A R T I C L E

CLINICAL USE OF THE ADULT ATTACHMENT INTERVIEW IN PARENT–INFANT PSYCHOTHERAPY

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ABSTRACT: This article provides an illustration of how the use of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) can be extended beyond the research arena to its use as a clinical instrument in parent–infant psychotherapy. The article is based on the ongoing work of the Parent–Infant Project team at the Anna Freud Centre, London, where psychoanalytically trained therapists routinely administer the AAI early in the therapeutic process. In the first part of the article, we introduce the thinking behind the use of the AAI as a clinical tool and its particular relevance to the field of parent–infant psychotherapy. In the second part, we track the accruing clinical picture built up from a case example of the initial clinical sessions with a father who attended the Parent–Infant Project with his partner and two young children, and from the father's AAI. The discussion of the AAI material illustrates the distinct, yet related, interpretations of the parent–infant psychotherapist and the independent AAI coder as each made sense of the father's interview transcript. The resulting dialogue, between the psychodynamic-clinical and the attachment-research based approaches to the AAI, aims to highlight the added value the interview provides to the clinical understanding and process in parent–infant psychotherapy, which may ultimately help bridge the gap between the research and clinical domains.

RESUMEN: Este ensayo aporta una ilustración de cómo el uso de la Entrevista de la Afectividad Adulta (AAI) puede ser extendido más allá del campo de la investigación para ser utilizado como un instrumento clínico en la sicoterapia entre padre e infantes. Este artículo se basa en el trabajo actual del equipo del Proyecto Padres-Infantes en el Centro Anna Freud, donde terapeutas sicoanalíticamente entrenados dan rutinariamente la mencionada entrevista en los primeros momentos del proceso terapéutico. En la primera parte de este artículo, introducimos el pensamiento que apoya el uso de la AAI como una herramienta clínica, así como la particular relevancia que la misma tiene en el campo de la sicoterapia entre padres e infantes. En la segunda parte damos seguimiento a la imagen clínica procedente de la construcción de un caso que sirve como ejemplo de las sesiones clínicas iniciales, con un padre que asistió al Proyecto Padres-Infantes con su pareja y sus dos niños pequeños, y de la Entrevista de la Afectividad Adulta de dicho padre. La discusión del material de la AAI sirve para ilustrar las distintas, aunque relacionadas interpretaciones del sicoterapeuta de padres e infantes y las del codificador independiente de la AAI, tal como cada una trató de buscar el mejor sentido de la transcrita entrevista del padre. El diálogo resultante, entre los acercamientos a la AAI, tanto los sicodinámico-clínicos como los basados en la afectividad y la investigación, busca subrayar el beneficio adicional que la entrevista les provee a la comprensión y proceso clínicos en la sicoterapia entre padres e infantes, el cual pudiera en última instancia ayudar a llenar el vacío entre la investigación y el terreno clínico.

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INFANT MENTAL HEALTH JOURNAL, Vol. 25(4), 284–299 (2004)

Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/imhj.20006

RÉSUMÉ: Cet article offre une illustration de la manière dont l'utilisation de l'Entretien d'Attachement Adulte (AAI—*Adult Attachment Interview*) peut être élargie au delà du domaine de recherche à son utilisation comme instrument clinique dans la psychothérapie parent-bébé. Cet article est basé sur le travail en cours de l'équipe du Projet Parent-Bébé au Centre Anna Freud, où des thérapeutes formés psychoanalytiquement administrent routinièrement le AAI tôt dans le processus thérapeutique. Dans la première partie de l'article nous présentons la réflexion ayant conduit à l'utilisation de l'AAI en tant qu'outil clinique et son intérêt particulier dans le domaine de la psychothérapie parent-bébé. Dans la seconde partie de l'article nous traçons le tableau clinique à partir d'un exemple de cas de séances cliniques initiales avec un père qui avait participé au Project Parent-Bébé avec sa partenaire et leurs deux jeunes enfants, et à partir de l'AAI du père. La discussion du matériel AAI illustre bien les interprétations distinctes et cependant liées du psychothérapeute parent-bébé et du codeur indépendant AAI alors que chacun essayait d'interpréter la transcription de l'entretien du père. Le dialogue résultant, entre l'approche de l'AAI psychodynamique-clinique et l'approche de l'AAI basée sur la recherche en attachement, a pour but de souligner l'importante valeur que l'entretien offre à la compréhension et au processus cliniques dans la psychothérapie parent-bébé, ce qui peut en fin de compte aider à rapprocher le domaine de recherche et le domaine clinique.

ZUSAMMENFASSUNG: Diese Arbeit bietet eine Illustration wie die Anwendung des Erwachsenen Bindungsinterviews (AAI) über seine Verwendung als Forschungsinstrument hinaus, als klinisches Instrument bei der Eltern Kind Psychotherapie verwendet werden kann. Die Arbeit basiert auf einem derzeit laufenden Projekt des Eltern Kind Projektteams im Anna Freud Zentrum, in dem psychoanalytisch ausgebildete Therapeuten routinemäßig das AAI am Anfang des therapeutischen Prozess anwenden. Im ersten Teil der Arbeit führen wir in das Denken, das hinter der Einführung des AAI als klinisches Werkzeug liegt, ein, insbesondere dessen besondere Bedeutung für das Feld der Eltern Kind Psychotherapie. Im zweiten Teil analysieren wir das Fallbeispiel der ersten Stunden mit einem Vater, der das Eltern Kind Projekt mit seinem Partner und zwei kleinen Kinder aufgesucht hat und besprechen dessen AAI. Die Diskussion des AAI Materials verdeutlicht die besonderen, wenngleich in Beziehung stehenden Interpretationen des Eltern Kind Psychotherapeuten und die unabhängigen AAI Werte, wobei beide im Bezug auf die Verschriftlichung des Vaterinterviews Sinn machten. Der sich daraus ergebende Dialog zwischen den psychodynamisch-klinischen und dem bindungstheoretisch-forscherischen Zugang zum AAI, bemüht sich den zusätzlichen Nutzen anzuzeigen, den das Interview dem klinischen Verständnis und dem Prozess der Eltern Kind Psychotherapie hinzufügt, der zuletzt imstande sein könnte die Kluft zwischen Forschung und Klinik zu überbrücken.

抄録：この論文では、成人愛着面接 Adult Attachment Interview の利用が、研究領域を超えて、臨床的な道具として親－乳児精神療法に利用されるにいたるまで、どのように拡張されることができたかについて、実例を提供する。この論文は、アンナ・フロイトセンターの親－乳児プロジェクトチームが現在進行中の仕事に基づいている。アンナ・フロイトセンターでは、精神分析の訓練を受けた治療者が、治療過程初期に日常的に AAI を実施している。論文の前半で、われわれは臨床的な道具としての AAI の利用の背後にある見解と、特に親－乳児精神療法の分野での妥当性について、紹介する。後半で、親－乳児プロジェクトに配偶者と二人の幼児とともに参加した父親の症例の最初の臨床面接から、そしてその父親の成人愛着面接から組み立てて得られた臨床像を、われわれは追跡する。親－乳児精神療法家と独立した AAI 評定者それぞれが父親の面接記録の意味を理解した時、AAI 材料の議論は、親－乳児精神療法家と独立した AAI 評定者の、はっきりと区別されるがしかし関係もある解釈を明らかにする。結果として生じた AAI への精神分析的－臨床的アプローチと愛着－研究に基づくアプローチとの間の対話は、面接が親－乳児精神療法の臨床的理解と過程に提供する付加価値を強調することを目的にする。それは、最終的には、研究と臨床の領域の間のギャップに橋を架けるのを助けるだろう。

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The therapeutic usefulness of an interview which thoroughly probes the family history of an adult was commented upon by John Bowlby in what is widely regarded as the first article on family therapy (Bowlby, 1949). The Adult Attachment Interview (AAI) developed by George, Kaplan, and Main (1985) is such an interview, as it translates attachment theory into a research tool probing the individual's earliest memories and evaluations of primary relationships. The interview, with its strong empirical and theoretical links to the "gold standard" measure of infant–parent attachment relationships, the Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978), has an obvious place in the burgeoning field of infant mental health. The AAI links these research techniques and clinical work with infants and their families through its emphasis on the parent's current state of mind and modes of mental functioning regarding attachment, which influence the quality of the attachment with the next generation.

In this article, we extend the discussion of the AAI as a research tool to consider its use as a clinical instrument in parent–infant psychotherapy. To date, examination of the AAI in the clinical context has focused on its application in augmenting social history taking (Minde & Hesse, 1996; Murray & Cooper, 1994). Our aim is to provide an illustration of the utility of the AAI in enhancing the therapist's understanding of the clinical process. In so doing, the article bridges the worlds of clinical practice and research investigation.

The article is based on the ongoing work of the Parent–Infant Project team at the Anna Freud Centre, where psychoanalytically trained therapists routinely administer the AAI early in the therapeutic process. First, we introduce the thinking behind the use of the AAI as a clinical tool and its particular relevance to the field of parent–infant psychotherapy. Second, we track the accruing clinical picture built up from the initial clinical sessions with a father who attended the Parent–Infant Project with his partner and two young children, and from the father's AAI. Sessional material is presented to illustrate how a father's model of attachment is enacted in the parent–infant/child interactions and how these inform the therapist's responses and interventions. While the AAI also was conducted with the mother, space limitations did not permit inclusion of both interviews in this article. The father's interview was chosen because it presented more of a challenge to the clinician—characterized by emotionally vivid and memory-laden material about his childhood, and yet a peremptory, dismissing stance towards the meaning of the experiences described.

In presenting the father's AAI, we include both the therapist's conceptualizations when she conducted the interview and the description of the independent coding using Main and Goldwyn's system (1998). The discussion of the AAI material illustrates the distinct, yet related, interpretations arrived at by (a) the parent–infant psychotherapist (TB) and (b) the AAI coder (MS) as each made sense of the AAI. The resulting dialogue, between the psychodynamic-clinical- and the attachment-research-based approaches to the AAI, aims to highlight the added value the interview provides to the clinical understanding and process in parent–infant psychotherapy.[1]

THE THEORETICAL FRAMEWORK: THE AAI AS A CLINICAL TOOL

The AAI, a semistructured interview of 18 questions, concentrates on eliciting a sense of what probably happened to individuals in childhood and a picture of the degree to which they have

[1] Note that the psychotherapist is experienced in the administration and interpretation of the AAI, and the coder is trained in psychoanalysis. Thus, the collaboration is between colleagues familiar with each other's approach.

evaluated those experiences.[2] As a clinical intake tool, the AAI yields a relatively deep social history at the level of experience and symbolic representation, with a particular focus on attachment-related experiences. "Deep" in this context refers to material that reflects both early memories and modes of responding to (or coping with) experience stored at diverse levels of awareness. In this gathering of information, the AAI allows for the assessment of the following three features of the respondent's inner world: (a) the nature of the speaker's probable childhood experiences with his or her parents; (b) the nature of the speaker's mental representations of each parent, including their emotional stance toward them; and (c) the extent to which loss or other traumatic events or life circumstances have influenced their development and current personality organization.

Information about significant losses or other traumatic experiences are crucial given the link between unresolved loss trauma and pathology in the infant–parent relationship (Lyons-Ruth & Jacobvitz, 1999; Main & Hesse, 1990; Schuengel, van IJzendoorn, Bakermans-Kranenburg, & Bloom, 1999; Solomon & George, 1999). The direct inquiry about loss in the AAI may reveal unresolved loss or trauma in the parent's mind to which, for a variety of reasons including the lack of disclosure, the therapist may not have been alerted so early in the work.[3] One of the compelling features of using the AAI in clinical contexts is that it focuses on the patient's ability to integrate challenging emotional and mental material. In AAI terminology, this can be conceptualized in terms of the central feature of coherence.[3] The clinical corollary may be the clinician's focus on the patient's ability to hold diverse emotions and cognitions in mind and to contain painful and disruptive psychic material.

Parent–Infant Psychotherapy and the AAI

Fraiberg, Adelson, and Shapiro (1975) coined the term "ghosts in the nursery" to describe the unconscious (and thus unintentional) repetition of maladaptive patterns of parenting across the generations. The "ghosts" are negative emotions and memories in the parent that have taken up "residence" in the transference to the baby, i.e., have been transplanted rigidly from past unresolved relationships to the new one. This occurs as a result of traumata from the parent's own childhood that have remained unresolved and often unintegrated, consequent upon parental use of disassociation and identification with the aggressor[4] as defenses against childhood pain and helplessness. Infant–parent psychotherapy was developed to address the intergenerational repetitions to free the infant from the burden of the past and to prevent or repair derailed development. In this (variably named as infant–parent or parent–infant) psychotherapy modality, the focus is on the interactions between the dyad as the entry to the representational world of each in relation to the other. Working towards an integration of the parent's childhood experiences within the safety of the therapeutic relationship enables them to move towards an empathic identification with the infant, which can help break the negative cycles (e.g., of neglect evident in pervasive maternal withdrawal from the infant). Working with the baby to promote

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[2] A fuller description of the AAI is provided in Appendix A as growing familiarity with the instrument is assumed.

[3] The coding of the AAI relies heavily on the evaluation of various features of the narrative. Foremost among these is the concept of "coherence" (Hesse, 1999). Coherence is defined specifically according to the linguistic features of "good" conversation as outlined by Grice (1975, 1989), which includes the following features: quality (Be truthful and have evidence for what you say.), quantity (Be succinct and yet complete.), relation (Be relevant to the topic at hand.), and manner (Be clear and orderly.).

[4] Disassociation is a psychiatric term describing the mechanism by which the mind defensively separates between the memory of an event and the associated affective experience, which is repressed/forgotten. Identification with the aggressor was described by Anna Freud as a defensive mechanism by which the child repels his experience of weakness and vulnerability by aligning himself (identifying) with the feared aggressor.

secure attachment behavior with his or her parents can act as a catalyst to change in their relationship (Lieberman & Zeanah, 1999). One of the main contributions of the AAI in parent–infant psychotherapy is its sensitivity to the parent's mental functioning in relation to unresolved attachment issues that could be unconsciously repeated in interactions with their infants.

THE PARENT–INFANT PROJECT AND USE OF THE AAI

The Parent–Infant Project at the Anna Freud Centre in London was established in 1997 to address relationship disturbances in the parent–infant relationship. Approximately 80 families per year are seen in the Project. Increasingly, families are referred within weeks or months of the baby's birth. In 1999, by which time the model of intervention and clinical service were consolidated, it was decided to introduce the AAI as part of the intake process. To date, 180 interviews have been collected.

Initial concerns were both procedural—how to introduce the interview to the patients, how to integrate it into the intake process—and clinical. In analytic work, crucial material about relationships and their representations arises within the flow of free association, and in the adaptation of the analytic techniques to parent–infant psychotherapy, structured information taking and diagnostic procedures had been avoided. There was concern that the introduction of the AAI would cut across the here and now of "Tell me what has brought you here."

Many of the concerns resolved once the therapists became more familiar and at ease with the AAI. Patients now are routinely told about the structured interview, which explores their experiences of being a child and how they have come to understand them. The AAI is then conducted in the second or third meeting with the parent. When both parents attend, separate AAIs are conducted with each by the same therapist. The very introduction of the AAI to the parents communicates a therapeutic assumption that there are links between their experiences of being parented and parenting their child. This can immediately touch upon conflictual relationships with their own parents, and the sense of having been damaged by flawed parents or of having lost the good parent. Patients often come to the AAI session manifestly anxious. The interview may provoke painful material for the parent, and at the end of the AAI, it is necessary to leave time for a clinical "holding" of raw feelings. At this point, the therapist also may make a link for the parent between information obtained in the AAI and material obtained from the initial clinical session. This is the beginning of a psychoanalytic formulation of the work ahead. Even where defenses such as idealization or denial are used (such as in the insecure-dismissive patterns of attachment), the parent—facing a reunion with his or her own vulnerable and dependent infant—is rarely unmoved by the AAI session. Importantly, there is potential for the parent to gain an experience of a shared, affect-laden discourse that is emotionally scaffolded (Lyons-Ruth, 1999) by the "mentalizing" stance (Fonagy, 2000) of the therapist. The opportunity to talk about their emotional, sometimes traumatic, experiences with an attentive and responsive adult has often not been available to many of the parents.

However, there also are potential pitfalls facing the therapist who includes the AAI in parent–infant work. The first is the assumption that because the material was brought in the AAI the patient is in fact ready to work with this material. This is an issue of timing in interpretation that is always crucial in analytic work. But it is here befuddled by the availability of the material outside the flow of free association. The second danger is that therapists, well honed in the art of spotting the repetition of the past in the present, may be tempted to focus on links between the parents' experiences with their parents and the difficulties they are currently encountering in parenting their infant. However, elucidation of the past may not serve the purpose of enhancing emotional functioning in relation to the infant, at least in the short term, which is what the infant most needs in this "critical period" (Schore, 1994) in develop-

ment. This is illustrated in the case of a mother whose tendency to ruminate on her internal world resulted in her 1-month-old infant being lost from her mind. The baby mostly slept, awaking briefly with loud cries for a feeding. The immediate therapeutic task was to engage the mother with her baby, and to rouse the baby from his compliant passivity, which reinforced her withdrawal. The work, therefore, was interaction led, as the therapist helped the mother find pleasure in her relationship with her baby with minimal engagement with conflicted intergenerational preoccupations.

There also is a question whether the AAI can be applied to all clinical cases. Our experience is that there is room for clinical thinking about whether the AAI is appropriate for a particular parent at the point of referral to a clinical service. Certainly, the ethical guidelines given in the preface to the AAI (George et al., 1985) are relevant. When working with a vulnerable population, the therapist should be the one to administer the interview, and the patient should be able to withdraw from the interview if she or he so chooses.

In the Parent–Infant Project, parents are given the choice of refusing the AAI—and a minority do so, usually on the grounds that it would be too disturbing to "revisit" their childhood. From a clinical point of view, it could be argued that the AAI is counterindicated where rigid defenses are crucial for the parents' short-term functioning with their infant. This reflects the vulnerability of the client population attending the Parent–Infant Project, some of whom are in the aftermath of a severe depressive or psychotic episode. A second population where a similar consideration arises is that of antenatal referrals, where a vulnerable woman is close to giving birth. Here, too, consideration is given to the defensive structure and the potential for highly conflictual material to rupture the mother's psychic organization just before the events of birthing. In this group, the AAI may be administered postnatally if the treatment continues.

AAIs Administered With Both Parents

Of the AAIs we have collected, 23% have been from fathers. Fathers are encouraged to participate in the parent–infant psychotherapy sessions either from the beginning or when sufficient work has been done with the mother to allow the father a place in the treatment. The parents' parallel AAIs have presented a clinical challenge in that the AAI material needs to be discussed between the couple so that the therapist is not in the position of holding "secrets." In some instances, working towards more open communication between the couple may not be part of the parents' aims in undertaking parent–infant psychotherapy, and the respective points of view need to be straddled.

Coding Categories of the AAI

It is important to note that because of the unique features of the population of adults who are referred to the Parent–Infant Project, the AAIs collected do not always neatly fit into the standardized coding system (Main & Goldwyn, 1998), which was derived from interviews obtained from a more normative population. Use of the standard coding system is nearly always possible, but is almost always a challenge when compared with nonclinical interviews. The Parent–Infant Project therapists are familiar with the formal coding of the AAI, but they are not trained to rate the interviews.

CLINICAL MATERIAL

In this section, we consider the clinical process and the information available to the therapist from the preliminary sessions with the family alongside the information obtained from conducting the AAI with the father.

The family—Jack (father), Mary (mother), Tommy (4 years old), and George (5 weeks old)—were referred by their family physician because of concerns about the impact of their violent marital relationship and mother's depression on the children. The therapist met with the family twice before separately conducting AAIs with both parents. In these unstructured sessions, she gained background information regarding the current difficulties: the history of their relationship, the births of the children, their concerns, and the concerns of the network of professionals involved in the case. The therapist also observed the interactions between the parents and children. She noted that the 4-year-old appeared overly self-reliant and had developed specific strategies to keep out of his parents' way. On the few occasions that he did approach his father, Jack responded in an appropriate, but remote, way. The baby, George, also kept a low profile by either sleeping for long periods or staring into the distance when awake. Jack interacted very little with him.

First Session

In the first 30 min of the session, Jack and Mary were focused on the therapist, explaining to her what had brought them for psychotherapeutic help. Baby George was propped up in father's hands, facing out. Four-year-old Tommy had immersed himself in play with a train, driving it and piling passengers into the carriages. There was no interaction between the parents and the children during this period, and the therapist assumed the task of keeping the children in mind, addressing them both indirectly and in conversation with the parents. The following is an excerpt from the observation of the family.

> Mother tells the therapist about walking out when Tommy was 2 years, leaving him with his father for nearly 6 months. The parents confirm that mother's departure was not talked about with Tommy either before or after the event. Tommy drives his train next to the therapist. She says "we are talking about when your mummy was not with you." Mother reaches out for Baby George and Father passes him to her without comment. Mother, Father, and Baby George look bland during this uncued and seemingly affectless transition. The therapist takes this in from the corner of her eye, only later consciously registering that Baby George is now with mother. The parents talk about their fights. Baby George starts crying in mother's arms and she puts him to the breast; he has a long feed—slumping from time to time into a doze. Tommy drives a carriage to the therapist making the noise of a siren. He clarifies that it is a fire engine. The therapist wonders whether there is a fire and whether the fire engine is coming to help those in trouble. She links this with a question they may have about the therapist and her helpfulness—will she be able to help them with their "fires?" Mother says she has attacked Tommy on a few occasions. Her emotional tone is unruffled. Father watches Tommy silently then offers him some additional train carriages. These are ignored. The emotions between the parents escalate as father describes mother's provocations and his responses, sometimes hitting mother. The therapist registers that the heightened affect between the parents contrasts with Father's detached affect in relation to his sons. Tommy crashes his carriages into each other. The therapist makes the link to Tommy: "Mummy and daddy are telling me about their fighting, and you are showing me, with your crashes, how you feel." Baby George is crying again and the therapist talks to him about being so very small yet also feeling the anger and pain. His face is red and scrunched up.

To avoid preempting the AAI, the therapist the did not explore the meaning of the sepa-

ration in the context of their pasts. Later, she learned from the AAI that each had experienced traumatic separation from their own parents in their childhoods: Father had been moved to live with his grandparents, and mother had endured a long hospitalization. In addition, they had each effected separations from their own children whereby father had become fully estranged from two older children from a previous marriage, and mother walked out for a period on this nuclear family. In this first session, the therapist was made aware that a major separation had taken place that could not be spoken about safely within the family. She therefore chose to both name the event separation ("when your mummy was not with you") to open it as a subject that could be discussed in the future and to adhere (for the time being) to the parental stance by using nonemotive words. Mother's response to the therapist's intervention of naming the separation was to claim Baby George by physically taking him from father, who handed him over. Both behaved as though he were an object rather than a baby with feelings and preferences of his own. The therapist furthered considered that the information about mother's lashing out at Tommy was very frightening to each member of the family and that the mother's "unruffled" tone she had observed was a familial mode of regulating the threat by being very controlled. The therapist further reflected that both children may be at risk with parents who, at an emotional level, had abdicated their adult caretaking responsibilities when they exposed them to violent rows and failed to protect them from the other's frightening rages. At this juncture, the therapist was unsure how Baby George felt in mother's arms: safely anchored and drifting into sleep or threatened and withdrawing into sleep defensively? His body tone and facial expression could have shed some light on this, but he was obscured by mother's arms.

In the course of the therapy, these ideas would be explored, as relevant, with the parents and children. But in this first session, the therapist focused on attachment experiences likely to build a therapeutic alliance by acknowledging the fires raging within the individuals in the family and between them. But, working alongside their defenses at this very early stage, she used the technique of "displacement." Through the pretend fire engine, she addressed the primary questions: Were they (each one and collectively) meeting a (parental/therapeutic) mind that can hear their "siren"/calls for help, and would they be able to respond? The mental stance of the therapist models the relationship with an adult, mentalizing mind, which is regarded as the developmental underpinning for a secure attachment (Fonagy, Steele, Moran, Steele, & Higgitt, 1991).

Twenty minutes later:
The emotional tone in the room is much calmer. The parents are still talking to the therapist, but the preoccupation now also embraces their children. Mother is attending to Baby George, who has fed and is now being jiggled and crooned to; Baby George is not crying but his face is tense. He dips in and out of little frets. Father and Tommy are looking at the Lego box and examining bits for the construction of airplane. Father's tone of voice is quiet and steady. Tommy uses his father's guidance and seems satisfied with what they are creating. But he gets restless and abandons the play when father's attention shifts to the adult conversation.

The children now appear more anchored within the parental minds. This suggests that the family's experience in the session enabled the parents to attend more to their children. The therapist considered this to indicate some potential to use therapy constructively. Yet, each child in his own way demonstrated how tenuous this "holding" felt since their tolerance of even the slightest move in the respective parent's attention away from them immediately re-

sulted in emotional hyperarousal. The therapist thought that the children may experience the cumulative trauma of neglect with these parents, i.e., may regularly and unpredictably be exposed to responsive parenting alternating with extreme parental withdrawal.

> As the session comes to an end, Tommy has organised a pretend tea-party for the people and the teddies. When he is told that it is time to tidy up, he bursts into tears. His sobbing is far more desperate than the more usual disappointment or anger shown by children at the end of a session. Mother, sitting opposite Tommy with Baby George still in her arms, tells him that he can continue with the "cooking" that he was doing at home before they came to their session. Father assures Tommy that he "can always come here again" and explains that it was like at school, where he also has to tidy up and leave. Their comments, although appropriate and even supportive, fail to capture the affective tone conveyed by Tommy, who sits stricken, tears running down his face, wailing. The therapist feels very moved. She squats by his side and speaks gently to him about how shocked and sad he is at this sudden ending which spoilt the lovely picnic he was making. Tommy continues to cry, although less violently. Baby George starts crying and is handed to father while mother finishes off clearing the toys away. The therapist notes that clearing the room has taken precedence over comforting her baby. Father pats Baby George and faces him outward. He watches the activity in the room and stops crying. Tommy eventually ceases his weeping and starts to put things away, slowly and carefully, assisted by his mother and the therapist. This collective activity seems to help the family to prepare themselves to leave the room.

Tommy's wish for everyone to partake in a pleasurable "feed, "the picnic, perhaps expressed the family's need for emotional replenishing before they left the therapy session. However, the ending faced everyone with their experience of not having had enough and of being left (abandoned by the therapist/mother/"firefighter") to their own devices in this fragile emotional state. Baby George and Tommy cried. Both parents offered rationalizing comments which were appropriate in their content, but lacked the emotional thrust needed to comfort their distressed son.

But for the therapist, it was her countertransference that immediately conveyed the probable attachment pattern. Her feeling so moved by Tommy's sadness while the parents were being pragmatic was the key to the anxiety and the defenses she witnessed in the session: Enormous pain is intolerable and its emotional significance is dismissed. The habitual nature of this dismissive isolation of affect would later become evident from reviewing the parents' AAIs. From her observations in the first session in the consulting room, the therapist already recognized that helping the parents and children to make sense of their emotional world would be one of her main tasks in the therapeutic work.

FATHER'S AAI

The Trained Coder's Perspective

The interview was analyzed by the first author, who was blind to all information regarding this patient other than that his status as a patient in the Parent–Infant Project. The overall rating of the interview was a classification of insecure-dismissing. Particularly indicative were the strong unsupported claims to normalcy and the related idealization of his parents, especially his mother. As well, he was rated as Unresolved with regard to the death of an aunt who died when he was a child and whom he claimed to have seen after she died.

Two main features of father's interview are discussed: (a) his use of idealization of his own strengths and of his attachment figures as a way of limiting access to the painful aspects of these relationships, and (b) his employment of a pseudoreflective stance when speaking of attachment-related issues, again to protect himself against resonating with his attachment history.

Central features to the rating of dismissing interviews are the subject's strong claim to normalcy and a strong reliance on themselves in childhood and beyond. This father exemplifies both features. Very early in the interview, when asked to describe his relationships, Father says "I think it was normal, normal relationships with my parents, they were just normal parents. We never really sat down as a family to dinner all together at a table or things like that (3-second pause) yeah I think it was just normal family." When asked what he would do when he was upset as a child, he says, "I wouldn't speak to my parents. I used to work the things out for myself for most of the things if I was upset . . . I don't know if I was emotionally upset ever, I can't remember anything like that as a child." He then offers two examples of having been upset: over being severely punished for not wanting to eat porridge at his grandparents' house and over a neighbor killing his kittens. In both examples, while he can describe the negative events, there is no comment on their impact from his perspective or how his caregivers dealt with the upset. These passages, taken together with the very positive way he described his mother at the start of the interview ("kind, happy, godly"), suggest that his memories of childhood difficulties exist in representations isolated from the painful feelings that would have accompanied their original occurrence. These passages from his interview contribute to the high rating assigned for idealization of parents. This defensive position functions to prevent accurate reflections on how his parents behaved and how he actually felt as a child.

In response to a question ordinarily demanding reflection and evaluation (i.e., if he thinks his childhood may have influenced who he is today), he says categorically:

> No. Yeah I would say it was later. I don't think there's anything from my childhood that I could remember that I think would have made me like how I am at all. Later [in adulthood] when I became more interested with the people around me and how they work and what they did and that's what changed me.

This need to dismiss the importance of his childhood while emphasizing significant recent adult relationships underscores his defensive strategy to restrict awareness of his painfully disappointing attachment history: If you can't remember it, how can it hurt you?

This father had a parallel style of discourse, which might lead one to believe that he is at times thoughtful and engaging in reflecting upon his attachment relationships. For example, when asked about his parent's marital discord and his mother's maintained "happy" state, he said: "I mean we never saw them arguing, maybe they did, but I didn't see it, do you understand, so I always thought they were happy." Here he comes across as cooperative with the interviewer, but asking if the interviewer understands and by using words like "maybe" to convey an open, flexible stance. Yet, importantly he falls short of really convincing us that he has a compelling understanding of attachment relationships. In this example, despite his parents splitting up, he claimed that there were no rows to recall, and mother was just always happy. If he truly was able to reflect on these experiences, the inherent contradiction between the two stances would be noticed, and he would provide us with evidence that he is able to think about these statements and question and evaluate his recall of them. These two features, the idealization and quasireflective stance, are described by Main et al. (1998). The coding system authors argue that some interviews which show an overarching dismissing stance to attachment

also may contain instances of perceptive, and even passionate, descriptions of individuals or aspects of childhood. In this particular father's case, there are elements in the interview which convey that he feels strongly and values certain attachment relationships. Interestingly, in response to the question regarding losses in adulthood, this father first mentions the estranged relationship with his children:

> Losses for me also would be like not being able to see my other children grow up. I mean not like even with my oldest son and he's got a baby now, I mean I've never seen it, I mean its not saying that I can't go there and see it, but is like he's my son but I don't know him, do you understand that we hang about, we do stuff, or whatever, but its not like I know him (26-s pause).

The interview raises a question in relation to the working through of possible physical abuse from a harsh, punitive father. Father describes his father as "hard:"

> He was hard, because we used to get, we used to get smacked with a belt but that was the way most parents could discipline their children, anyway 'cause we were very unruly children, we just used to do stupid things.

Father is not willing to see his own father in a negative light: He normalizes the punishment with the assertion that his father's behavior was the same as everyone else's, and even more dramatically, it was in part his own fault. These ideas hold in place the representations of the parent as "good," even if it requires blaming oneself and so believing that the beatings were well deserved. This feature of AAI has been noticed in some samples of clinical populations (Steele et al., 2003). Specifically, with regard to both physical and sexual abuse, certain individuals use a strategy of blaming themselves for having in some way provoked the abuse and thus deserved it. This strategy seems to serve a similar purpose as the idealizing stance, which works to limit the full weight of negative affect that would otherwise rest firmly on the caregivers' shoulders. The self-blaming combines with the felt derogation, contempt, and lowered self-esteem that often accompanies the abuse.

Father's AAI satisfies a coding of Unresolved with regard to loss, trauma, or both in his description of a number of losses in his past. These seem to have the potential to topple his habitual defensive strategies and leave him overwhelmed. There is the sense of loss he feels in respect to his older children, who stayed with their mother when he left, the loss of a close friend during adulthood years (When talking about this, there was a sudden surge of tears.), and most importantly, the loss of an aunt during his childhood. Notably, this latter loss was spoken about in a way that suggests an ongoing lapse in his capacity to monitor what is reasonable as compared to what is impossible. This father describes the loss:

> My aunty had died, we went to the funeral, and I remember having a bath one day after the funeral it was and she came to me in the bathroom and I told my Mum that I saw her and my mum was saying "oh no you didn't see her" and I said I did because I did see her and after that I used to always go through the house trying to find her. . . .

The description and conviction that he had seen his dead aunt pervades his present discourse. He does not qualify the description as one that he has since relegated to the thinking of a young child, and this leads to rating the interview as unresolved with respect to past losses. This Unresolved rating has important implications with respect to possible concerns about his parenting behavior, in terms of the propensity of parents with unresolved loss to appear frightening

or frightened in the baby's perception, leading to the intergenerational transmission of disorganization (Lyons-Ruth & Jacobvitz, 1999; Main & Hesse, 1990).

The Clinician's Perspective

Father responded thoughtfully and in detail to the questions of the interview. He gave a comprehensive picture of certain aspects of his childhood and important events in his adult life, elaborated through vivid examples. Yet, to some questions, Jack responded in a flat, affectless way most strikingly regarding the question of use of the adult for comfort. Overall, the therapist thought that Father emerged as a richer personality in the AAI than he presented in the sessions, but the therapist felt puzzled by the unevenness of his narrative. During the AAI, she fluctuated between feeling unusually engaged (especially when contrasted with the experience of administering AAIs to other parents in the Parent–Infant Project) and confused. At times, it felt as though reality was left behind and his meanderings became self-absorbed ruminations; the therapist struggled to keep to the confines of the AAI, reflecting her own wish to bring order.

The following points summarize the clinician's conceptualizations consequent on conducting the AAI:

1. Father's childhood experiences with his parents and siblings suggest repeated disappointment in his attachment figures in the sense that they did not provide him with a sense of reliable and predictable safety and comfort. As a consequence, it is likely that he does not appreciate the importance of these relationship features for his children.
2. His mental representations of his parents are unintegrated. For example, mother is described as kind, and yet, he did not turn to her when needy (ill, hurt, upset). The therapist wondered whether his understanding of his children's need for him is based on a rational, intellectual formulation rather than on emotionally grounded experience and empathy.
3. The pain he felt in his childhood was apparent to the therapist through her countertransference, but not to himself. The therapist attributed this to defensive preclusion of awareness of his unhappiness, through disassociation between memory and affect, in the absence of experiences of safety and comfort. She was concerned to observe resonating emergent patterns in the children.
4. Childhood events underpinned by rejection and loss, such as the move to his grandparents and the slaughter of his kittens, were associated with lapses in Father's mental reasoning, and the therapist was confused as to what happened and why. This presumably mirrored his lack of psychological processing, so that the trauma of the past was carried through to the present. The therapist was aware that ruptures were being repeated in the current nuclear family: Father had left his older children and had gone along with mother's abandoning Tommy.
5. There was denial of the effects of childhood experiences on his adult personality. The therapist wondered whether this stance enabled Father to relieve the adults (his parents, himself) of the burden of responsibility, blame, and guilt for the difficulties of the children. At the same time, the underlying rage towards parental figures was manifest in his obsessive recriminations toward his partner during the clinical session.

Comparison of the Therapist's and Coder's Perspectives on the AAI

To a large extent, the therapist's assessment was confirmed in the classification of the AAI. The therapist noted the dysfluency in the speaker, the contradictions in Father's story, and the

sense of being cut off from more reality-based (particularly negative) feelings regarding his attachment history. The coding of the AAI throws more definitive light on areas of ambiguity.

In this case, the father holds two parallel frames of reference in relation to attachment. On one hand, he provides affect-laden language to describe discrete, vivid attachment-related memories. Within this frame of reference, he also shows a valuing of attachment relationships as conveyed, for example, by his remorse over the loss of a relationship with his older children. On the other hand, he is dismissing in relation to attachment, and his highly idealizing stance serves to uphold this state of mind by keeping at bay the more painful and critical evaluation of his childhood. The coding of the AAI clarified for the therapist her confusing impressions, from the clinical sessions and from conducting the interview, regarding the father's availability to attachment-related experiences in his children.

REVIEW OF THE CLINICAL SESSION IN LIGHT OF INFORMATION FROM THE AAI

The AAI elucidated two central and related features of the clinical sessions. The first feature was the intergenerational repetition of early separation from attachment figures as an organizer for the psychological stressors experienced by all members of the current family. More specifically, the discovery of use made by this family of a defensive strategy to ward off psychic pain in response to separation/rejection emerged, both in the clinical minutiae of the sessions with the family and highlighted in father's AAI. In the session, the therapist observed that the parents were unable to resonate with the children's pain around separations (in discussing mother's absence and when Tommy and Baby George became distressed at the end of the session). In his AAI, Father was unable to provide a convincing explanation for his separations (both as a child from his parents and as an adult from his children). We may see the two as linked in that the events continued to lack an explanatory narrative (of when and how and why) and remained emotionally unprocessed and poorly represented. Were these the reasons why he could give over Baby George during the session and had not protected Tommy from mother's desertion and attacks?

The therapist observed the co-construction (Beebe, 2000) between parent and infant of disassociation as defense in the course of the session. For example, Tommy continued playing without reference to his parents while they were discussing very painful events that were related to him—namely, mother's absence. Hints that Baby George also was adopting this defense precociously lie in his blank expression when handed over from father to mother: He showed neither dismay at leaving father's arms nor pleasure at the embrace by mother.

Reviewing the focus of the intervention following the AAI, the therapist concluded that her clinical task would be to represent the parents' and children's emotional experiences and give them meaning. The aim in so doing would be to enhance the parents' capacity to integrate mental representations of attachment figures and recognize the significance of attachment experiences. All of these were seen to be important in helping the children make sense of *their* attachment worlds.

SUMMARY

In this article, we have illustrated some of the applications the AAI may have in psychoanalytic parent–infant psychotherapy. We have suggested that the AAI informs the therapist's thinking both in the process of its administration and with the analysis provided by the trained rater who later reads the transcript. We see these as overlapping and discrete sources of information concerning the possible influences from significant childhood experiences of the parent, how

they have come to be represented, and the extent to which they are integrated in the mind of the parent. By addressing these questions early in the therapeutic contact, the therapist is opening up the question of intergenerational transmission. Often, in the course of parent–infant psychotherapy, a parent will make links themselves either in terms of repetitions they observe or in terms of patterns they wish to avoid. But, it is our view that inclusion of the AAI as part of the initial clinical intake catalyzes critical issues and opens the way for addressing them.

Finally, we offer some thoughts regarding the coding of the AAI in the clinical setting. Formal rating and classification of an AAI permits comparison across diverse cultural and clinical groups, thereby locating the specific features of an individual AAI that fit with globally recognized patterns likely to be transmitted across generations; however, it is apparent that the categorical nature of the taxonomy relied on in the research literature does not easily accommodate the multidimensional mode of thinking the clinician uses.[5] The move in research to address the complexity of the defensive structures within each category is informed in part by clinical experience. There is recognition (Main, 1991; Slade, 1999) that every speaker who is dismissing in the context of the AAI is unconsciously preoccupied while the preoccupied speaker is unconsciously dismissing or restricted in feeling.

This certainly characterized the mental functioning of the father described in this article, and this duality was played out in the interactions with his sons. Conducting the AAIs early in the therapeutic work clarified the therapist's thinking about attachment experiences in this family and informed her interventions. The coding of the AAI added an understanding of the limits to father's reflective function posed by the unresolved trauma around separation and loss, and his defensive use of idealization and disassociation in relation to this.

Future systematic research that includes the AAI in parent–infant work will expand our understanding of the contribution of the AAI to the therapeutic process, both for the therapist, as we have suggested here, and the patients. We believe that, used sensitively and with appropriate clinical skill, the AAI can help parent patients understand the "ghosts" they have unwittingly brought into the nursery, promote integration and reflective capacities, and limit their reliance on primitive defenses that impede their emotional responsiveness to their babies.

APPENDIX A

The AAI is structured around the topic of attachment, principally the individual's relationship to mother and to father (and/or to alternative caregivers) during childhood. Interviewees are asked both to describe their relationship with their parents during childhood and to provide specific memories to support global evaluations. The interviewer asks directly about childhood experiences of rejection, being upset, ill, and hurt as well as loss, abuse, and separations. In addition, the interviewee is asked to offer explanations for the parents' behavior and to describe the current relationship with their parents as well as the influence they consider their childhood experiences to have had upon their adult personality.

Ultimate classification of the interview into the autonomous-secure or one of the insecure groups depends largely on the extent to which the narrative is judged to satisfy four criteria of coherence: (a) a good fit between memories and evaluations concerning attachment, (b) a succinct yet complete picture, (c) the provision of relevant details, and (d) clarity and orderliness (Main & Goldwyn, 1998). The basic classification system assigns interviews to one of three groups, two insecure and one secure: (a) insecure-dismissing, an interview which is brief

[5] The most common element to the AAI literature is the discussion of autonomous-secure versus insecure (dismissing or preoccupied) classifications on one hand and resolved versus unresolved classifications on the other.

but incomplete, marked by a lack of fit between memories and evaluations; (b) insecure-preoccupied, an interview which is neither succinct nor complete and contains many irrelevant details, together with much passive speech or high current anger; and (c) autonomous-secure, an interview which robustly fulfills all or most of the criteria of coherence. In addition, alongside the best-fitting classification, some interviews also are considered unresolved with respect to past trauma or loss. An interview is considered unresolved when the speaker refers to loss or trauma in a way that suggests an extreme bereavement reaction, and/or lapses in the monitoring of speech concerning the loss or trauma which, for example, suggest that the speaker harbors irrational feelings of guilt or an irrational belief that a dead relative is actually alive. Criteria for deciding whether an interview is unresolved and autonomous-secure versus insecure, together with a set of 30 interval-rating scales (including one for lack of resolution of mourning) comprise the Manual for Rating and Classifying AAIs (Main & Goldwyn, 1998). Training in the use of this 200-page document involves attendance at a 2-week training session (taught by Mary Main or other designated trainers) followed by extensive tests of interrater agreement.

As a diagnostic aid in the therapeutic intervention, the AAI provides insight into the mental processes of the parent in the organization and elaboration of primary attachment experiences. These include defensive maneuvers such as dismissal of attachment experiences, disassociation between traumatic events and the associated emotion, inhibition of mental processes such as integration of feelings, thoughts, and actions, reality testing (the ability to distinguish between and adapt internal perceptions and external reality), linking cause and effect, and perseveration of thinking patterns as in obsessional rumination. As has been demonstrated, the mental functioning of the parent in relation to attachment can be observed in the spontaneous (procedural, enactive) interactions with the infant (Baradon, 2002). Moreover, the infant joins the parent in co-constructing defensive organizations that are developmentally maladaptive (Beebe, 2000).

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