Attachment Theory as a Guide to Understanding and Working With Transference and the Real Relationship in Psychotherapy

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Recent decades have witnessed an extraordinary amount of conceptual and empirical work on attachment theory in psychology and psychotherapy. Attachment theory is discussed in the present article as a way of understanding and fostering therapeutic work with 2 other key relationship constructs that have been theorized to be elements of all psychotherapies: client transference and the real relationship existing between the therapist and patient. Fundamental features of attachment, transference, and the real relationship are summarized. Particular emphasis is given to the role of the therapist as a secure base and a safe haven within the real relationship, and to the patient’s internal working model as it relates to transference. A case of long-term psychodynamic psychotherapy conducted by the first author is presented to illuminate the 3 main constructs. The case demonstrates both the usefulness of attachment theory and the fact that any single theory cannot explain all of the complex features of a given treatment. © 2013 Wiley Periodicals, Inc. J. Clin. Psychol. 69:1160–1171, 2013.

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The relationship that exists between patients and their therapists is generally considered to be a vital part of successful psychotherapy of all theoretical orientations. Many psychotherapists view the patient’s transference to the therapist and what may be termed the real or personal relationship that exists between therapist and patient to be two key elements of the therapeutic relationship. Both of these relational constructs (transference and the real relationship) originated within psychoanalytic theory. For example, transference has been seen as perhaps Freud’s greatest discovery pertaining to psychoanalysis as a treatment. Freud also mentioned the real relationship as important, as did a number of other psychoanalysts (see Gelso, 2011 for a review), although this concept has been theoretically and empirically neglected until recently. Despite the fact that transference and the real relationship originated within psychoanalysis, the first author and his collaborators have theorized that both of these concepts are an important part of all therapeutic relationships, regardless of the therapist’s theoretical orientation (see summary by Gelso, 2014).

Attachment theory, too, has originated within psychoanalysis, having been developed by the psychoanalyst, John Bowlby. However, despite the obvious connection, there has always been an uneasiness between attachment theory and psychoanalysis, an uneasiness that could be quite contentious in earlier years (Eagle, 2013). This troubled relationship has occurred for a variety of reasons (Eagle, 2013), including attachment theory’s focus on interpersonal (vs. intrapsychic) relations; its emphasis on what parents actually did with their children that would produce psychological health, and psychopathology; and its de-emphasis on the role of sexual and aggressive drives in development. In recent years, though, there has been a growing acceptance of attachment theory in psychoanalysis in general, and what is more broadly seen as the relational tilt that is now very prominent in psychoanalysis. In fact, many, including Bowlby himself (1988), view attachment theory as a branch of object relations theory, which itself is often seen as one of the four psychologies of psychoanalysis (the others being drive theory, ego psychology, and psychoanalytic self psychology; Pine, 1990). Within psychology and psychotherapy more broadly, attachment theory has had a major impact. It has been vigorously studied for a number of years.
now in both developmental and social psychology (Cassidy & Shaver, 2008) and psychotherapy (Levy & Kelly, 2009).

In the present article, we examine how attachment theory may serve to illuminate the aforementioned key aspects of the therapeutic relationship: transference and the real relationship. We begin by discussing these two relational components of psychotherapy, and then we briefly summarize key features of attachment theory and how it bears upon transference and the real relationship. We present a case of long-term psychodynamic psychotherapy conducted by the first author as a way of exemplifying our conceptions and anchoring them in clinical practice.

Transference and the Real Relationship: Two Sides of the Therapeutic Coin

Transference Past and Present

Although transference was one of Freud's greatest discoveries, it has also been the source of great controversy, both within and outside of psychoanalysis. Within psychoanalysis, controversies have focused on just what transference is and what definition may best capture it. All conceptions address the patient's feelings and attitudes toward the therapist, that in some sense the past is carried into the present, and that aspects of the process are unconscious. At odds, however, is whether these feelings and attitudes represent a distortion of the therapist based on the patient's past; whether the patient's experience of the therapist is a carryover from particular conflicts in specific stages (e.g., Oedipal conflicts); whether transference represents simple stimulus generalization rather than processes that are more complex; and whether and the extent to which the therapist or analyst contributes to the transferences.

Although Freud offered many observations about transference, perhaps his most fundamental view was that the Oedipus complex formed the nucleus out of which transference emerges. Thus, what is transferred onto the therapist pertains to the unresolved issues with mother and father, beginning in the stage during which the Oedipus complex develops. From the early days of psychoanalysis, a range of differing views about transference emerged. For example, interpersonal and neo-analytic theoreticians (e.g., Sullivan, 1954) developed a broader view of transference as a repetition and displacement of early conflicts with significant others into the therapy relationship and onto the therapist. Both the early Freudian and the interpersonal conceptions viewed transference as a distortion of the therapist in one way or another. However, postmodernists such as intersubjective and relational psychoanalytic theoreticians are more inclined to view transference as a co-construction of therapist and patient and to disfavor the view that transference involves distortion. Some go so far as to view transference from a totalistic perspective, i.e., as any of the patient's perceptions of and reactions to the therapist/analyst. They do not differentiate transference from other elements of the therapeutic relationship, such as the real relationship. In fact, because reality is constructed rather than existing, the idea of a real relationship is not meaningful to this postmodern tilt.

In keeping with Gill (1982), our view is that transference must involve some degree of distortion, although the distortion may be highly complex and subtle. A viewpoint that seeks to integrate intersubjective/relational and more classical thought, and one that serves as our working definition for the present article, is that transference reflects the patient's perceptions and experiences of the therapist that are shaped by the patient's own psychological structures and past. These perceptions and experiences involve a carryover from the past, and a displacement onto the therapist of attitudes, feelings, and behaviors belonging rightfully in earlier significant relationships (Gelso & Bhatia, 2012; Gelso & Hayes, 1998). The therapist, regardless of how neutral he or she seeks to be, does contribute to the transference, and it is important for patient and therapist to grasp the therapist's contribution. However, the heart of transference, the element that distinguishes it from other relational ingredients, is the carryover from the past and its displacement onto the therapist. The carryover may reflect the patient's fears and aggressive feelings (as in negative transference) or wishes (as in positive or idealizing transferences). This view is consistent with Bowlby’s (1973) use of Piagetian concepts of assimilation and accommodation to explain transference. In assimilation, the patient wraps new
information into an existing mental scheme, whereas in accommodation, the pre-existing scheme is modified to take into account the new information. Transference represents a predominance of assimilation.

As Gelso and Bhatia (2012) have suggested, transference is more than simple stimulus generalization. If it were only stimulus generalization, transference could be readily extinguished. However, any therapist who has worked with the transferences knows that these reactions are tenacious and not easily modified. This bespeaks a process that is conflict based and motivated. Transference is conflict-based in the sense that it originates in unresolved conflicts with significant figures in childhood, conflicts that get activated in the therapeutic relationship. Transference is also motivated in that the patient hangs on to the transference despite contrary evidence. Recently Levy and Scala (2012) have made a similar point about transference being dynamically rooted, rather than being an exclusively cognitive process.

Why the patient hangs on to transference perceptions and experiences is part of a broader question of why transference happens in the first place. Over the years, several reasons have been offered for why transference happens, i.e., why the patient maintains his or her perceptions of the therapist in the face of contrary evidence. For example, Freud suggested that transference occurs so that the patient (a) can obtain satisfaction in the present of which she or he had been earlier deprived; (b) can satisfy human beings’ basic tendency to repeat (repetition compulsion); and (c) as a way of avoiding painful or frightening memories, i.e., as a way of not remembering (Freud, 1958). Regarding this last reason, if the patient hangs on to a perception of the therapist as rejecting and punitive, she or he does not have to remember or re-experience painful, repressed experiences with his or her parents. Another reason for the occurrence and maintenance of transference is that it is a familiar way of dealing with stress, a way that provided protection and a sense of safety during highly vulnerable periods of childhood, even though in the present the transference perceptions are maintained at a great cost.

As we have indicated, transferences tend to be maintained or hung on to despite evidence to the contrary. This tenaciousness has traditionally been viewed as one of the markers that help the therapist detect transference (Greenson, 1967). Other markers are (a) inappropriateness of affects toward and perceptions of the therapist (that just do not fit); (b) great intensity of reactions (assuming the intensity is not warranted) or the opposite, the absence of emotional reactions to the therapist; (c) highly erratic or changeable feelings toward the therapist or what at times has been called “floating transferences”; and (d) repressed ambivalence in which one part is conscious and the other repressed, e.g., loving feelings at the conscious level and hateful feelings unconsciously. Although these may be useful markers, we would offer that perhaps the most reliable way to detect and understand transference reactions is to explore the patient’s past to get a sense of the relationship themes and patterns that consistently reappear in his or her life. It should also be noted that although it is helpful and important to detect transference reactions, just how to deal with them is another matter and depends a great deal on the therapist’s theoretical orientation. Some therapists prefer well-timed interpretation, others provide a safe relationship, and still others ignore transference unless it poses a problem, preferring instead to focus on modifying problematic cognitions and behaviors.

The connection of transference to another complex term, resistance, deserves some note because it is relevant to the case we shall be describing. One may view transference itself as a resistance because, as we have noted, part of the theorized reasons for its existence is allowing the patient to not remember or emotionally re-experience painful feelings and experiences from childhood. Gill (1982) delineates two types of transference resistance. The first type is resistance to the involvement in or awareness of transference. Here, the patient avoids talking about the therapeutic relationship. She or he keeps feelings toward and perceptions of the therapist out of the room and literally out of his or her mind. The second type of transference resistance is resistance to the resolution of transference. Here, the patient does talk about the relationship, but avoids awareness that his or her feelings and perceptions are assimilative or rooted in unresolved childhood conflict rather than the here-and-now therapeutic relationship.
The Real Relationship

The first author has written extensively about the real relationship (e.g., Gelso, 2011) and has viewed it as the foundation of the therapeutic relationship. This ingredient has been defined as “the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other” (Gelso, 2011, pp. 12–13). As can be seen from this definition, the real or personal relationship has two key ingredients, genuineness and realism or realist perceptions. These ingredients vary in terms of how much of them are present and the extent to which they are positive or negative. Real relations in which there is a good bit of genuineness and realism between the participants, and in which the feelings are largely positive, would be considered a strong real relationship.

The real relationship exists from the first moment of contact between therapists and patients, and it is part of all therapeutic relationships. Indeed, it may be viewed as part of virtually all relational communications between therapists and patients. Recent evidence strongly points to the conclusion that the strength of the real relationship is an important part of the success of psychotherapy across diverse orientations (see summaries by Gelso, 2011, 2014). Despite its universal nature, the real relationship is often a silent part of the relationship, residing in the background and coming into the foreground at certain times, e.g., the beginning and termination phase of treatment, when it is needed as a buffer against negative transferences.

It is useful to distinguish between the salience and the strength of the real relationship. A salient real relationship is one in which the personal relationship is upfront and the therapist shares a great deal of what he feels and thinks. We would not contend that salience is an important factor in therapeutic success. Strength of the real relationship is such a factor, as noted above. Gelso (2011) has discussed ways in which one can develop a strong real relationship without a high degree of self-disclosure and other behaviors that create salience.

What is the correlation of the real relationship to transference? It may be tempting to conclude that these two constructs are on the opposite sides of a dimension. However, we would argue that both might exist to high or low degrees in any given treatment, segment of treatment, or even in any relational communication. That is, a given statement by a patient may partly reflect transference and partly reflect the real relationship. Thus, there are real relationship elements in all transferences, and transference elements in all real relationships. Still, one would expect that there would be a modest to moderate negative relation between the two, especially between the strength of the real relationship and negative transference, and that is precisely what has been found in several studies (see review by Gelso, 2014).

A particularly important way in which the real relationship relates to transference is through being a buffer against negative transference reactions. Thus, when the patient and therapist have a strong personal or real relationship, negative reactions that emerge within the patient toward the therapist and negative projections unto the therapist are less likely to seriously damage the overall therapy relationship. Instead, the real relationship and its therapeutic cousin, the working alliance, operate in tandem to facilitate the patient’s efforts to understand these negative reactions rather than act them out in a way that could poison the relationship. This buffer function was most evident on a qualitative study of 11 cases of successful, long-term psychodynamic psychotherapy conducted by Gelso, Hill, Mohr, Rochlen, and Zack (1999). These researchers found that virtually everything the therapists said implied that the real relationship and the working alliance worked together as key buffers, allowing often very difficult transference reactions to come into the open and get resolved. The researchers used attachment theory terms when stating that “solid working alliances and real relationships seemed to provide the client with a safe haven and a secure base – a place from which they could venture out (or perhaps, more aptly, venture in) to explore otherwise too threatening feelings” (p. 265).

Attachment Theory

Attachment theory was originated by the psychoanalyst, John Bowlby, to explain certain patterns of behavior exhibited by people of all ages that were “formerly conceptualized in terms of dependency and over-dependency” (1988, p. 119). Rather than reflecting issues around
dependency, attachment behavior pertained to the basic, biologically rooted human tendency to form intimate emotional bonds with particular individuals. Bowlby also considered attachment behavior as applied to the patient–therapist relationship in psychotherapy. Over the past several decades, empirical evidence has fortified the utility of attachment theory as it pertained to both human development and psychotherapy.

**Some Basic Elements of Attachment Theory**

Human beings are equipped with an inbuilt system, the attachment system, aimed at generating attachment bonds to others (Bowlby, 1973). In the face of threat to the infant and young child, the attachment system becomes activated, and the infant/child seeks proximity to someone who is stronger and wiser in order to gain protection. Once sufficient proximity has been achieved, the attachment system is deactivated, or at least diminished (Cassidy, 2008). Throughout his work, Bowlby made clear that various attachment patterns develop during childhood, and these patterns are deeply influenced by how parents, and the primary caretaker in particular, treat the child in response to the child’s attachment behavior. In short, the infant’s experience with parents when the attachment system becomes activated can result in secure or insecure attachment patterns (Main, Kaplan, & Cassidy, 1985).

Based on infant research by Ainsworth and her colleagues (Ainsworth, Blehar, Waters, & Wall, 1978), three attachment patterns were most prominent. If attachment figures (i.e., primary caregivers) are sensitive, available, and responsive to the child when she or he seeks proximity, then the child will likely develop a secure attachment pattern. That is, she or he develops a sense of security that will allow him or her to explore the environment with comfort and confidence, and engage rewardingly with others. The child will also develop mental representations of attachment figures as available and responsive. However, if primary caregivers do not provide a secure base for the child, and are not experienced as a safe haven in times of stress, one of two insecure patterns is likely to develop, depending on the specifics of how the parents treat the child around matters of attachment: an anxious resistant pattern or an anxious avoidant pattern. A fourth pattern, labeled disorganized/disoriented by Main and Soloman (1990), was later identified. Evidence gathered over the years has suggested that these patterns tend to persist into adulthood, although they can be somewhat modified by experience.

Repeated experiences and interactions with attachment figures lead to not only secure or insecure attachment patterns but also, perhaps more fundamentally, expectations that get organized around mental representations of self and others. These representations are called internal working models (IWMs), and they are of great significance for development in general and the psychotherapy relationship in particular. The significance of IWMs is tied to the fact that these models guide behavior, cognitions, and emotions related to both self and others. In addition, they function as rules that determine our access to information related to attachment. They determine what we see in others, what we see in ourselves, and how we behave toward others. We tend to develop representations of ourselves, and we treat ourselves, in a way that reflects how we were actually treated by our caregivers from infancy onward. Sensitive, reliable responsiveness to attachment behaviors begets a sense of self as lovable and worthy. Similarly, our representation of others develops out of how we were actually responded to by primary caregivers around attachment needs. Others in our IWM may be represented on a continuum from high to low on dependability, caring, and responsiveness.

Bowlby (1973) postulated that attachment experiences during infancy continue during childhood and are carried into adult relationships through IWMs. This postulate of attachment theory is supported by research in the areas of adult romantic attachment and the psychotherapy relationship. Regarding romantic attachment, Weiss (1991), for example, has described how aspects of the infant-caregiver bond such as maintaining proximity, protesting separation, and establishing a secure base are also characteristic of most romantic relationships. Attachment in adult romantic relationships has been studied extensively, and the most prominent method of conceptualizing it currently is as existing on two dimensions, attachment anxiety and attachment avoidance (Feeney, 2008). High attachment anxiety signifies a hypervigilant attention to attachment-related concerns, and worries around how responsive attachment figures are or will
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be. Attachment avoidance, on the other hand, reflects the tendency to avoid or withdraw from close relationships and minimizes their importance. Attachment security is represented by low levels of avoidance and anxiety, such that persons feel relatively secure about attachment-related matters and relatively comfortable opening up to others and relying on them as a secure base.

Attachment Theory and Psychotherapy

Bowlby (1988) suggests that attachment theory can be used to guide psychotherapy in five ways. First, the therapist provides a secure base from which the patient can explore difficult and painful material that might be impossible to consider without “a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance” (p. 138). The remaining four ways involve the therapist helping the patient explore the patient’s IWMs. Thus, second, the therapist encourages the patient to examine the ways in which she or he engages in current significant relationships and the unconscious biases that push him to select inappropriate persons for significant relationships. Third, the therapist encourages the patient to examine their own therapy relationship and how the patient carries over into their relationship those perceptions and expectations of how an attachment figure (the therapist) will behave toward him or her.

A fourth way in which the therapist uses attachment theory to guide therapy is to encourage patients to examine the ways in which current perceptions, feelings, and expectations are a product of childhood events with his or her parents. Fifth, attachment-oriented therapists, according to Bowlby (1988), will help patients examine how their internal concepts of self and others may or may not be appropriate to the present and future.

These five ways in which Bowlby claimed that attachment theory can guide the psychotherapist are highly pertinent to transference and the real relationship, as we have described them in the first part of the article. Other attachment theorists have proposed the therapeutic relationship itself as an actual attachment bond and have examined how the therapist serves as an attachment figure for the patient. For example, Mallinckrodt (2010) suggests that some clients (a) regard their therapists as stronger and wiser; (b) seek proximity through emotional connection and ongoing sessions; (c) experience their therapist as a safe haven in times of stress and threat; (d) experience their therapist as a secure base; and (e) experience separation anxiety when anticipating loss of their therapist.

An Attachment Perspective on Transference and the Real Relationship

Perhaps the major way in which an attachment perspective can shed light on transference is through the concept of internal working models (IWMs). Through IWMs, the patient makes “forecasts” (Bowlby, 1973, p. 206) about the therapist, who is in the role of an attachment figure. In other words, the patient has a working model or an internal representation of how people in a caretaker role will respond to him or her. This model gets transported into the therapeutic relationship as the transference. To the extent that the patient suffers from an insecure attachment pattern, the IWM is likely to be negative. The patient will be distrustful of the therapist and experience him or her in a hostile and critical light, and respond in ways that reflect such perceptions. However, Bowlby also states that the patient may look to the therapist to provide all that she or he has yearned for but not received in the past, or the present for that matter. In the former case, a negative transference will ensue, but in the latter, a positive, eroticized, or idealizing transference may develop. The IWM itself, and thus the specific quality of the transference, will partly depend on the patient’s present general attachment pattern, which, to refer back to the dimensions of attachment anxiety and attachment avoidance, may be any combination of these two dimensions, including a secure attachment pattern (low anxiety and low avoidance).

The patient’s past and present attachment patterns, as evidenced in their IWM’s, have a significant effect on their particular pattern of attachment to their therapist. As discovered by Mallinckrodt and his collaborators (Mallinckrodt, Gantt, & Coble, 1995), three general attachment-to-therapist patterns appear to exist: secure, avoidant-fearful, and preoccupied-merger. Each of these patterns reflects a certain IWM, which in turn is indicative of the
transferences that will form for different patients. The attachment-oriented therapist works to help the patient understand his or her internal working model, how it relates to the patient's early experiences, the therapist (as transference), the actual person of the therapist, and relationships with significant others in the patient's life. The aim, particularly in longer term, dynamically based treatment, is to modify working models to accommodate the realities of new experiences and new relationships, including the realities of the therapist. This can be done through exploring and working through the transferences and/or the creation of a secure base and safe haven in which the therapist, in essence, behaves contrary to the patient's problematic IWM.

Regarding the real relationship, attachment theory relates to it most basically in terms of the therapist's stance toward the patient. First, the therapist is a real person who, as indicated, seeks to provide a safe haven and a secure base. The therapist does this by behaving, in Bowlby's (1988) terms, as a trusted companion who offers a supportive, encouraging, and caring therapeutic ambience, as well as occasional, carefully timed guidance. Although the therapist may seek to maintain a healthy neutrality in the sense of not taking sides in the patient's inner struggles, the therapist clearly and fundamentally aligns with the patient's inner being or self. And the therapist shows this, through his or her genuineness and the attempt to create an accepting, caring, empathic relationship. Because the therapist works to provide a secure base, otherwise too dangerous transference feelings are more likely to emerge, including negative transferences as discovered in a quantitative study by Woodhouse, Schlosser, Crook, Ligiero, and Gelso (2003) and the aforementioned qualitative study by Gelso et al. (1999). This strong, attachment-informed real relationship is likely curative in itself and of itself, as a number of studies now suggest (Gelso, 2011, 2014), and it benefits the patient by the provision of an image of an attachment figure who is different from the transference-based IWM.

The Case of Thomas

Thomas is a 62-year-old White man with whom the first author (henceforth referred to in the first person) has worked in two stints of long-term psychodynamic psychotherapy on a once-a-week basis. The first occasion was for 4 years, beginning when he was in his late 20s, and the work revolved around his at times paralyzing anxiety, work inhibitions, depression, and emotional pain related to a childhood marked by trauma and deprivation. That therapy was successfully terminated, although a referral was made to a behavior therapist to help Thomas with panic attacks when traveling, a serious life problem given that Thomas' profession required frequent travel.

Thomas contacted me again 5 years ago, some 25 years after our termination. He was experiencing re-emergence of some old symptoms, as well as some new ones. The precipitant for these symptoms was the death of his elderly father. He had other losses at the same time, e.g., a friend's death in an accident, his only daughter's emergence into adulthood, and his own sense of growing old. Thomas is the youngest of seven children (four boys and three girls), and he had always felt young. But the father's death seemed to symbolize his own aging, as well as the fact that there would never be the loving family he had always yearned for but never had.

Thomas is a political consultant who is highly successful by any yardstick but his own. He is energetic, charming, bright, and funny. He works hard at being liked and is, in fact, impossible not to like. As a patient, he also works hard and effectively at the tasks of seeking understanding and making changes. He has been happily married for many years, and there seems to be much mutual caring in his marriage. Still, he often does not feel connected to his wife in that he does not let her get too close. He has one daughter who sounds quite successful and very likeable. Thomas worries that she is not married, and would like a handful of grandchildren with whom to surround himself, just as he often wishes he had more kids.

Background

Thomas grew up in a family situation that seemed almost devoid of healthy, caring attachments. He has had a telling repetitive dream of standing outside a big house as a child, looking in,
and seeing only emptiness. His mother, who from his description suffered from a borderline personality disorder, was highly volatile and self-centered. Having so many children was probably the last thing that she needed, and the demands of mothering were more than she could manage. Thomas vividly recalls her explosiveness and frequent episodes of rage, during which on several occasions she threw dangerous objects (e.g., knives) at the children. Thomas’ father was profoundly noncommunicative, having a schizoid quality to him, including hidden rage. A successful accountant, he would come home from work, sit in his chair and read, have dinner, and simply not speak. Although an athlete and musician in his younger years, and a sound provider for the family, it was as if the demands of fathering and being a husband were much more than he could handle. Although the mother had always been the bad object in Thomas’ mind, in recent years he has come to understand that his father’s profound withdrawal and refusal to protect the kids from their volatile mother was just as damaging.

Although Thomas and his brothers and sisters had plenty of material things, they lived in a deeply depriving home environment. No one seemed to get emotional nourishment, and the level of aggression among the children was intense. It was as if all the children were angry about what they were not getting. Thomas was often physically assaulted by two of his older brothers, who no doubt resented him for what he got from the mother. As the youngest, she often took him on excursions with her, and when he returned from these excursions, Thomas had hell to pay with two of his brothers. He recalls virtually no experiences in which anyone in the family took an interest in him, responded to him with affection, or taught him anything about the world or psychological life. He recalls truly outstanding athletic performances as a child, after which he walked home alone with a deep sense of emptiness. No one in the house ever asked him about what he had done, and he could not initiate discussion of his accomplishments for fear that it would arouse his brothers’ envy and aggression.

Interestingly, Thomas never felt much about his accomplishments. There seemed to be an absence of healthy mirroring, but an abundance of dangerous anger bordering on rage that ran through the family, overtly in the mother and brothers, and covertly in the father. In attachment terms, Thomas’ childhood represented the antithesis of a secure base and a safe haven during times of stress, although there is some evidence that in his earliest years, both of Thomas’ parents were more responsive to their children’s needs. All things considered, the early (around 6 years of age) attachment pattern that would seem to fit Thomas best is what Bowlby (1988) described as the anxious resistant pattern. Children with this pattern show a mixture of insecurity, including sadness and fear, and of intimacy alternating with hostility, which is sometimes subtle. In certain cases, the anxious resistant child may seem self-conscious and even artificial, “as though they were anticipating a negative response from the parent, they try to ingratiate themselves by showing off, perhaps being cute or especially charming” (p. 128).

Thomas was highly successful on the outside, as a student and athlete. He was so charming and likeable that he was popular with teachers and fellow students. Yet he never felt close to anyone, as there was a central part of him that was held back from everyone. He carried an ongoing feeling that he had to charm people to win them over, that he needed to win them over, and that if he let inner parts of himself be known, he would be uncared for and damaged.

**Personality Dynamics**

Thomas has suffered from the classic indicators of profound narcissistic injury, e.g., deeply damaged self-esteem and its flip side, grandiosity, as well as a chronic sense of emptiness. In this respect, he has said tellingly that his goal was to feel like he was with someone when he was alone. Although he has and has always had what look like successful relationships from the outside, he has chronically experienced an ongoing sense of not being connected to anyone. As noted above, this was part and parcel of Thomas’ withholding deeper and personal parts of himself. For instance, no one other than his wife has ever known he was in therapy, and only in the last couple of years has Thomas been able to share vulnerable parts of himself with people he considers close friends. Others feel more connected to Thomas than he does to them. He yearns for contact and connection, and loves to be with others; as soon as they leave, however, his loneliness and emptiness set back in, as if the others had never been there. In this sense,
Thomas’ adult attachment pattern is a mixture of anxious attachment and avoidant attachment. The IWM he carries within is that others are dangerous and would despise him if they knew him deeply, while at the same time he yearns for connection and caring.

Symptomatically, Thomas experiences at times severe anxiety and unhappiness that seems like depression, but is not quite that. He used to wake up often with what he calls night terrors, intensely feared being alone on long trips, and feels a sense of pain and desperation around abandonment. For many years, his work performance has been excellent, as he makes great use of his charm, energy, curiosity, and intelligence. Often when he is doing his best work or succeeding at his highest levels, he experiences the greatest anxiety, as if he will be damaged and will fail. He has great trouble with the alone part of work, e.g., writing, because when he is alone, the emptiness and feelings of abandonment set in. Also, his anxieties have interfered with his devoting as much time to his work and family as he would have liked.

A key part of Thomas’ internal struggles revolves around his mixture of grandiosity and insufficiency. He is never satisfied with what he is and has accomplished, and always feels he deserves to be more, and that the greatness that is due to him is nearby. His preoccupation with his own suffering, as well as repression and denial, has interfered with his appreciation of how others suffer. In recent months, he has become increasingly aware of others’ pain and failures. He has repeated what he calls “awakening moments,” sudden realizations of how given persons in his life have failures and pain. These empathic insights are part of his healing, as they have occurred along with his growing sense of having a self or, in his words, “being with someone when I am alone.” His grandiosity has diminished markedly, he is moving forward in his willingness to let others in, and he is experiencing more self-empathy.

Psychotherapy and the Therapeutic Relationship

Thomas and I have worked together for a long time. Psychotherapy has been a deep healing experience for him, and he has worked hard in his patient role. The insights and changes he has made have been hard earned, including working through the inevitable depression around his increasing emotional awareness, re-experiencing the profound deprivations of childhood, and the decisive realization that what was missed cannot be recaptured.

We have always had a sound working alliance. Despite the defensive charm he exhibited, and the transference implications of that, I believe we have had a strong real relationship, too, one that has strengthened throughout the work. The real relationship has served as a secure base for exploration and a safe haven when anxiety and stress were greatest.

At the same time, what Thomas has experienced inwardly as his IWM has shown up thematically in the transference. He has been charming with me and has only in recent years allowed hidden transference feelings to enter the work. I suspect that I have always felt more connected to him than he to me. As for my reactions to him, I have mostly felt in tune with him, liking and caring of him, pained by the enormity of the pain and deprivation residing within him with roots in childhood, and deeply interested in his inner world and his story. At times, though, I have felt that the transference was too hidden, as if there was a chronic transference resistance (see the “Transference Past and Present” section). This resistance is what Gill (1982) aptly termed resistance to the awareness of transference, which is to be differentiated from resistance to the resolution of transference.

As part of this transference resistance, until recently he kept negative feelings toward me out of the work, and for several years resisted seeing me as other than an equal, a kind of wise and safe brother (the positive transference). This, along with the real relationship and working alliance, helped him experience our relationship as a secure base and a safe haven. Still, this security was attained at a cost in the sense that his IWM, including deeper fears of and anger toward me in the transference, were kept out of the room and out of consciousness. Some of the deeper fears and anger, I think, have been diminished and silently worked through as he has gained insight into his projections onto others and, in effect, his working models of self and others outside of the psychotherapy office.

As often occurs in psychotherapy with patients suffering from major narcissistic injury, there have been elements of my being both the idealized object and the empathic mirror in
the transference. As should be clear, Thomas did not have good empathic mirroring, and I have served some of that function, genuinely admiring his accomplishments. I have seen and experienced very little in the transference of me as the dangerous, emotionally volatile mother or the dangerous, emotionally silent father. Still, it has seemed to me that these projections were sitting in the background. It has taken a very long time for Thomas to trust that he does not have to charm me into liking him and some of this still continues. So there has been a negative undertone in the transference that has emerged more in the last few years, as he has developed a more genuinely secure attachment to me (Woodhouse et al., 2003). Key parts of Thomas' dynamics and the transference are evidenced in a dream he reported 2 years ago:

Thomas is in the woods, populated with damp sycamore trees. Three menacing lions are roaming around. Thomas is one-half way up a tree and is scared that these lions will get him. He is completely alone and isolated (like being in hell). The lions are prowling around, looking. A HUGE prehistoric black panther appears. He is ferocious. He jumps down and prepares to fight the lions. The three lions are lined up to fight the panther (who roars). Thomas watches from the tree. A fourth lion spots Thomas and approaches him ominously. There is a cabin in the background and Thomas cannot get to it. It is far off and ill defined.

Thomas’ associations were that he was powerless, that he had no weapons with which to fight, and that he was all alone. The lions were vicious and merciless. His associations to the three lions were two of his brothers and his father. The panther was me, and I represented the truth. The three lions do not care about truth. The fourth lion was Thomas’ grandiosity, which is what prevents him from getting to safety. The cabin in his associations represented the safe home that he yearned for but could not experience.

My being, symbolized as the huge, prehistoric black panther who defends him and represents truth, to my mind, represents both idealization in the transference and unconscious fear that I can be damaging and can turn on him. This part never came to the surface, but was inferred by his great discomfort about emotionally letting go and being vulnerable in the moment in our sessions. As implied, however, transference feelings that are part of his IWM fears have quietly and slowly emerged in recent years. This emergence and the exploration of these fears have strengthened the security of Thomas’ attachment to me within the real relationship, as well as a modification of his IWM.

Thomas has progressed slowly but surely. During the past 2 years, his insights and ability to integrate them have increased sharply, as he has become more able to feel whole, less anxious, less alone, and more empathic of others’ pain. His grandiosity and sense of insufficiency have changed accordingly. He has developed more secure attachments to others, and a deeper empathy for others’ pain. He rarely has panic attacks or feelings, and when he does, he is usually able to understand their triggers quickly so that the panic subsides. The shift in his attachments represents movement in the direction of what is often referred to in the attachment literature as “earned security” (Main et al., 1986). A more recent dream reveals the changes Thomas has made and his continuing struggles:

Thomas is with a group of people at the racetrack, and he notices horrible-looking, jagged, terrible, frightening cluster of holes in the track. He says anxiously that the horses are going to get badly hurt, but others say not to worry; they were unconcerned. The horses did okay for a while, but were sure to get hurt.

Thomas’ associations were to three brothers and another family relative, and to a fear that they would turn on him, as well as to his parents who didn’t care or protect him from danger. He then associated this to others in his life, but realized that he often fears that they are mad at him and feeling rejecting toward him when they are not. He sees how he carries the past into the present, how his IWMs are distorted. He talked about how he felt lonely since the last session, even though his business is booming and things are going so well. To succeed meant to
be endangered and abandoned, again carrying the past into the present. He felt I was rejecting
him, but again saw how, in effect, his working model is no longer valid. In addition, for one of
the first times, he began to see how actually he turns others away, and how he must come to
accept what he didn’t have as a child, and emotionally realize that he can never get that. Sessions
that followed contained the theme of the outside world and other people, outside being generally
caring and kind toward him, but that he maintained his loneliness by shutting others out.

Clinical Practices and Summary

In this article, we have presented some basic elements of transference, the real relationship, and
attachment theory, with a particular focus on how attachment theory can be used to understand
and describe transference and the real relationship. We have presented the case of Thomas
as a way of exemplifying an attachment perspective on transference and the real relationship.
The reader will have noticed that other perspectives are woven into the case, as we do not
believe a single perspective is able to capture the enormous complexity of the human psyche and

Similarly, the case of Thomas does not represent a clean fit with attachment theory. For
example, Thomas’ adult attachment pattern did not cleanly fit an attachment type, but instead
seems like a mixture of attachment anxiety and attachment avoidance. Thomas’ attachment to
the therapist was secure in that he allowed the therapist to serve as a secure base and a safe
haven within the context of a strong real relationship. However, what has been referred to as a
transference resistance bespoke an insecure attachment to the therapist at a less conscious level.
Thus, elements of both secure and insecure attachments were present. Still, the case of Thomas
also exemplifies how key concepts of attachment theory can illuminate and clarify the roles
of transference and the real relationship. In particular, in explicitly attempting to provide the
patient with a safe haven and a secure base within the real relationship, the therapist will foster
the sense of safety and security that is needed if the patient is to do the difficult work of looking
inward and facing painful affects and experiences. In addition, by exploring the patient’s internal
working model of self and others, the therapist aids the patient in seeing what relationships she
or he selects and why, what she or he carries into relationships, and what she or he creates in
relationships, including the relationship with the psychotherapist.

Selected References and Recommended Readings

Books.
Books.
Books.
integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), Attachment theory and close relationships
(pp. 46–76). New York, NY: Guilford Press.
doi:10.1177/0146167205282740
Cassidy, J. (2008). The nature of the child’s ties. In J. Cassidy & P. R. Shaver (Eds.), Handbook of attachment:
Theory, research and clinical applications (pp. 3–22). New York, NY: Guilford Press.
Cassidy, J., & Shaver, P. R. (Eds.) (2008). Handbook of attachment: Theory, research and clinical applica-
NY: Guilford Press.
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