-month-old infant. Later, using event-related functional MRI, mothers were shown 60 novel face images of their own infant and a matched unknown infant (Figure 4). Between-group differences in oxytocin response and brain activation were assessed using repeated-measure ANOVA and random-effects analysis.

Results

As hypothesized, mothers with a balanced (Type B) adult pattern of attachment showed preferential activation of two key reward regions, the ventral striatum and medial prefrontal cortex, when seeing their own babies' happy faces ($p<0.05$, false discovery rate corrected). They also showed higher blood oxytocin responses after interacting with their infant ($p<0.05$), which were positively correlated with brain responses in the ventral striatum ($rS=0.57$, $p=0.002$).

Whereas Type B mothers also activated these reward regions on viewing their own infant's crying faces, Type A mothers showed more

activation of the dorsolateral prefrontal cortex, which is involved in cognitive information processing, as well as the insula, a region associated with feelings of pain, disgust and negative affect.

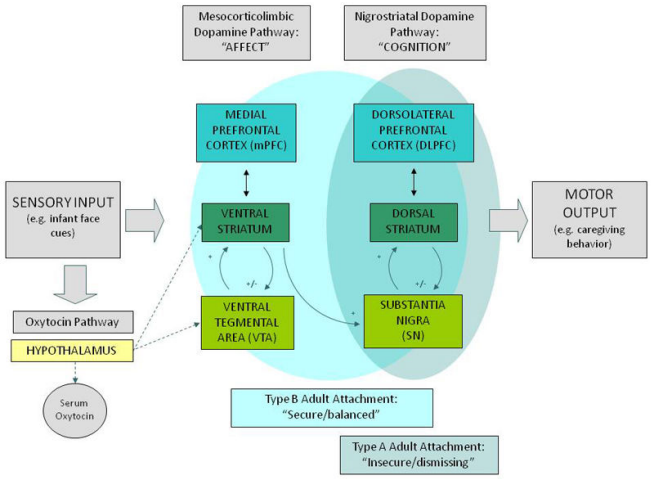


Figure 3

Conclusions

Thus, Type B mothers showed significantly greater activation of regions involved in dopamine-associated reward processing, in response to both happy and sad infant faces. In contrast, Type A mothers seemed to show more cognitive brain responses and appeared to mirror their own infant's negative affect, with more activation of the insula. Current research is exploring how differences in maternal brain response may predict infant attachment strategies using the Strange Situation

Procedure. We are also examining maternal brain responses in high risk populations, such as cocaine exposed new mothers. Understanding the brain and hormonal correlates of adult attachment may ultimately lead to more refined behavioral and pharmacotherapeutic interventions, to assist mothers become more attuned to their infant's behavioral and affective cues, and potentially alter the transmission patterns of insecure attachment.

Lane Strathearn, MBBS, FRACP, Assistant Professor, Department of Pediatrics, Baylor College of Medicine.

References

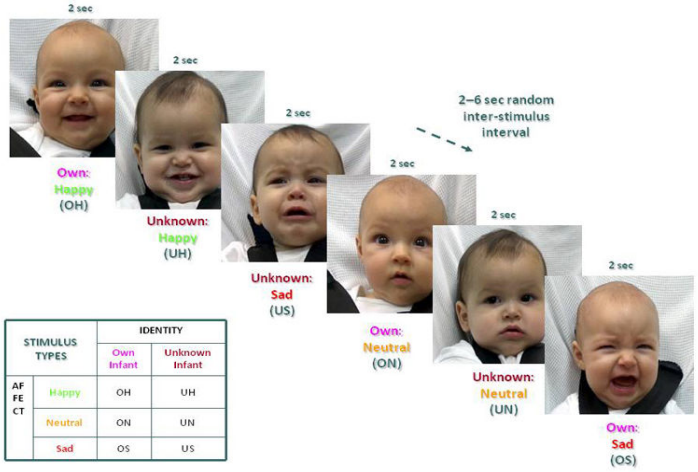
(1) Strathearn L, Li J, Fonagy P, Montague PR. What's in a smile? Maternal brain responses to infant facial cues. Pediatrics 2008 Jul 1;122(1):40-51.

Figure 1: Activation of brain reward regions when mothers view smiling faces of their own infant

Figure 2: Dopamine-associated pathways activated in mothers in response to infant sensory cues

Figure 3: How differences in adult attachment patterns may correspond to brain reward processing pathways

Figure 4: Baby face presentation paradigm in functional MRI experiment. Reproduced with permission from Pediatrics, Vol. 122, Pages 40-51, Copyright © 2008 by the AAP.



STIMULUS TYPES		IDENTITY: Own Infant	IDENTITY: Unknown Infant
AFFECT	Happy	OH	UH
	Neutral	ON	UN
	Sad	OS	US

Figure 4

Highlights . Conference Highlights . Conference

"The four strands aimed at people with different interests worked very well, the presentations I attended in the Parent-infant strand were very good. *(UK)*

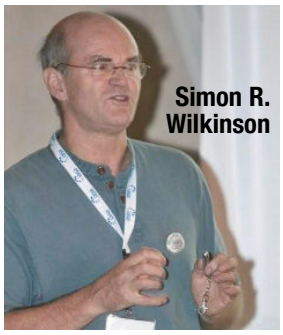
"In terms of content, I appreciated the plenary talks and found them really inspiring; in terms of surroundings, I simply loved the conference site!" *(Germany)*

"Standardising an acceptable attachment protocol for court-room use." *(Many!)*

"As a family lawyer, I loved and benefited most from the informal inter-disciplinary contact. I expected to enjoy the conference and to find some of the presentations interesting. I was surprised how very much I enjoyed it; all the talks I attended were not only interesting, but useful too." *(UK)*

Review: *Raising Parents: Attachment, Parenting and Child Safety*

Crittenden, PM. (2008) Willan publishing. ISBN 978-1-84392-498-2



Simon R. Wilkinson

When Pat Crittenden analyses tapes of dyadic interactions or transcripts of adult attachment interviews with groups of professionals, her cry goes up: Where is the evidence for what you say?

Here you see a masterful feast for thought that attempts to integrate an enormous breadth of evidence from biology to psychology. The illustrative vignettes place parenting in a developmental perspective and clarify the difference between 'dispositional representations', and 'internal working models'. The book is a rigourous scientific enquiry and timely attempt to improve the basis of clinical practice and child protection. It confirms the adage that the more we know, the more we know that we do not know.

We all need to explore what sort of evidence we have for what we do – be that as a healer or a parent. We are always partially blind to what drives us and noticing the paradoxes is difficult, but vital, to seeing what is there. As the Danish philosopher Kirkegaard put it: A thinker without a paradox is like a lover without passion.

Pat Crittenden has passion. She relentlessly tracks down the paradoxes in attachment observations and in the accepted attachment story too. Focusing on how self-protection, adaptation, and reproduction shape information processing, Crittenden addresses the complexity of development. This radically improves the clinical usefulness and applicability of theory Attachment theory starts to become accessible to clinical practice. The devil is in the details. The going gets tough when the sort of detail required to understand the most deviant psychopathological strategies is included. Nevertheless, this book shows why it is worth the struggle.

The Dynamic Maturational Model (DMM) aims to wed epigenetics, evolutionary psychology and other sciences in a coherent whole. The book raises questions about presuppositions regarding the precedence of biological processes in the aetiology of neuropsychiatric disorders. Here readers need to have followed the details in the early chapters, particularly her use of a transactional bio-psycho-social model to integrate information across modalities. If you did, then you can judge whether she has gone beyond the evidence or shown shortcomings in the 'evidence'.

At the end of the day, remember her mantra: Where is the evidence? Ask yourself if Pat Crittenden really does have enough evidence, or whether you can help build the knowledge base by asking further critical questions. The search for paradoxes in her thesis should be celebrated in style and shared with colleagues. In the meantime, good hunting. Feast on this book.

Simon R Wilkinson, Ullevål University Hospital, Oslo

"I never completely recovered from my surprise at how many people from many parts of the world are interested in this topic of attachment." *(Canada)*

"A beautiful venue! But what I liked best were the exchanges with clinicians and investigators working with an attachment perspective all around the world." *(Spain)*

Dear Pat,

I've taken an interest in the DMM for the last few years and have just read your Raising Parents book. I'm not usually given to writing to authors (I am English, after all!), but I want to congratulate you on making the model so accessible. I've got 25 years behind me now as a systemic family therapist and a psychoanalyticpsychotherapist, but I can't currently think of any single book that I have found more helpful. Anyway, enough gushing.

I've just seen a thirteen-year-old girl with a two year history of ME, psychogenic abdominal pain, and loss of education. It wasn't hard to see that she was in the A3-4 range so I had a good hunch from the model that she had split off negative affect.

Over the last few years, three or four professionals following a largely cognitive model of treatment had concluded that everything in the family was fine because there were no obvious bad feelings. I knew from the DMM that this was unlikely.

Fortunately for testing my hypothesis, when her father was unable to attend a treatment session, her deep unhappiness spilled out. She thought that her father was completely disinterested in her. It seemed to me that the more she tried to please him, the iller she got and the more frustrated he seems to have gotten with her ... and so on in a horrible cycle.

Mother, too, had given up trying to influence the father who was a remote, but highly successful, manager. I suspect she also felt deeply unhappy and trapped.

After that session, I helped the girl's mother to avoid simply dismissing her daughter's feelings (mother had dismissing parents) or cheering her daughter up, but, instead, to really hold her daughter's feelings for the first time. Eventually the daughter said, "I'd sooner be ill than have the family break up" which seemed to sum it up.

I think the key issue which the DMM guided me on is the relation between over-emphasised cognition and minimised affect. The DMM alerted me not to believe previous views of professionals that there were 'no difficulties in the family'.

Instead, before I met the family, my default starting point was that there were most probably 'emotional' difficulties in the family that, so far, no one had been able to talk meaningfully about. I was certainly helped in that by the father not attending. I might have got there eventually, but the DMM certainly provide a focus on hidden affect and distorted cognition.

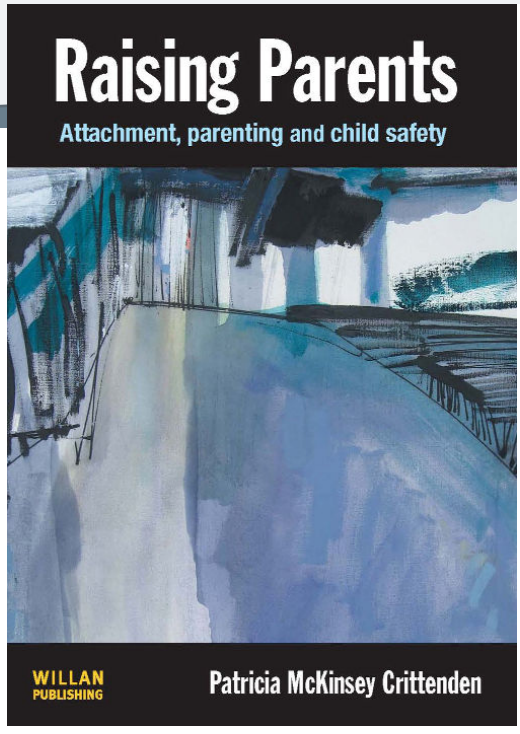
Anyway - The main purpose of writing was to feedback my gratitude for the Raising Parents book and the case was an illustration of how it had helped to maintain a clear focus in a session that had ended ten minutes before writing.

I felt I was very well guided by your model.

David Pocock

Head of Family Therapy, Child and Family Consultation Service
Marlborough , UK

"The variety of presentations." *(Switzerland)*



"I gave an extra copy of Raising Parents to my supervisor. His background is marriage and family therapy. He said that he has never read anything like it before." *(USA)*

Minds That Heal:
Charicteristics of Therapists that Promote Successful Therapy


Furio Lambruschi

Introduction and Rationale

Central ideas

The psychotherapeutic process can be described as the meeting of two minds that influence each other reciprocally. The process assumes that one of the two minds has specific theoretical and procedural equipment (drawn from a theory of treatment) as well as a specific kind of personal psychological organization that reflects integration of different forms of representation.

The choice of techniques of therapeutic intervention with each patient should be based on an adequate assessment of the patient that leads to detailed hypotheses regarding the specific features of the self organization that the patient has been able to mold during his or her development. The therapeutic techniques can then be selected to foster gradual harmonization (wider areas of integration) of his/her psychological processes.

However, the environment in which the therapeutic techniques are used, that is, the psychological organization of the therapist, has possibly an even greater importance than the therapeutic strategies because it is the physiological basis that fosters the integration of the patient's self. To be helpful, the therapist should display adequate metacognitive monitoring of his or her own cognitive and emotional processes and be free from important integrative deficits.

Previous studies

The psychotherapeutic relationship has been variously analyzed from an attachment perspective. However research has tended to focus on how patient attachment strategies affect the therapeutic alliance and treatment outcome, thus implying either that the therapists' functioning is of no consequence or that therapists can be assumed to function integratively. One or both of these assumptions may be inaccurate. If so, that could affect the success of psychotherapy for patients.

The attachment strategies of therapists may partially underlie what is understood as counter-transference (Goodwin, 2003). Secure (Type B) and avoidant (Type A) therapists appear to perform better than therapists using a Type C strategy; however, it also appears that, if not secure, then, it is important for the therapist to have an opposite attachment strategy to the patient (Dozier, 1990; Dozier et al, 1994; Tyrrell et al, 1999; Mallinckrodt, 2000; Meyer and Pilkonis, 2001; Rubino, Barker, Roth, & Fearon, 2000; Black, et all., 2005; Bruck et al, 2006).

The Research Questions

1. How are the attachment strategies distributed among Italian psychotherapists?
2. How does this distribution compare with that of normative Italian adults and Italian patients in psychotherapy?

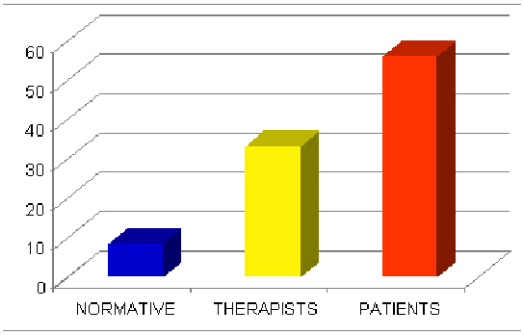
Method

Fifty-one (51) AAIs of Italian psychotherapists were gathered and classified using the Dynamic Maturational Model classification method (Crittenden, 1999). Each interview was coded by at least two coders, and, in case of disagreement, a third opinion was always sought. The distribution of the classification was compared to archival data from normative adults (N = 128) and adult patients in psychotherapy (N = 279) using the same classificatory method.

Preliminary Results

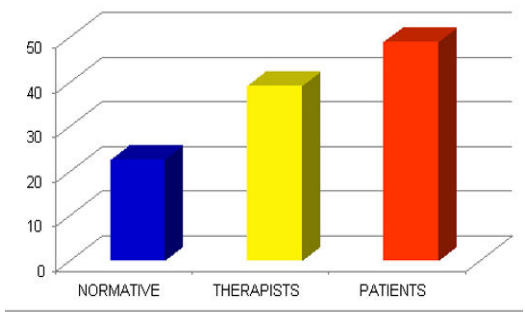
The distribution of attachment strategies

Compared to the patients sample (0%), Italian psychotherapists (25,5%) and Normative (29,7%) sample were more often classified as Type B. However, almost 40% of therapists used, on a daily basis in their own lives, interpersonal strategies that are typical of people who have been extremely endangered, not become integrated as adults, and are in need of psychotherapy (extreme subclassification: A5-8, C5-8)! That is, therapists appear to be a bi-modal group, either very well integrated and psychologically balanced or extremely unintegrated and highly distorted in their thinking. Our concern is how this might affect their behavior with patients.



Unresolved trauma

One third of therapists have not only experienced traumatic events in their childhood, but also are currently unresolved about these.



Unresolved loss

In addition, more than one third of therapists show unresolved issues with regard to loss of attachment figures in their childhood.

Extreme types of lack of resolution of trauma or loss

A 'generous' 27.5% of therapists were classified as having the most extreme types of unresolved traumas and losses. Specifically, instead of coming to accept and understand past endangering experiences, these therapists displaced the experience onto something or someone else, vicariously experienced an attachment figure's traumas as their own, imagined that the trauma explained psychological symptoms that it almost certainly was unrelated to, hinted that someone had deceptively endangered them, blocked the trauma from recall, or confused various traumatic events in a disorganized manner.

Modifiers

In addition, however, 20% of Italian psychotherapists were reorganizing their

psychological processes in the direction of integration. This was significantly more than among patients (7%).

On the other hand, nearly 6% of therapists were 'disoriented', i.e., confusing sources of information and different people's perspectives and interests. Is it possible that this has an iatrogenic origin? That is, psychotherapists' disorientation may be the result of lengthy personal analysis using approaches that are primarily interpretive or largely based on semantic representation and, perhaps, on 'obedience' in therapy, with little consideration, recognition and articulation of the implicit representations.

Conclusions

Overall, psychotherapists' psychological functioning appears to fall between that of the normative population and patients. Our concern is the almost two-thirds of therapists who function more like patents.

These data suggest that psychotherapists' training should be structured to monitor and promote greater integration of implicit representations with explicit semantic representations. The desired outcome would be greater flexibility, cohesion and meta-cognitive competence in mental functioning of the future therapist. Future research will address the relation of specific theories of psychological treatment (e.g., psychodynamic, cognitive, and family systems) to psychotherapists' attachment strategies.

Which should be our main areas of concern? Surely any unresolved loss or trauma in the therapist's history that are not adequately integrated into the therapist's daily functioning. Let's devote particular attention to the therapists with Type C organization, indicative of a preoccupation with their own feelings and perspectives; their difficulties in building a proper alliance and in addressing and resolving the inevitable rupture in the therapeutic relationship could harm patients. Helping trainees to observe themselves in the relationship with several patients, in complementary and counter-complementary situations could be a useful technique. Finally, supervision of both trainees and independent psychotherapists might best be informed by both an initial AAI and on-going observational methods, i.e., videotape or live observation of treatment, as opposed to easily distorted semantic approaches that rely on what the therapist recalls and tells the supervisor.

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