WE ARE THE TOOLS OF OUR TRADE

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WE ARE THE TOOLS OF OUR TRADE: THE THERAPIST'S ATTACHMENT HISTORY AS A SOURCE OF IMPASSE, INSPIRATION, AND CHANGE[1]

For almost twenty years, my work—practicing, teaching, and writing about psychotherapy—has been inspired by a mixture of curiosity and conviction about the power of attachment theory to enhance clinical practice. Along the way, that work eventuated in a book, *Attachment in Psychotherapy* (2007), in which I identified three research findings that appeared to have the most profound and fertile implications for treatment: first, that co-created relationships of attachment are the key context for development; second, that preverbal experience makes up the core of the developing self; and third, that the stance of the self toward experience is a better predictor of attachment security than the remembered facts of personal history themselves. Accordingly, my approach as a clinician has focused on the therapeutic relationship as a developmental crucible, the centrality of the nonverbal dimension, and the transformative influence of reflection and mindfulness. Within this framework, attending to the attachment history and patterning of the therapist is of vital importance.

In the pages that follow, I will discuss the advantages and vulnerabilities that arise from the therapist's characteristic career trajectory with its roots in a history of trauma and adaptation to trauma. I will go on to explore how, as therapists, we can identify our own states of mind with respect to attachment and the implications that flow from recognizing that our state of mind is presently secure, dismissing, preoccupied, and/or unresolved. Then I will describe how mindfulness and mentalizing can be enlisted to help us recognize and work with the enactments of transference/countertransference that take shape where our own attachment patterns interlock with those of the patient. Finally, I will present an illustrative clinical vignette.

ATTACHMENT AND THE THERAPIST

Despite the reality that "we are the tools of our trade" (Pearlman & Saakvitne, 1995), the impact of the therapist's own psychology upon his or her clinical effectiveness is a topic the psychotherapy literature has largely ignored. From the attachment perspective within which I work, this omission appears very problematic. At the heart of the matter is my assumption that, in childhood and psychotherapy alike, the relationship is where the developmental action is. Just as the child's original attachment relationships make development possible, it is ultimately

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the new relationship of attachment with the therapist that allows the patient to change. But development, of course, takes two. For this reason, the finding of attachment research that the parent's security, insecurity, or trauma is regularly transmitted to the child must surely catch our attention. For it suggests that not only as parents but also perhaps as therapists, our ability to generate a secure attachment relationship will be profoundly affected by the legacy of our own attachment relationships—a legacy that is, for many of us who choose this work, marked by trauma. Regardless of our theoretical orientation, then, our own attachment patterns may well be the single most influential factor in shaping—that is, enhancing but also constraining—our capacity to create with the patient a genuinely therapeutic relationship.

Let me be more specific. Attachment history is "engraved" in the psyche. It takes the form of internal representations and rules for processing information that derive from our experiences of what has and has not "worked" in relation to particular attachment figures. These "rules of attachment" are quite literally rules to live by, given that they initially emerge from interactions with caregivers upon whom we depend for our very survival. The key issue here is what has been ruled in and what has been ruled out in the relationship with our original attachment figures. Put differently, the question is: What have we been able to integrate (because it elicited an attuned response from attachment figures) and what have we needed to defensively dissociate (because it threatened the survival-critical attachment bond)? The answers to this question shape our attachment patterns, determining not only how we relate to ourselves and to others, but also what we allow ourselves to know. For what in infancy began as behavioral "strategies" for optimizing the relationship to attachment figures soon become emotional, cognitive, and attentional strategies that determine how freely we can feel, think, sense, and remember.

As therapists, then, our own (more or less troubled) attachment history—marked by the dissociations it has imposed and the integration we have managed to achieve, often with the help of personal therapy—is always both an asset and a liability. On the one hand, we know others most profoundly on the basis of what we know about ourselves. Such self-knowledge can be a therapeutic resource to the extent that we have been able to recognize, tolerate, and make meaningful sense of the painful aspects of our own history—that is, to integrate them. Then our personal experience may confer a heightened capacity for empathic understanding grounded in our partial identification with the patient's own difficult experience. Moreover, the freedom we have won to think deeply and feel fully can equip us well to kindle or strengthen the patient's capacities for reflection and emotion regulation. Finally—because of the mutual reciprocal influence therapists and patients inevitably exert upon one another—our real-time awareness of the ways our attachment patterns are presently being enacted with the patient can help to illuminate the patient's own attachment patterns.

On the other hand, the impact of the therapist's history—particularly experiences that have yet to be integrated—can have adverse effects on treatment. To begin with, our view of

the patient can be clouded by what we are unable or unwilling to know about ourselves. Additionally, our own attachment-derived skew toward thinking at the expense of feeling—or vice versa—can undermine our ability to upgrade the patient's ability to think and feel in an integrated fashion. Most problematically, impasses in treatment can arise out of the need to keep at bay our own unbearable, and hence dissociated, experiences of self or other. These impasses can take the form of collusions or collisions (Goldbart & Wallin, 1996). In keeping with our own attachment rules and patterns, we may find ourselves colluding with the patient to avoid experiences that are troubling to us and, not infrequently, to the patient as well. Alternatively, disowned aspects of ourselves—not only our dissociated experiences and our dread of them, but also our wish to work them through—can be defensively "relocated" in the patient. Then we may find ourselves caught in collisions with patients who evoke reactions in us that initially arose (but often had to be suppressed) in response to our original attachment figures. Or we may find ourselves embroiled in conflict when we unconsciously push our patients to take on developmental challenges that we have only ambivalently or incompletely addressed ourselves. As therapists, in short, we need to be aware of the ambiguous relationship between what we recognize in the patient on the basis of overlapping experience and what we project onto the patient on the basis of what we have yet to fully integrate in ourselves.

For many therapists, I would propose, this unfinished work of integration involves a history of early trauma to which we have adapted with what attachment researchers call a "controlling-caregiving strategy." Longitudinal studies (Main and Kaplan, 1988; Wartner et al, 1994) show that many infants assessed at twelve months as "disorganized"—presumably as a result of growing up with attachment figures whose own unresolved trauma made them frightening to their babies—have by age six developed a distinctly solicitous role-inverting strategy. Like these children, I would suggest, many future therapists have learned to take control of scary parents by taking care of them. Put differently, many of us are "wounded healers" who in the role of "parentified" children first acquired many of the skills—but also the constraints—we now bring to our clinical work.

IDENTIFYING AND WORKING WITH THE THERAPIST'S ATTACHMENT PATTERNS

From an attachment perspective, therapy heals when the quality of the therapist's presence and interventions can help patients both to deconstruct the attachment patterns of the past and to construct fresh ones in the present. From a slightly different angle, the therapist aims to create a relationship within which the patient may be able to integrate experiences that have previously had to remain dissociated. But our deliberate efforts to offer the patient a new and healing attachment relationship are invariably complicated, if not undermined outright, by the hidden pressures and constraints of our own attachment patterns.

For research purposes, identifying the attachment patterns of adults with singular descriptors (secure-autonomous, dismissing, preoccupied, unresolved) has been shown to have enormous value. For clinical purposes, however, it may be both more useful and true to the facts to assume that therapists in the course of their work can inhabit more than a single "state of mind with respect to attachment." In particular, therapists who have had a lot of therapy—and consequently a breadth and depth of self-knowledge and experience—will likely be well-acquainted with a multiplicity of such states of mind in themselves. These states of mind are developmentally determined, to be sure, but they are also context-dependent. By this I mean that the therapist in the clinical setting may find herself or himself in a secure, dismissing, preoccupied, or unresolved state of mind depending on the particular moment in the particular therapy of the particular patient.

Recognizing the state of mind in which, as therapists, we are presently lodged can be especially important when that state of mind is dismissing, preoccupied, or unresolved—and thus imposes limits on our awareness and effectiveness. Advantageously our very effort to notice and identify our state of mind can begin to loosen its grip—for then that state of mind may become an *experience* that needs to be understood rather than a *fact* that defines (and confines) us. Through such a process of attention and reflection, the constraints associated with particular states of mind can be transformed into therapeutically productive questions. For example, having noticed that we seem to be in a dismissing state that leaves us cut off from our feelings, we can ask ourselves, "What might be the feelings we don't now wish to feel?" Scrutinizing our experience in this fashion helps us to get out of our own way. And because our state of mind is always determined in part by the relational context, our efforts to grasp the nature of our own experience often wind up illuminating aspects of the patient's experience as well.

The Therapist in a Secure State of Mind

Two key words describe our experience when we can inhabit this much-to-be-desired state of mind: freedom and flexibility. We have the freedom here to reflect, to feel, and to be aware of bodily sensations. We also have a kind of "binocular vision" which permits flexible access to a wide range of experience both in ourselves and in our patients. Consequently, we are able to value, recognize and manifest in our conduct the balanced capacity for attachment and exploration that is the hallmark of secure attachment. Put differently, we are able in a secure state of mind to experience our relationship with the patient as a context in which there is room for two—two voices, two perspectives, two centers of desire and initiative.

In an insecure state of mind, by contrast, we tend to experience the therapeutic relationship as a setting in which there is only room for one. In a dismissing state of mind, as I will explain, that one is the self; in a preoccupied state of mind that one is the other.

The Therapist in a Dismissing State of Mind

The key word here is *isolation*. As therapists in a dismissing state of mind, we tend to be isolated both from the patient and from our own internal experience. "Compulsive self-reliance" was Bowlby's shorthand to describe this drift toward disconnection and emotional shutdown. Sustaining such a stance may require us to think too well of ourselves and too little of the patient. It may lead us to be more involved with conveying our own perspective than in empathizing with or deepening the experience of the patient. In such a state we are gripped by the "deactivating" attachment strategy characteristic of avoidant infants and dismissing adults alike. This means that rather than feeling comfortable with the primary biological attachment strategy—which is to turn to others when in distress—we are prone to tune out, in ourselves and from the patient, whatever cues might activate the attachment behavioral system. Clues to the therapist's deactivating strategy may be found in the research showing that infants classified as avoidant have usually been raised by controlling attachment figures who reject their overtures for closeness. In other words, therapists who become distant from their feelings and from their patients may unconsciously be protecting themselves from the threat of being rejected and/or controlled—which threats may also carry the potential to activate the therapist's feelings of shame.

Against this backdrop, it should come as no surprise that in a dismissing state of mind we tend to be dissociated from attachment-related emotions, impulses, memories, and vulnerabilities. In particular, we may be "allergic" to experiences of need and shame. More broadly, we may be cut off altogether from the world of feelings and bodily sensations—especially in ourselves, but often in our patients as well. From a certain angle and with certain patients—especially, perhaps, those in a preoccupied state of mind—these liabilities can be seen as assets (see Dozier et al, 1994), in that they allow the therapist to focus in a disciplined fashion, to analyze (albeit with limited empathy), to establish boundaries, and, ultimately, to cope.

Primarily, of course, we need to be aware of the constraints to which we are vulnerable when we find ourselves in a dismissing state of mind. In the overview, we are likely to pay inadequate attention to attachment-related experience, may analyze the patient's experience rather than deepen it, may think rather than feel, and may focus too much on behavior and too little on internal states. "Merger wariness" (Goldbart and Wallin, 1996) in the dismissing state of mind can lead to withdrawal rather than intimacy. There may also be a tendency to externalize, so that the patient rather than the therapist is regularly felt to be responsible for whatever problems arise in the relationship.

Rather than wear these constraints like an invisible straitjacket, we can, ideally, use our awareness of them as information that may allow us to correct our course. Whenever I find myself in a dismissing state of mind—isolated from my feelings and distant from the patient, engaged in a conversation between "talking heads," bored and sometimes drowsy—I try to

take a step forward in the direction of the patient and my own internal experience. I also try to remember to ask myself, “What is it that I don’t want to experience now?” Or alternatively, “What is it in myself and/or in the patient that I have needed to isolate myself from?” Finally I tend to wonder if I may be involved in a collusion with the patient to avoid emotional experience that is troubling not only to me, but to the patient as well.

The Therapist in a Preoccupied State of Mind

The preoccupied is in many ways the polar opposite of the dismissing state of mind. In the latter, we inhabit is a “left-brain” world in which thinking prevails over feeling and the self, rather than the other, is the center of gravity. In the former, we are in a “right-brain” world in which strong feelings can drown out thought, and the other is the center of gravity—the partner in the relationship with influence and importance. To capture our experience as therapists in a preoccupied state of mind, the key word is *accommodation*. We accommodate to the patient, or try very hard to, out of the fear that if we do not, the patient will leave us. While we may feel very connected to the patient, we have little solid sense here of our own value, our ability to be of real help, or our potential significance to the patient. As a consequence, we can find ourselves reflexively attempting to please and reassure the patient in any number of ways. We may bend over backwards to communicate our empathy. We may disclose our identification with the patient’s experience. Or we may yield to the temptation simply to say what we think the patient wishes to hear.

Our surplus insecurity and fear of losing the patient, as well as our compulsive accommodation, can be understood in light of certain aspects of the “hyperactivating” strategy common to ambivalent infants and, of course, preoccupied adults. This strategy arises out of repeated experiences of abandonment by unpredictably responsive attachment figures (now you see them, now you don’t) upon whom we are dependent and from whom we learn that our best hope for securing the support and attention of others is to make our distress too conspicuous to ignore. In the context of this strategy, our helplessness and vulnerability are felt to foster connection while our strength and autonomy are felt to threaten it. The problem with this solution is that our need to keep the attachment system chronically activated can undermine our potential to feel emotionally balanced, confident about ourselves, and trusting in relation to others.

As therapists, this preoccupied approach is clearly constraining. On the other hand, it also enables us to resonate with the experience of our patients and to offer them the experience of “feeling felt” (Siegel, 2001) that is critical to forming a therapeutic relationship. We have valuable resources here—particularly our access to our emotions and intuition—but they can be hard to capitalize on because of our fears that link autonomy to abandonment. When we have trouble experiencing a relationship as a setting that has room for two, how are we to have a mind of our own?

Among the consequences of this quandary for the therapist in a preoccupied state are the following: Expressions of our authentic autonomous self can too easily be suppressed or dissociated, in which case it will be hard to have—and still harder to convey—views that differ from the patient's. This means that as we relate to the patient our freedom to *interpret*—that is, to recognize and articulate alternative perspectives—can be very constrained. Much the same is likely to be true when it comes to appropriately asserting, as therapists, our influence upon the patient, our needs, and our desires. Instead we are vulnerable to a kind of boundary loss or merging in which our independent experience of ourselves seems to "disappear" as we are absorbed in the experience of the patient. The other side of the same coin may be our tendency to attribute traits of our own to the patient. Recall in this connection the social psychological research showing that "anxious" (aka, preoccupied) subjects are prone to over-identify with others through a bias toward "false consensus" (Mikulincer and Shaver, 2003). Thus we need to be cautious about assuming that our own psychology and that of the patient are the same. Needless to say, perhaps, we also need to be wary of our tendency to drift toward conflict avoidance, submission, self-blame and shame.

Noticing that we are caught in these kinds of undercurrents can be informative. I can identify my state of mind as preoccupied when I feel that I am losing myself in the patient's experience while becoming out-of-touch with my own—or that I am full of feelings but unwilling or unable to consider what these feelings might mean. When I observe, in short, that I am too gripped by the impulse to accommodate, then I realize that I need to take a step back both from the patient and from the "literalness" of my own emotional experience. To this end, I often find it helpful to ask myself questions such as these: "How am I accommodating to the patient in ways that may not be useful?" "What is it that I have been afraid to say or do, out of a fear of losing or hurting the patient?" And "What is it in myself, in the patient, and/or in the nature of our relationship that might help explain my fearful inhibition?"

The Therapist in an Unresolved State of Mind

As suggested earlier, therapists are often "wounded healers" with our own history of attachment-related trauma to which we have adapted with a "controlling-caregiving" strategy. Despite all the work we have done on ourselves—and the "earned security" we hope for as the result—most of us still have elements of this traumatic history that remain unresolved. Thus we are usually vulnerable to four distinct experiences of ourselves in relation to others that Liotti (1995, 1999) describes as features of an unresolved state of mind. Having been on the receiving end of trauma, we can experience ourselves as victims. Having experienced ourselves as both angry and responsible in response to trauma—and also perhaps identifying with the aggressor—we can experience ourselves as persecutors. Having experienced with attachment figures the role reversal involved in being "parentified" (recall that disorganized infants often become caregiving—i.e., controlling—children) we can experience ourselves as rescuers. And

finally, because as victims of trauma we have had recourse to the defense of dissociation, we can experience ourselves as cognitively incompetent or confused. Like the dismissing and preoccupied states of mind, an unresolved state in the therapist confers both strengths and vulnerabilities. The strengths associated with this state of mind include a heightened sensitivity to the patient's experience of trauma as well as the potential to understand it on the basis of partial identification. On the downside, therapists in an unresolved state of mind can tend to become too rigidly lodged in one or more of the roles I described above—victim, persecutor, rescuer, or cognitive incompetent.

The other day I found myself feeling apprehensive as I waited in my office for a particular patient to arrive. I was aware of feeling anxious at the possibility that I might be attacked by the patient or that she might experience me as attacking her. Worried about being a victim or a persecutor, I saw that I was standing at the edge, so to speak, of my own unresolved state of mind with respect to attachment. Unsurprisingly, I saw this patient, too, as inhabiting (much of the time) an unresolved state of mind. As mentioned earlier, the states of mind we experience with our patients are both developmentally determined and context-dependent. Thus, while our potential to occupy an unresolved state is established by our history, it is activated in a specific relational context—and usually that context is our relationship with a patient who is unresolved with respect to trauma.

Of the various states of mind with respect to attachment, it is the unresolved state in ourselves that is usually the most difficult to manage and make use of. Our fears of being victims or persecutors can be very threatening indeed. And our default options here—the roles of "space case" and rescuer—may afford us some protection but at the price of undermining our ability to help our patients. The conscious and unconscious threats that hover around us in an unresolved state can make it hard to think straight as we find ourselves becoming defensively drowsy or spaced-out. Alternatively, we may find a modicum of security as we take charge of scary patients by taking care of them—thus repeating in the context of clinical work the "controlling-caregiving" strategy we learned in childhood. The problem, of course, is that consoling, soothing, and/or giving advice to patients is an inadequate substitute for the genuine empathy, limit-setting, and activation/regulation of intense trauma-related emotions and memories that are essential to the integration of unresolved states of mind.

My advice to myself when working with such states is not to avoid them—neither in myself nor in the patient—but instead to recognize, describe, understand, and discuss them with the patient. Of course, this advice is often easier to offer than to implement, because the threatening roles of victim and victimizer evoke fear and shame of an intensity that is sometimes hard to manage. But this is exactly what we must try to do in whatever ways we can. And in this effort, as I will shortly explain, our own mindfulness and mentalizing have key roles to play.

MINDFULNESS, MENTALIZING, AND THE THERAPIST'S SELF-INQUIRY

Identifying the state of mind—secure, dismissing, preoccupied, or unresolved—in which we are lodged at a specific moment with a specific patient enlists a particular "map" to orient ourselves as we attempt to generate a new and developmentally facilitative attachment relationship with the patient. But such a map is not the territory, and certainly not the whole territory for it may leave out the specific and *personal* details of our here-and-now participation in what we hope will be a healing relationship. Scrupulously examining what in fact we are doing as we relate to the patient can help us to access the nonverbal subtext of the therapeutic conversation, which may in turn reveal the impact of our own attachment patterns as they interact with those of the patient. Such self-scrutiny also has the invaluable potential to illuminate the perceptible edge of dissociated experience in both partners in the therapeutic couple—which is vital because accessing dissociated experience is a precondition for its eventual integration. To make all this clearer requires a brief turn to the realm of nonverbal experience.

All of us are profoundly affected by experiences that are difficult to put into words. Such experiences can be hard to articulate for different reasons: Their origins may be preverbal, they may be defensively dissociated, or they may have occurred in the shadow of trauma that disabled the brain structures that underpin speech and autobiographical memory. Though unspoken or unspeakable, these implicit experiences—Bollas (1987) called them the "unthought known"—are nonetheless communicated. How so? In treatment, therapists and patients regularly evoke in each other and enact with each other aspects of themselves (memories, feelings, conflicts, internalized images of self and other) that they are unable to put into words. Both for better and for worse, these nonverbal communications generate the web of transference-countertransference enactments that arises as the attachment patterns of therapist and patient interlock. And given the inescapable reciprocal influence that helps shape such enactments, the therapist's attachment patterns are nearly always manifest in ways that are meaningfully, rather than adventitiously, related to those of the patient.

Repeatedly asking ourselves what we are actually doing with the patient can thus help us both to identify our role in these ongoing enactments and to access the dissociated experience that psychotherapy aims to integrate. To be most effective, the self-inquiry I advocate should pose not only the key question—"What am I actually doing with this patient?"—but also two others aimed at deepening our understanding: "What is the implicit relational meaning of what I'm doing?" and "What might be my motivation for doing what I'm doing?" As I'll explain shortly, the first question can best be answered when the therapist mobilizes a mindful stance, the next two when the therapist mobilizes a reflective or mentalizing stance.

Recognizing our role in enactments can be a considerable challenge because we are never altogether transparent to ourselves. We remain ignorant of much of what we do, partly because it is simply an automatic, unreflective expression of who we are, and partly because we tend to suppress awareness of what might trouble or unsettle us. The latter can be a particular problem for therapists whose history of trauma has imposed dissociations, including—almost universally—dissociated feelings of shame.

Adopting a stance of mindfulness—the centerpiece of a 2,500-year-old Buddhist tradition—can help to overcome these barriers, because it breaks the trance of conducting treatment as if we were on autopilot. When we aim to be mindful, it is as if we "snap out of it" by deliberately choosing to pay attention to our here-and-now experience with the patient as, moment by moment, this experience unfolds—neither judging nor evaluating it, but simply pausing to notice what we are doing while we are doing it. Moreover, cultivating mindfulness promotes acceptance, so mindfulness can function as an antidote to the shame that constricts self-awareness. Finally, a mindful stance not only facilitates the recognition of our role in enactments, but may also help to loosen their grip.

Simply asking ourselves what we're doing with the patient is a kind of "mindfulness in action" (Safran & Muran, 2003) that allows us to grasp—at a literal, explicit, "facts of the case" level—the details of our participation in the ongoing enactment. Then, having explicitly identified the nature of our action (empathizing, interpreting, offering advice, making a joke), we need to understand its implicit meaning—particularly in light of the relationship between our own psychology and that of the patient. For again, the clinician's attachment patterns as played out in the therapeutic interaction are nearly always meaningfully related to the attachment patterns of the patient. In trying to understand our conduct both in terms of its implicit relational meaning and in terms of our motivation, our key resource is our ability to mentalize—that is, to make sense of behavior by inferring the mental states (feelings, beliefs, desires) that underlie it.

With one rather prickly patient, for example, my initial self-inquiry—mindfulness in action—allowed me to see that what I was actually doing early in the session was . . . nothing. At the explicit behavioral level, I was making room for the free flow of the patient's spoken thoughts by making sure to share none of my own. Privately exploring the implicit relational meaning of my silence, I recognized my fear that whatever words I spoke, my patient would experience them as intrusive and hurtful—and would probably become angry. Yet I felt in a bind, for if I could not speak, I could not help. And as for the question of my motivation? I realized that with this particular patient (and no doubt with others as well) I was bending over backwards to avoid experiencing myself as destructive.

Eventually I broke my silence by sharing my dilemma about speaking—wanting to say something useful, but fearing his anger in response to words of mine he was likely to experience as disruptive incursions on his own thoughts. This disclosure allowed him to share

with me a related dilemma of his own: Should he risk "letting me in" when his history had proven that his only safety lay in mobilizing an off-putting "force field" of ever-ready anger? As he went on to describe the "three-headed monster" (narcissistic father, seductive mother, sadistic brother) against which his force field had originally been deployed, it suddenly occurred to me that the fear of destructiveness that had shut me up was linked with another kind of monster: a dreaded, shame-ridden facet of myself that I had recently come to call the "Bug."

CASE EXAMPLE: JACOB, THE "BUG," AND I

To begin at the middle of this story, I will say that one memorable day I was sitting with a patient who, despite a history replete with horrific trauma, seemed to bear no visible scars. Apart from some discontent with the quality of his intimate relationships, Jacob was apparently a very happy man who lived a charmed life. Yet he lived, I felt, on the surface. To keep safely distant from the neglect, loss, and abuse of his traumatic past, he was distant from himself while letting no one fully know him. To offset this distance and compensate for what (I felt) was missing in his life—the experience of being known and deeply cared for as a whole person—he indulged in various forms of "acting out" that put him at considerable risk.

On the day in question, Jacob was telling me with pleasure about still another stroke of good fortune that had recently come his way; he followed this with some uncurious words about his risky behavior, a little as if he were confessing. Such communications from Jacob were all too familiar to me, as were my responses to them. To today's good news, I responded as if I shared in his pleasure; to the confession, as if his conduct were worth exploring in an effort to better understand its meaning and allure. Then, rather suddenly, it struck me that the words I was speaking to Jacob had begun to have a hollow sound and that his face in response to them was unexpressive. Plainly something was off. Deliberately attempting now to land in the present moment, I paused to silently inquire of myself, "What was it that I was actually doing as I related to Jacob?" I became aware of the effort I was expending in order to be there for him, for it certainly was not coming naturally. I realized that I had been operating as if on autopilot, without thoughtful intention, almost compulsively offering Jacob what amounted to a kind of pseudo-therapy. If I were to talk about what was really going on inside myself, I would have to say something about my anger and my envy that Jacob seemed to be able to do whatever he wanted whenever he wanted to do it—with no repercussions or even pangs of conscience! I was extremely distressed at the intensity of what I was feeling and tried, silently and privately, with little success, to make sense of what I was experiencing. I felt immobilized and realized that I had, in fact, been effectively immobilized for some time. I recognized that my patient and I were at an impasse. Taking a step back for a moment, I would say that sometimes as therapists we are capable—having recognized the impasses in which we are lodged—of understanding and resolving those impasses through diligent self-analysis and dialogue,

negotiation, and exploration with the patient. On the other hand, there is often truth to the old joke that the problem with self-analysis is the countertransference. As I have mentioned, we are never completely transparent to ourselves, in part because we are compelled to remain blind to sights that deeply trouble us. Moreover, our capacity for useful reflection is always compromised when we find ourselves gripped by intensely disturbing feelings. Hence the necessity at times for the "two-person mentalizing" available in the form of consultation and the therapist's own therapy, both of which I made use of in attempting to resolve the impasse with Jacob.

In a small group consultation with colleagues Susan Sands and David Shaddock, I talked about my experiences with Jacob—and specifically the problem of doing therapy with someone who communicates as if he has no problems. With an obvious surplus of emotion I discussed the anger and envy I had recently become aware I felt in the presence of this man who seemed to possess the psychological and practical wherewithal to live with nearly perfect freedom. I also discussed the repetitious and frustrating sequence of the work with Jacob's high-risk behavior: how we would approach it, seem to get somewhere, then find it slipping off the radar screen, only to have it reappear again—and again. The patient I sketched seemed large and strong, capable of being intimidating—though I was not aware of feeling intimidated. What I did often feel with Jacob was a sense of lack, as if I had much less to offer than I usually feel I do. Sometimes it was hard to think clearly or feel fully in his presence. At worst I could feel deadened or invisible. Rarely did I feel needed.

About all this my colleagues had many useful things to say. But what opened my eyes and my heart was Susan's saying, "We now know about what it's like for you to be with him, but can you tell us something about how he got to be the way he is? Something about his childhood?" I literally felt stunned to realize that I had not said a single word about Jacob's experiences growing up, which were largely experiences of coping with trauma. As I began to describe this lonely story of constant squalor and intermittent horror, I had two nearly simultaneous images so vivid that they were like living presences: The first was of Jacob as a helpless and humiliated little boy; the second was of *myself* as a similar kind of little boy. And what felt like the superimposition of our related—though certainly not identical—experiences, one upon the other, brought me to tears. As I sobbed, the meaning of the impasse with Jacob crystallized for me, virtually in an instant.

In my own therapy I had recently been struggling with a profound and disturbing set of feelings that I had come to refer to as the "Bug" (think: Kafka's *Metamorphosis*). I initially experienced these utterly excruciating emotional sensations as nearly impossible to bear and no easier to name, though the visceral sense they carried was that I was disgusting, destructive, dangerous. Because they were inside me, or I because I felt at some primal level that they simply were me, there seemed no escape from them save through self-destruction. Perhaps

needless to say, I never believed that the Bug was all of me, so I could feel the self-destructive impulses without feeling compelled to act on them. What I have come to believe is that the Bug is a residue of my preverbal experiences with a mother who found her baby's needs (and undoubtedly her own needs) disgusting and dangerous.

The emotional response to being treated as a bug is probably best summed up with the word shame—the nearly intolerable pain of feeling not just that one has done something bad, but that one is bad. In my own therapy I had stumbled upon this dissociated pain and I was apparently averse to dragging Jacob—who I "knew" intuitively was as vulnerable to it as I—into that particular torture chamber. Nor evidently did I wish to spend any more time there myself, even vicariously, if I could somehow avoid it.

And so I had avoided it—by colluding with Jacob in living out a relationship between the two of us in a safer realm where need, vulnerability, and shame were relegated to the sidelines. At center stage in that psychological Green Zone were variations on the theme of omnipotence (and, perhaps, impotence). Rather than experience the danger of seeing or feeling in Jacob the shamed and fearful boy (or baby) with whom I might painfully identify, I had been focused self-protectively—if angrily, enviously, and somewhat impotently—on the man who could do anything.

Perhaps unremarkably, when I next met with Jacob our relationship had a profoundly different and deeper "feel"—I presume because, through Jacob in a sense, I had further integrated a disowned part of myself. This allowed me both to be more of a whole person when I was with him and to experience him as more of a whole person. Of course, there was no "miracle cure." But shortly after the session we agreed to meet more frequently and to address in a more deliberate and head-on fashion the "acting out" with which we had previously grappled superficially, only to let it slip away. In the sessions following that pivotal meeting, Jacob also began to talk—often pointing with his hand in the direction of his belly—about his vague, shameful sense of inferiority and its origin in the troubling experience of his early years.

CONCLUDING COMMENTS

My choice to concentrate in these pages on the impact of the therapist's own troubling origins and attachment patterns has to do, in part, with the fact that this important matter tends to be slighted in most of the clinical literature—as it does, I suspect, in much of our clinical practice—despite the fact that the primary creative instrument of the therapist is a self whose resources and liabilities are originally forged in the crucible of personal history. And as I have mentioned, the therapist's personal history is liable to be one that bears the scars of trauma.

In suggesting that the therapist's attachment patterns are often shaped by trauma, I am departing from a conventional view that patients and therapists alike may be tempted to embrace—namely, that the vulnerabilities in the therapeutic couple reside primarily if not exclusively in the patient. This view is a fiction that may serve the hopes of the patient and the self-protective needs of the therapist. But it is a fiction that diverts attention from the important reality that it is actually the interaction of the attachment patterns of both partners—their strengths and vulnerabilities, their integrations and dissociations—that ultimately determines the extent to which a new and healing attachment relationship will develop in psychotherapy.

I am proposing that we regard the therapist's vulnerabilities, like those of the patient, as integral and inevitable facts of life in psychotherapy. They are not necessarily best understood as psychopathological. Instead they may be seen as evidence of human imperfection. These vulnerabilities—in interaction with those of the patient—can generate difficulties in therapy that present obstacles, but also opportunities. When enactments engage the core vulnerabilities of the patient and the therapist, there is a risk of rupture, to be sure, but there is also the potential to provide the patient with a corrective relational experience and the therapist with a chance to further his or her own ever-unfinished psychological work.

In concluding, let me return to the point I asserted in the title of this paper. The therapist's attachment history can indeed be a source not only of impasse but also of inspiration—for there are unique advantages potentially bestowed upon the clinician by the experience of an unhappy or traumatic childhood. Of course, realizing these potential advantages depends upon the clinician's working through and integrating much (though probably never all) of the pain and difficulty imposed by such a childhood. It is the "earned security" achieved through subsequent attachment relationships in therapy, analysis, and elsewhere that eventually allows "the clinician's wounds to serve as tools" (paraphrasing Harris, 2009). As wounded healers many of us know the patient's struggles at first hand. And having made the journey ourselves—at least part way from dissociation to wholeness—we may be exceptionally well equipped to help patients undertake their own healing journey.

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