

## **The Therapist as the Patient's Attachment Figure and Secure Base**

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The last time I spoke at the March workshop I indicated that many of the tenets of attachment theory are implicitly present in Control-Mastery theory, in that Control-Mastery theory largely consists of advice on how a therapist should go about establishing and maintaining a psychologically beneficial relationship with a patient, thereby in effect becoming a patient's "perfect friend" from a developmental standpoint (Comello 2003). This time, I would like to show what an outline of Control-Mastery theory would look like if attachment-related concepts were explicitly incorporated into the theory.

When I speak of Control-Mastery theory implicitly including many attachment-related concepts, I'm referring specifically to the following aspects of the theory: making a patient feel safe, letting a patient set the therapeutic agenda, becoming the patient's ally, and Joe's emphasis on the therapeutic benefits of multiple aspects of the patient/therapist relationship.

If it is true that Joe Weiss implicitly built into Control-Mastery theory attachment-related ideas, the question arises why he didn't make those ideas explicit in the sense of formally integrating Control-Mastery theory with attachment theory. One reason, I think, is that integrating the two is by no means a straightforward exercise, as I indicated in my last talk. The problem is that John Bowlby's attachment theory is a very strange theory. Bowlby correctly portrayed attachment as encompassing the need for physical security, the processes of psychological and social development, pair bonding relationships, and interpersonal bonding in general. But he failed to follow through on this insight by providing an evolutionary/ethological basis that embraces all of these areas and shows how attachments structure human societies. Instead, Bowlby merely established an evolutionary/ethological basis for the need for physical security and then proceeded to either ignore that basis on certain occasions or distort the formulation of other attachment-related areas by force-fitting the physical security basis to them.

Bowlby was a visionary, rather than a scientist. As a result, his theory is a hodgepodge held together by ambiguous language and a willingness to completely abandon the physical security basis when including it would be obviously inappropriate, as in the following quote, in which Bowlby stated that one of the main functions of the therapist "is to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds it difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance" (Bowlby 1998).

One consequence of Bowlby's conceptual elasticity is that it is extremely difficult for anyone to truly integrate attachment-related concepts into any theory (e.g., Eagle 2003 and Fonagy 2001). Of particular importance for us here is the distorted attachment-related description of psychological development. In what follows, I will sketch my fix and show how this leads to an attachment-based interpretation of Control-Mastery theory.

I will begin by establishing an evolutionary/ethological basis for the participation of attachments in human learning and psychological development. Like Bowlby's basis, this evolutionary/ethological basis will be limited in scope. It will nevertheless represent an improvement in that it is appropriate to the attachment area under discussion.

Humans are the most adaptable of all beings. We try to make a big deal out of this by claiming to be the most intelligent of all animals, but what it really means is that human behavior is initially more deficient in direct instinctive guidance than is true of any other being. As a result, humans are initially the most incompetent of beings until they have acquired the learning needed to make up for this deficit. While young humans are in their initially incompetent state, they of course must be protected from predators. So it is quite true that the instinctive attachment control system that operates inside them has a security-based aspect. But this is only a small part of the story. Ensuring human survival in the long run is an orderly, instinct-driven learning process whereby an individual gains the perceptual, motor, and motivational skills needed to survive.

For a human to learn everything he needs, he must be teachable, which turns out to mean that he must be highly social. According to my use of the term, highly social means that human nervous systems are designed to be influenced by the nervous systems of other humans. The thoughts, feelings, emotions, motives, and actions of others tug on our nervous systems to bring our feelings, emotions, thoughts, behaviors, and motives into compliance, and this tugging begins in infancy. Rewarding compliance is the circumstance that we humans derive our greatest satisfactions in life from harmonious relationships with other humans.

Having nervous systems that are sensitively attuned to the nervous systems of others obviously creates a problem regarding inner stability. The way Nature addressed this problem was through the establishment of a hierarchy of attachments that operates throughout life.

**Primary attachment relationships.** A person's primary attachment relationships occur during a person's first years of life, when what is learned on the basis of compliances with caregivers shapes a person's personality, thereby providing a great deal of inner stability with regard to the person's dealings with other humans later on. An infant's attachment relationships with its caregivers are designated as developmentally primary because their main function is self-programming toward the establishment of an integrated personality.

**Secondary attachment relationships.** The attachment relationships that occur outside of the caregiver/sibling circle of influence from childhood on involve secondary attachments with friends, mentors, teachers, lovers, and spouses. Secondary attachment relationships also have a developmental component to them, but generally whatever is learned in these relationships does not penetrate very deeply into the core of a person's personality. In a secondary attachment relationship, a person basically strives to apply and extend his core personality, rather than change its internal structure. Secondary attachment relationships are defined by fairly definite boundaries. There are of course boundaries in child/caregiver/sibling relationships, too. But those boundaries are inherent to shaping personality development, while the boundaries established in secondary attachment relationships are largely protective of personalities that were formed earlier.

**Tertiary attachment relationships.** These are the relationships one has at a distance, involving the relationships one forms with role models one has encountered through books and the media and attachments to one's local community, state, country, and God. Included also are attachments made to fictional characters encountered through short stories, novels, plays, TV programs, and movies.

All of these types of attachment relationships are instinctively structured, but only primary attachment relationships exhibit the full range of attachment-related developmental instincts. The developmental instincts that operate in primary attachment relationships include: imitation, identification, oedipal competitiveness, unconscious relational testing, and altruism, which often expresses itself in terms of the Three Sisters of Guilt — omnipotent responsibility guilt, separation guilt, and survival guilt.

What I have done here is taken notions that have been floating about in psychological circles for a number of years and given them an anchor by interpreting them as components of the attachment control system. The reason it is legitimate to do this is that all of these modes of operation are instinctive, they all function within the context of attachment relationships, and they all structure interpersonal learning. In infant/caregiver primary attachment relationships, the overall purpose of the attachment instincts is to bind the infant/child to caregiver ways in the sense of enabling caregiver personalities to become the scaffolding on which personality development occurs. The specific ways the various attachment instincts operate in producing personality characteristics depend on the types of relationships established between the infant and its caregivers. The character of these relationships is mainly determined by caregiver behavior. The infant's contribution is mostly reactive, as it tries to sustain a level of connection despite whatever caregivers may do.

Attachment theory specifies four types of attachment relationships. Joe Weiss once indicated that he distinguished 12 types. Nevertheless, there is universal agreement that the secure attachment relationship is the most beneficial psychologically. Caregiver characteristics that give rise to this type of relationship are sensitivity to an infant's needs and caregiver responses that show appropriate amounts of energy, interest, and engagement. The securely attached caregiver additionally helps keep the infant focused on its development goals and encourages activities that are appropriate to the infant's current developmental level. Overall, the securely attached caregiver treats the infant as a friend, and ideally may act as the infant's "perfect friend" from a developmental standpoint. These behavioral patterns gradually give rise to cognitive structures that form the foundation of an infant's belief system. The types of beliefs fostered by this type of caregiver behavior include: I am interesting, I am important, I am fun to be with, human relationships are helpful and pleasurable, I'm okay and the world is a pretty nice place.

Bowlby recognized that attachment relationships are about more than just interpersonal interactions, that such relationships play important roles in an infant's exploratory activities as well. He described this as the infant using a caregiver as a secure base. In his writing, he typically envisioned a one-year-old infant continually checking back on a caregiver's availability as it explored new toys and new areas of its local environment. He theorized that the infant was concerned about physical security, and developed a sense of security from the caregiver's continued presence and interest. Using the argumentative hand waving that typifies his theory, Bowlby claimed that continued caregiver

availability translated into infant self-confidence and resultant mastery of its environmental setting.

What Bowlby failed to mention is that most times when an infant checks back with its caregiver, it isn't because of concerns over physical security. Infants typically check back with questions in their mind: Is this a good thing to play with? Is it okay to go here? What should I do now that this happened? That is, infants most often check back to gain information from caregivers through the process of social referencing. And as for the matter of environmental mastery, studies have shown that this too comes not in some mystical fashion as a spin-off of mere caregiver presence and interest, but because securely attached caregivers give infants exactly the right kind of emotional support and context-appropriate help they need to keep them pursuing their play goals (Comello 2003). The secure base function does address an infant's concerns about physical security, as Bowlby indicated, but it also in itself fosters the learning that enables an infant to meet its developmental goals in its explorations.

The things that have been said about the functioning of a secure base with respect to an infant are easily generalized to include situations that arise later in life. A sensitive, caring parent acts as a secure base when helping a child in dealing with the demands of the outside world, pertaining to school, peer group interactions, romantic episodes, etc. When acting as a secure base, the parents help the child to achieve its goals through emotional support and insightful advice, demonstrations as to how things should be done, and by being appropriate role models in general. Teachers, mentors, friends, and other attachment figures may function as secure bases in essentially the same way, as may therapists.

### **Integrating an Attachment Perspective with Control-Mastery Theory**

#### ***Initial testing***

When a patient comes to a therapist for help with his pathogenic beliefs, he begins testing the therapist almost immediately. Let us consider for a moment what that implies. How does a patient decide to do this, given that he probably knows nothing about the therapeutic process? Also, what is it that the patient hopes to achieve through this behavior?

To understand this, I think it is important to realize that when a therapist begins therapy with a new patient, he intercepts that person's developmental process at a particular point in the person's life. I have stated that secondary attachment relationships don't generally impact a person's core personality very much, that they are about merely applying and extending the person's core personality. However, attachment relationships between close friends contain something more — an attempt to establish a primary attachment relationship at least with respect to certain interpersonal issues. As a result, an attachment relationship between close friends is usually a mixed bag, in that it is a secondary attachment relationship with respect to many areas of a person's life and primary in a few pocket areas in which mutual interest enables both parties to provide at least the hope of the concerted support needed to make developmental inroads. Unconscious testing takes place with respect to these pocket areas. Were each a perfect friend for the other, their mutual interaction would enable each to combat their pathogenic beliefs to a significant extent. In practice, however, most close friends don't tolerate the level of unconscious

testing required to make significant headway. Another limiting factor is that each friend is working on issues of his own through unconscious testing, which means that the friends may at times operate at cross purposes.

So when a patient initially tests a therapist, he does so with the hope that the therapist will respond differently than any of his friends, that he will in effect be a “perfect friend” from a developmental standpoint. The therapist successfully feeds that hope by passing the patient’s test. Passing the test does disconfirm the patient’s pathogenic belief to an extent, but it also suggests to the patient that it may be safe to establish a primary attachment relationship with the therapist.

It has been shown empirically that patients regularly respond to the passing of a test by becoming more relaxed and generally more insightful and more able to consciously access hurtful memories. These phenomena have been interpreted as being a direct consequence of the disconfirmation of a pathogenic belief. While disconfirmation is certainly the *sine qua non* of what occurs, more is going on, which I will now try to describe.

The patient comes to the therapist’s office hoping to reprogram himself in such a way as to negate the harmful effects of his attachment relationships with his former caregivers within the context of a primary attachment relationship with the therapist. To accomplish his goal, however, he needs to test the therapist as he never dared test his friends so as to progressively explore and address the gray areas of their relationship, just as he explored them with his parents when a child. The issue in doing so is one of safety, as Joe claimed. The disconfirmations are important in themselves, but they are also a means to an end. The patient’s primary motive is to become assured that the therapist will act as a trusted ally in his quest for a new life. The patient wants to feel that he can anchor his quest in an attachment relationship with this person, and disconfirmations provide this assurance. So it is that the patient becomes more relaxed and more comfortable with therapist when a test is passed. The increased insightfulness, however, is related to something else.

I see the increased insightful and the increased ability to produce troubling memories as indications of the burgeoning attachment relationship between patient and the therapist. The insightfulness and the ability to recall troubling memories have the natural effect of mounting a barrier between the patient and the caregivers who fostered the development of his pathogenic beliefs, thereby weakening the patient’s attachment relationships with them. Insightfulness and memory recall are, therefore, indications that the patient is moving ever so slightly toward detachment (independence) from these individuals as he strengthens his attachment relationship with the therapist. So what is going on here is a shift in allegiances.

### ***Viewing the course of therapy***

In the typical summary of Control-Mastery theory, the therapeutic process is depicted as consisting of a series passed tests interspersed with pro-plan interpretations, the net effect of which is to disconfirm certain of the patient’s pathogenic beliefs. If the patient’s developmental initiatives outside of the therapist’s office are considered at all, they are usually seen as being due to generalizations the patient has made from what was learned during the therapy. To apply the secure base concept to therapy, I need to add some detail to this picture.

What has kept a person's pathogenic beliefs in place is his reticence to test their veracity in his everyday life. When a therapist passes a patient's test or offers a pro-plan interpretation, the disconfirming power of these interventions lessens this reticence, which may lead the patient to undertake a disconfirming initiative in his daily life. Daily-life initiatives of this sort are essential to the therapeutic process, I believe, so much so that the disconfirmation of a pathogenic belief in the therapist's office should be conceptualized as only beginning the disconfirming process. A single complete instance of disconfirmation requires that the patient also successfully challenge the pathogenic belief in some small way in his daily life.

I am suggesting that a successful therapy involves a two-pronged attack on a person's pathogenic beliefs, with the field of battle shifting constantly between therapist's office and the patient's everyday life, and that therefore both activities and the feedback between them need to be considered in a full description of the therapeutic process. In-office disconfirmations alone won't produce a successful therapy. I am pointing to the difference between a patient ending therapy saying that it helped him a lot and alternatively leaving with the attitude that therapy taught him things about himself, but in the end didn't help him.

The interplay between what goes on inside and outside the therapist's office is best viewed in terms of the attachment relationship between the patient and his therapist, as I will discuss. This viewpoint also increases the awareness that a patient receives many other disconfirming experiences during therapy besides passed tests and pro-plan interpretations.

During the course of the attachment relationship, the therapist conveys his acceptance of the patient and his interest and enjoyment in working with him. This in itself has a disconfirming effect, as does just being with a therapist who takes seriously the new identity the patient is striving to establish. Additionally, as the attachment relationship deepens, the patient begins looking to therapist to broadly model the attitudes the patient should have about himself and his developmental efforts. This too has disconfirming power, whether or not a test or a pro-plan interpretation is involved.

Control-Mastery theory postulates that a patient has inside of him a sensing as to the kinds of experiences he needs to counteract the inhibiting effects of pathogenic beliefs; it is this sensing that enables the patient to formulate therapeutically beneficial goals and plans. This developmentally positive sensing is not, however, a powerful developmental force without outside help, because it has achieved relatively little validation through experience. By aligning himself with the patient's goals and by passing the patient's tests, the therapist in effect comes to embody the patient's developmentally positive vision of himself, with the difference being that the therapist isn't inhibited by the patient's pathogenic beliefs. By forming an attachment with the therapist, the patient comes to internalize the therapist's steadfastness in pursuing his own developmentally positive aspirations, which gradually becomes the basis of his growth initiatives in his everyday life.

### ***Secure base interventions***

At the same time, the therapist acts as a secure base with regard to two exploratory activities. One of these involves the effort at self-analysis, as Bowlby indicated, and the

other involves the patient's attempts to apply what he has been learning in therapy in his everyday life. As far as the patient is concerned, self-analysis is an exploration of the unknown, so he looks to the therapist for direction and help in dealing with painful memories and affects, and for a sense that the hornets' nest of feelings that are being stirred up inside him will subside and everything will come out all right in the end. The flipside of unconscious guilt is shame and self-loathing. The therapist helps to counteract these feelings, thereby encouraging further self-explorations.

With respect to his daily life, the patient looks to the therapist for encouragement and help in interpreting events that don't go quite as well as the patient would like. The therapist participates also very often as an internalized presence, in the sense that the patient comes to ask himself how the therapist would handle particular situations. The therapist additionally acts as a secure base by being someone the patient knows he must report back to regarding his efforts at overcoming his pathogenic beliefs in his daily life. The therapist's continuing interest helps the patient to not backslide when he is tempted to do so. Backsliding triggers separation guilt, which induces the patient to redouble his efforts.

### ***Implications for research***

The recognition that therapy intercepts a person's developmental efforts at a particular point means, among other things, that the initial test the patient presents the therapist with probably relates to an issue that is important to him in his daily life at the moment, and that the test may be in anticipation of a similar test the patient would like to apply in his daily life, but has been hesitant to do so. That is, in testing the therapist, the patient may be using the therapist's response to gauge whether a particular test has a chance of succeeding in his daily life. In other words, a test in the therapist's office may be reactive or proactive as far as issues in the patient's daily life are concerned. So far as I know, the correlations between in-office tests and issues concurrently active in the patient's life have not been the subjects of empirical studies, but I am suggesting that they possibly should be.

The view that successful therapies involve a dynamic interplay between in-office activities and developmental initiatives the patient successfully undertakes in his own life implies that it should be possible to find empirical evidence of this interplay. It should also prove true that a correlation should exist between unsuccessful therapies and either a patient's reluctance to apply what he learned in therapy to his everyday life or an inability to do so successfully.

### **References**

- Bowlby, J. 1998. *Secure Base: Clinical Applications of Attachment Theory*. Oxford, UK: Routledge.
- Comello, V. 2003. Control Mastery Therapy as a Secure Attachment Relationship. Available at <http://controlmastery.org> and <http://hdbkpersonality.com>.
- Eagle, M. 2003. Clinical Implications of Attachment Theory. *Psychoanalytic Inquiry* 23(12), 27–53.
- Fonagy, P. 2001. *Attachment Theory and Psychoanalysis*. New York: Other Press LLC.