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Before, Between, and Beyond Interpretation: Attachment Perspectives on Couple Psychoanalytic Psychotherapy

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ABSTRACT

This article considers the process of psychoanalytic couple therapy from an attachment perspective. A brief and selective history of the transference interpretation sets the scene for considering applications to couple psychoanalysis, where there are multiple transference sites, and some implications of attachment theory where the unconscious is viewed not only in dynamic terms, but also as nonconscious information processing systems. Attention is drawn to the potential for working with the nonverbal communication of affective states which, through affectively charged repetitive sequences over time, impacts on procedural knowledge. Implicit intersubjective interactions, often expressed through behavior, make up the temporal region described as being *before* interpretation, whose impact may well go *beyond* verbal interpretation in terms of its mutative effects. This distinction is also used to distinguish interpretations that understand present behavior as a repetition of the past (in this sense of *going before*) from those that focus on its function in trying to achieve an aspired to future (*going beyond*). In both cases, couple psychotherapists work in the space between intersubjectivities.

Introduction

Attachment theory derived from observing behavior. It highlights the significance of behavior for communicating about emotional experience. Its primary focus is on the role relationships play in neurological, affective and behavioural developments occurring in the first eighteen months or so of life, many of which are affected by parental behavior, by which time attachment patterns are usually firmly established and the foundations of an internal world of object relations—what the father of attachment theory, John Bowlby, described as internal working models (Bowlby, 1973)—are set in place. This implicit knowing about relationships is embedded in procedural memory, which, unlike many aspects of autobiographical memory, is not accessible to conscious awareness but stores important information about what to expect from and how to adapt to environmental circumstance. These early months are also a time that precedes language: that capacity to symbolize and communicate about experience through words. What implications might this theory of early development have for psychoanalysis, the *talking cure*?

The talking cure

The moniker of *talking cure* applied to psychoanalysis is very misleading in that it implies that the changes it seeks to effect are mediated solely through language—talking. It glosses over the function of listening and suggests a medicalized view of psychoanalysis in which illnesses are treated to produce a cure. These assumptions don't capture the processes and outcomes that lie at the heart of the psychoanalytic venture. However, talking does imply the existence of a relationship, which psychotherapists of all persuasions agree is central to the therapeutic process. It is the nature of

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that relationship—what happens within it—that provides a focus of debate when considering therapeutic outcomes.

Attachment theory falls within the canon of psychoanalysis in that it informs the understanding of unconscious processes within and between people. It falls most naturally within the conceptual schools of object relations and self psychology because it conceives of the internal world as a system of representations of self-other relationships bound together by affect. Where it differs from some psychoanalytic theories is its eschewal of the role of constitutionally generated unconscious fantasy in producing psychopathology. Instead, attachment theory emphasises the significance of the imprints left by real encounters with others. Unlike Freud, Bowlby was prepared to believe that his patients had experienced sexual abuse in childhood and were not describing fantasies that contained repressed wishes. Unlike Klein, he did not assume the preexisting role of unconscious fantasy in organizing states of mind. For him, environmental trauma was a real and present factor in the psychogenesis of mental ill health, even though his patients might be unaware of it. Yet Bowlby did buy into the notion of a dynamic unconscious and its implications for therapeutic practice, and into the potentially mutative effects of interpretation.

Historically, the mutative interpretation was thought to emerge from the painstaking analysis of a patient's transference to the therapist (Strachey, 1934). The fundamental assumption was that the therapeutic relationship is a fantasy relationship, an expression of the patient's internal world, and the job of the therapist was to interpret the fantasy. From this perspective, disclosure of the therapist's emotional responses to the patient was firmly discouraged because the fantasy relationship would then degenerate into a real relationship, thus robbing patient and therapist of the primary opportunity provided by therapy—to test internal realities.

Strachey was operating a Freudian model, where defences were understood to be bastions against instinctual impulses, especially sexual and aggressive impulses. The therapeutic process was tracked through becoming aware of tension within the ego, revealing the defences deployed to manage this tension and uncovering the unconscious impulse contributing to internal conflict—a slow, staged, incremental process. In all of this, the therapist served as a kind of auxiliary superego to the patient, acting to strengthen the ego by uncovering rather than repressing impulse.

Implicit in this early approach were assumptions about the therapist's objectivity and neutrality in working with a patient's transference. His or her own subjective responses, contained in the countertransference, were isolated from the experience of the patient and regarded as if they were generated within the therapist independently of the patient's effect on him or her. When operating outside consciousness, and in ways that were detrimental to the therapeutic process, they indicated a need for further analysis to free the therapist of emotional responses that were assumed to be unconnected with the patient's struggle. Although analyzing transference was central to the process, it was essentially a nonrelational approach to therapeutic practice—at least, in theory.

This view was to change with the contribution of post-Kleinian analysts, where projective identification described not only a process of evacuating toxic aspects of the self (Klein, 1946) but also a preverbal, unconscious form of communication (Bion, 1959). Where there were no words, there might still be vivid experiences for therapists that communicated what their patients were feeling. Therapists were likely to experience unconscious pressures to act in ways that accorded with the assumptions of their patients' internal worlds so that something vital to their predicament might be conveyed to them (Spillius, 1992). The shift that had occurred was an acknowledgement that without being open to experiencing what it was like to be in a patient's shoes there could be no psychoanalysis. Maybe this reality had always been recognized; Jung's comment that "In any effective psychological treatment the doctor is bound to influence the patient; but this influence can only take place if the patient has a reciprocal influence on the doctor. You can exert no influence if you are not susceptible to influence" (Jung, 1929: 71) suggests this might be the case.

Focusing on the countertransference as a sensor capable of picking up unconscious cues from the patient brought the therapist into the picture as an object of analysis, but not just in terms of screening out his or her own psychopathology. Considering the countertransference as a form of

unconscious communication required therapists to reflect on their own experience as containing projections from their patients in order that they might contain the anxiety that drove them. This involved taking up a *third position* (Britton, 1989), a metacognitive stance in which the patient-therapist relationship became the object of analysis, not just the patient.

Back in the 1950s, the classical Freudian model was represented in relational terms in a way that I found very helpful in working with couples. This depiction moved away from the *archaeological dig* image of the analytic process, where the site of the investigation was the analysand, toward a focus on relationships (Ezriel, 1956). Ezriel described the traditional tripartite model of defence against internal conflict associated with instinctual impulse in terms of there being a required relationship (the defence) that countered an avoided relationship (a way of being with others associated with anxiety), because the avoided relationship was unconsciously believed to be capable of triggering a relational catastrophe (the expression of unfettered impulse). Here the ground was prepared for thinking about shared trauma, mutual defensive systems, and shared unconscious fantasy, concepts that were to become and continue to be of fundamental importance for psychoanalytic couple psychotherapy (Scharff and Savege Scharff, 2014).

The stage was now set to view the analytic encounter as the theater within which everything a patient brought into the analytic relationship could be viewed as part of the transference (Joseph, 1985). Contemporary link theory may constitute a logical extension of this position, in which intergenerational histories and traumas, as well as current socio-political and cultural environments may be gathered into the transference and become the object of analysis. Attachment is one link in the total field—the dynamic intersubjective structure generated between therapist and patient (Baranger, 1993)—which may or may not become the primary site where the therapeutic pair operate as a couple, but it is one that lends itself closely to transference interpretations as conventionally conceived. Unbounding the scope of factors that influence transference relationships to include a wider field of intersubjectivities, and viewing these as jointly constructed by patient and therapist, increases the complexity of analytic work, and cautions against being too confident in our understanding of clinical experiences without heeding the contexts in which that understanding occurs.

Analysts like Bion, Winnicott, and Bowlby expressed their caution about sharing their understanding prematurely through interpretation, positively valuing the therapist's stance of not knowing in bringing about change. Bowlby's conception of the therapeutic process was very much in terms of providing a secure base from which individuals might be freed to explore themselves and their relationships, a similar process to his depiction of a young child feeling safe to circle further and further afield from his mother to explore the wider world, confident of her enduring presence, support, and encouragement. Interpretation was emphasized less by him than providing a facilitating environment (to move into the language of Winnicott) where the patient was in the driving seat: "You know, you tell me," he was likely to say to his patients (Bowlby, 1988: 151). Insofar as interpretations featured for Bowlby, their value was less in their explanatory power than in their capacity to encourage further exploration. His father was an eminent surgeon, and he used the analogy of the orthopaedic surgeon creating conditions in which broken bones might mend to highlight the essence of the therapeutic change process: creating the conditions in which the fractured self might heal.

From this overview of the mutative interpretation, it is possible to identify a number of interrelated developments affecting the nature of psychoanalysis:

(1) a move away from focusing on individuals as entities and toward one that focuses on their relationships, and how these become internalised and structured into a sense of self;
(2) a shift in understanding what happens in the key transference relationship—that between patient and therapist—as bidirectional rather than unidirectional phenomena, reflecting a growing interest in understanding therapeutic process as something jointly created by interactions between the different subjectivities of patient and therapist;

(3) regarding the analytic encounter as the theater in which everything a patient brings can be viewed as part of the transference (but not in a reductionist way) so that the influence of intergenerational trauma and socio-cultural context may be gathered into the transference and become the object of analysis;
(4) a conception of the therapeutic process less in quasi medical terms of *cure* and more in terms of exploring what constitutes a caring environment, and how that might be affected by what each party brings to the relationship;
(5) a heightening awareness of the role of countertransference in accessing unconscious communication; and
(6) a focus on the myriad ways in which people communicate about themselves, often quite unconsciously, challenging our capacity as therapists to tune into the chatter that takes place outside, as well as within the domain of language.

Taking account of this last point writers, like Allan Schore have suggested describing psychoanalysis as the *communication*, rather than *talking cure* (Schore, 2012). Although maintaining the linguistic drawback of *cure*, his suggestion highlights the myriad ways in which we communicate to others about ourselves, not least through the intuitive right brain to right brain flashes of unconscious communication that constitute an important aspect of intersubjectivity in transference/countertransference dynamics. He sees psychotherapy as an application of developmental psychology in which clinical practice is based on what we have learned about human development from the observation of infancy and early childhood, not something that is solely reliant on retrospective constructions of childhood based on adult stories told in the context of psychotherapy and filtered through the lens of a therapist's particular theoretical persuasion.

Attachment and couple psychotherapy

Bowlby was clear that attachment behavior was not restricted to the vulnerable early years, but was evident throughout the life span when individuals felt frightened, upset, or ill. There has been some discomfort about conceiving of intimate adult peer relationships in terms of attachment when we ordinarily think of attachment as behavior displayed in circumstances of perceived threat by an infant toward a parent or similar caregiver who is considered older and wiser. This problem of asymmetry has been resolved by highlighting the interdependence of attachment and caregiving systems in adult couple relationships, the mark of security being the capacity of partners to move flexibly and appropriately between depending on and being depended upon by each other (Fisher and Crandell, 2001), using and being used by each other as both a safe haven and a secure base (Crowell and Treboux, 2001).

Completing the triangle of primary behavioral systems associated with adult romantic love, and perhaps constituting its key distinguishing feature, is sex. Sexual behavior has a pivotal role to play in drawing potential partners together in couple relationships and maintaining their bond. Alongside its pro-generative function, sex serves to bind couples together in sensual, as well as sexual, ways. The physical intimacy afforded by sex resonates with the earliest experiences of being held, touched, caressed, and responded to in physical terms, communication conveyed by this primary language of the body, which has the capacity to release opioids such as vasopressin and oxytocin to excite and soothe the couple and their relationship. Attachment, caregiving, and sexuality are interrelated systems, central to adult couple relationships (Mikulincer and Goodman, 2006), each assuming predominance according to age, relationship stage and the impact of life events, and each having the capacity to be confused with the others (Castellano et al., 2014). Sex can be used in the service of seeking attachment, caregiving mistaken for sexual invitation, and both as a conduit for expressing sexual desire. In this mix, there is much scope for confusion, anxiety, and relationship conflict. Within it comes the therapeutic conundrum of whether to interpret toward or away from sexuality (Colman, 2009); for example, to see sexual problems as being symptomatic of ingrained attachment

difficulties and, therefore, treated as signposts toward these deeper issues, or to understand hostility in a relationship as symptomatic of what is or isn't going on sexually between the partners.

In many respects, the attachment-caregiving-sexual behavior triad is a very limited view of adult couple relationships, especially when the focus is on attachment—a behavioral system activated by the perception of threat. Certainly there are limitations in focusing on the dynamics of attachment and caregiving, because much of a couple's life is motivated and sustained by pleasurable enjoyment of each other's company. The less specific but no less important dimension of intersubjectivity between partners, an area that encompasses common interests, beliefs, values, and aspirations, and one that is driven by the need to share with others, provides a conceptual means of filling this gap. Stern described intersubjectivity as "an innate primary motivation system, essential for species survival, [with a] status like sex or attachment" (Stern, 2004: 97). He described it as a system activated by threats to psychological cohesion and self-identity, as well as the desire for emotional intimacy. There is, however, debate about whether intersubjectivity can be compared with other motivational systems. It encompasses positive, as well as negative, interactions; the triggers that switch it on and off are not discrete; it is evident across the board of other behavioral systems and is not restricted to any one relational domain: mutuality, playfulness, and cooperation are as evident in the earliest preverbal conversations between mothers and infants as they are in the sexual relationships of adults. Better, perhaps, to see intersubjectivity as a specifically human asset, created and facilitated by the exceptional development of the brain cortex that accounts for our abilities to read and reciprocate the feelings and intentions of others, and to enjoy their company (Cortina and Liotti, 2010).

We psychotherapists see couples when their relationships are in trouble, which may explain why we tend to focus our attention on attachment and caregiving patterns. We have the potential to become objects of attachment in their inner lives. From this comes our special duty of care. How is this duty best discharged in the intersubjective field we find ourselves in and have a part in creating? In considering this question, I explore what comes before interpretation, emphasizing the significance of nonverbal cues, and what lies beyond it in terms of the impact an interpretation can have on what comes next. In both contexts, the interpersonal focus is key. Whether attention is focused on the relationship between partners, or with their therapist, it is the space between them that provides fertile ground for change. These temporal and spatial distinctions are artificial, and misleading if they detract from what are inherently interlinked dimensions of our role as therapists, but they may be useful in untangling our thinking about how best to achieve what we, and those who consult us, are attempting to achieve.

Before interpretation

The knowledge that early attachment experiences influence the physiological architecture of the brain; that this architecture reduces in plasticity over time, and that trauma can interfere at a physiological level with brain functioning, challenges a fundamental basis of interpretations rooted in the conception of a dynamic unconscious. The dynamic unconscious assumes some prior awareness of threat or anxiety against which defences must be put in place. The assumption that interpreting the function of these defences in a containing environment will allow that latent prior awareness to become manifest knowledge is thrown into question if there is no prior awareness to be defended against. Then the problem for therapists is not that patients won't incorporate the essence of an interpretation, because they defend against its implications, but that they can't because they lack the mental experience and neurological equipment to do so. What is the point of asking a brain to process information in a particular way if it has not established the necessary connectivity to do so? This is to ask the question in extreme terms and also to risk distorting the evidence: At a subcortical level, there is always a prior awareness of potential threat (and opportunity) and an

arsenal of physiological, emotional, and behavioral responses to deal with it (Panksepp, 1998). But the question does invite us to consider whether therapeutic work may be as much about generating experiences that allow connections to grow as about unblocking connections that already exist. The work may then be creative and generative as well as restorative and reparative.

The dilemma of not knowing whether blocks in communication and emotional contact derive from unconscious resistance or incapacity featured with a couple who came for help to manage the impact of physical disability on their relationship:

> The couple, who were very active in their local community caring for others, faced a crisis in their relationship following a road accident that had left the husband with paraplegic injuries.[1] The wife had been struggling to look after her husband at home, but had reached the point where they both realised she could no longer do this and that he needed to have special residential care.
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> They described visiting a potential home. The door was opened by someone who just stared at them. When they explained they had made an appointment to look around, she was blank. The wife asked to see the manager and someone sidled out of a side room saying it was her. She didn't seem to know about the appointment, even though it had been made on the phone with her. The wife turned on her heels and wheeled her husband out. She described sitting in the car across the road and fuming about what had happened.
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> Talking about this, the wife was full of feeling. Her husband had said nothing, and at one point had closed his eyes. I asked what the visit had been like for him. He shrugged and said he had known immediately that this was not the right place. I asked how. He said, "There was no energy." I asked what he meant. He said there was no response in the face of the person opening the door, just a void. He knew instantly that this was a nonstarter. I was curious about the "energy," what did it feel like, but this was something he could not put into words. His wife came in as his interpreter, saying that she thought he was conveying not so much having "feelings" about it (something she had in spades) but more about his having a "sense" about it—"sensibility" rather than "feeling"—a distinction that I understood her to be making in terms of something less consciously known about but nevertheless decisive.
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> She described their drive home from the visit, when she had continued to express her anger and distress at the encounter. Her husband had not responded, except by trying to change the subject. She then found herself becoming angry with him for not responding to her distress. When I asked how this experience in the car with his wife had made him feel he shrugged, saying he isolates himself as there is nothing to be done other than discard the place as a possibility. She came back at him, saying she was not wanting him to do anything, just to acknowledge how she was feeling and to hear that he felt similarly. He found it impossible to respond.
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> It was very much in my mind that he, and they, had suffered a major trauma as a result of an accident that had profoundly changed their lives, and that despite their kind natures and caring disposition toward each other both must be feeling angry and bereft as a consequence of this event. Insofar as their needs to be looked after had been managed through looking after others, the accident had disturbed their shared defensive system and confronted them with managing a burden of need, and all the feelings associated with it, inside rather than outside their relationship. I thought that for her, this could be the straw that broke the camel's back, because she had always resented being the *turned to* member of her family whenever there was a crisis, without much attention being paid to her needs. For him, the dilemma of where to target his anger was compounded by a history of, in effect, losing both parents at a very young age to be brought up in a rural community with relatives who left him to his own devices. I appreciated that he had learned to be solitary and self-sufficient, and I wondered about his capacity even to know what he was feeling in these circumstances.
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> This became a focus of my attention, and it highlighted a dynamic between them that had preceded the accident. His wife said that throughout their marriage, she had felt his emotional absence, but their shared community activities brought them together and provided common projects that made them feel like a team. She also thought he was brilliant with other people who had problems, and sometimes she had felt jealous that he could respond to them in a way he couldn't to her. At the start of their relationship, when she had had problems of her own, he had looked after her really well, and they had talked a lot. "What changed?" I asked him. "She got stronger," he said. I commented that it sounded like his wife would need to have a disability to engage him, and she roared with laughter, saying that was right—when she was ill, he couldn't be more attentive. "So why not in other circumstances?" I asked. At first, he responded by saying there was nothing he

[1]Identifying features have been removed from this and other case vignettes in this article, which are based on composites of real clinical encounters with these dynamic themes.

could practically do. I pushed him. There was a sheen of tear in his eye when he said that if he couldn't fix things, he felt vulnerable. He had always walked away from situations where he might feel vulnerable, avoiding conflict and turning inward. And now he found himself in a place where he was literally unable to walk away. She said it made a huge difference just hearing him say that. She had arrived at the session feeling very tense in her body, but now she was feeling relaxed, as though she had been freed of a heavy burden, by which I took her to mean the burden of carrying his feelings as well as her own.

Attachment theory challenges us to take account of implicit communications. In general terms, an interactive rhythm must be established between all concerned to establish therapy as a secure base in which relationship patterns and emotional experience can be explored (Holmes, 2010). In establishing this rhythm, we therapists try to be in tune not only with the couples we see but also with ourselves; there needs to be *self-contingency* as well as *interactive contingency* to regulate affect in the therapy relationship (Beebe and Lachmann, 2013). Here the focus is not only on eye-to-eye, face-to-face, voice-to-voice, touch-to-touch, body-to-body, and behavioral communications, but also on the countertransference.

In this case, my countertransference changed in the session as my sense of the husband as someone who might not have a capacity to know about his emotional experience shifted to one of growing awareness of the struggle he was having inside himself, one that had been compounded by the accident. At first I felt constrained, desperately wanting to access what he was feeling but restrained by the thought that I was asking him to do something he wasn't capable of, and that it would be hopeless, if not damaging, to persist. Like him, I felt disabled and frustrated in my role as a care giver. I kept prefacing my questions with statements like, "I know I may be asking the impossible by wanting to know how you are feeling about this because you have spent a lifetime keeping a distance from your feelings and those of others, and for very good reason: the fear is you might get hurt, but …" and then I would ask the question anyway. In the end, I learned that this was not a man incapable of feeling, far from it, but a man who was overwhelmed by the emotional impact of his disability and who feared that his sense of himself would be compromised if he disclosed this. Part of him felt rage, and this both frightened him and compounded his sense of disability. So there was not only the pain associated with a fear of being further disabled that he would have to contend with if he allowed his feelings to be seen, but also an existential dilemma in which he feared he might become a stranger to himself. Understanding this dilemma, I felt more sympathetic toward, than frustrated by, him, which I imagine was also the change taking place in his wife's countertransference in their marriage.

The temptation to infer what this man might be experiencing was often strong, and here interpretation can be risky. Exploring links with history may intensify, rather than reduce, affective dysregulation, especially when history is embedded with trauma. Even interpreting the function of behavior in terms of trying to restore emotional equilibrium may carry dangers, because it carries the presumption that one person knows the mind of another. It is a short step from offering something in the spirit of developing a capacity to think about feelings to be experienced as an intrusion, if not an attack, on psychic reality. There are strong indications that interpreting the transference, or any kind of interpretation, is likely to be counterproductive with borderline couples—a couple descriptor that does not necessarily imply one or both partners have a borderline personality disorder but that their "thinking and emotional experiences become greatly disorganised in an attachment relationship" (Nyberg and Hertzmann, 2014: 119). Borderline states of mind are linked with overpermeable relationship boundaries, so therapists who want to encourage mentalizing will not presume to know what is going on for their patients but will actively foster curiosity about their experience through the unknowing stance that they take up. There are risks attached to inferring the emotional states of others; exploration can be curtailed by explanations, and the options might then seem to lie between complying with or rejecting what is being offered rather than exploring the possibilities raised by an intervention. Either way, deciding upon a strategy that focuses on what precedes affective knowledge may need to come before interpretation.

Between interpretation

Because couple relationships are also sites of transference, couple therapists continually face two broad operational dilemmas: which transference to work with and how? In the case illustrated, a conventional transference interpretation might focus on their visit to a place providing alternative care as being emblematic of the disabled relationship that the couple was seeking care for from their therapist, and their anxiety—or even experience—that this care would fall, or had fallen, short of their expectations. Their transference to those who would take care of them as individuals and as a couple might then be interpreted in terms of an anxiety about placing themselves in the care of others, and an unconscious expectation that neglect, or an absence of energy, perhaps *vitality affect* (Stern, 1985), in terms of attuning to their experience, would result from the encounter. In other words, the question in the transference might be whether I, as their therapist, could be trusted to look after their disabled relationship.

Moving the site of the transference interpretation to the relationship between the partners places a different slide in the microscope, drawing attention to what is happening between them. Here the intensity of feeling experienced by the wife in contrast to the apparent absence of affect in her husband might suggest an unconscious arrangement between them in which she carried, and functioned as the voice for, his feelings as well as her own, an arrangement that became too much for her after his accident.

As well as deciding upon which site to focus when making a transference interpretation, there is the question of how to work with affect in whichever site it surfaces. Psychoanalytic approaches are likely to seek to understand emotional experiences arising in the work in terms of transference, and to interpret this as a means of providing a cognitive framework that might help contain and regulate affective experience (Scharff and Savege Scharff, 2014). Other approaches may eschew interpretation in favor of the therapist working with each of the partners to engage and reprocess different levels of their affective experience and, most importantly, to encourage them to address each other directly in undertaking this task. By enabling a couple to have a different kind of emotional experience with each other from the one dictated by the partners defensive ways of being, it is claimed that deep-seated change can be effected without interpretation (Johnson, 2004).

There is no compelling reason for having to choose between these (and other) approaches in building better emotional connections between partners. The interesting question is whether different approaches might be better suited to different states of mind in the couple. In this the mirror role of the therapist offers some helpful guidelines for working in the space between a couple and their therapist, and between the partners themselves (Clulow, 2007, 2014). The mirror role derives from Winnicott's seminal concept of *maternal mirroring*, which he saw as being crucial to the contribution made by parents to the emotional development of their children, helping them not only to regulate their affective experiences but also to use those experiences to come into themselves as thinking, feeling, sentient beings (Winnicott, 1971).

Winnicott's (1971) attention to the early months of an infant's development demonstrated the ways young children rely on visual, auditory, and sensual responses from those looking after them in this developmental process. His particular interest was in the capacity of the mother's face to contain and convey her infant's experience: "What does the baby see when he or she looks at the mother's face? I am suggesting that ordinarily, what the baby sees is himself or herself. In other words, the mother is looking at the baby, and what she looks like is related to what she sees there" (p. 112). This, for him, provided a paradigm for thinking about the therapist's function:

> This glimpse of the baby's and child's seeing the self in the mother's face … gives a way of looking at analysis and the psychotherapeutic task, Psychotherapy is not making clever or apt interpretations; by and large it is a long term giving back what the patient brings. It is a complex derivative of the face that reflects what is there to be seen. [p. 117]

Of course, the mother (or therapist) does not simply provide a reflection of the infant's affective state. She does not cry as her infant cries, or get angry when her infant has a tantrum. Instead, she offers a response that acknowledges what he or she is feeling, but delineates it in a way that makes it clear that the experience is that of the infant and not her own. She thereby provides a relational experience for her infant of someone who can both pick up his/her affective state in a *contingent* manner and also *mark out* her responses to delineate the feelings as belonging to her infant and not to her (Gergely and Watson, 1996). Linking these responses with the mother's attachment state of mind, it has been proposed that secure attachment will facilitate maternal mirroring that is both contingent with, and marked from, the infant's experience. Insecure dismissing attachment is likely to be low on contingency, affect being avoided, and high on marking out differences of affective experience. Insecure preoccupied attachment may have the reverse effect, maximizing an empathic response to affective cues but failing to distinguish who is feeling what (Holmes, 2001).

Mirroring what goes on between therapist and patient, or partner and partner, does not preclude simultaneously going before interpretation when behavior is the chosen mode of communication. The therapist's response may be thought of as an attempt to engage with what Stern described as the *observed infant*, distinguishing this from the *clinical infant* provided by patients' representations of earlier relationship experiences (Stern, 1985). The observed infant communicates, in part, through behavior. In these circumstances, it is from our affective reactions to enactments in the therapy that we might gain access to the feelings and fantasies that haunt those who consult us:

> I am sitting with my cotherapist in our consulting room having a relaxed conversation prior to seeing a couple whose session is due to begin shortly. Unexpectedly, one of the partners bursts in on us, giving us a welcoming smile, informing us she is on her way to visit her mother and making her way to a chair, saying her (female) partner would be along shortly. We both feel irritated by this intrusion. I say, with some anxiety that she might take it as either shaming or rejecting, that she is early for the session, and would she mind waiting outside until the appointed time. She expresses some surprise but says she will, asking if she can leave her case with us, to which we agree. When we open the door to them at their start time, her partner has arrived and they come in together.
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> The woman who had arrived early opens the session by asking her partner: "How will it be while I'm away?" Her partner looks a bit nonplussed, but then describes how difficult it is dealing with their 3-year-old child who wakes in the middle of the night demanding a bottle. She says she has been told she must be firmer with this little boy, but finds it hard to do so. I am thinking her partner is asking if she will be missed by her while she's away, and is perhaps trying to elicit a response that will echo her own sense of loss at the pending separation. Her partner ducks this question. So I ask if that was really what she was asking. She doesn't immediately respond, and her partner comes in saying that, of course she will miss her, but she'll be very busy with their child, and she was also looking forward to having some time on her own.
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> I make some general comment about comings and goings, and ask the partner who had arrived early what it had been like to walk in on us before the session and be asked to leave. She said it was really nice to see the pair of us talking together in an amicable way, just a nice image. She said she hadn't felt put out, and had been able to get on with some work while waiting for her partner to arrive. I said that if we had started the session early her partner would have been excluded from part of their time together; instead they started as a couple. My cotherapist added that being together as a couple, placing a boundary around their relationship, so to speak, was an area they were struggling with in relating to their son. They built on this observation, saying their pressures came not only from parenting him but also from keeping the demands of work out of their relationship, and, more pointedly, protecting themselves from the intrusiveness of a mother (the subject of the visit) who could be a demanding presence in their lives. Exploring why it was so hard to resist these intrusions, she said that because her mother was old and ailing she was anxious about ignoring her various complaints in case one of them turned out to have serious and possibly fatal consequences.
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> In my mind was the thought that, for both partners, their caring responses defended against mobilizing the aggression that might enable them to manage boundaries better, and that their identification with a needy child, the pressures of work, and a demanding mother made it hard for them to draw a line that might protect them against these without feeling they were becoming the rejecting, destructive, and demanding objects they felt subjected to. These were thoughts that could, and at times were, offered as interpretations. But perhaps the main intervention-cum-interpretation we offered was through how we behaved: asking one of the partners to

> leave until the appointed start time of the session. This bounded the therapy, preserved our relationship as a cotherapist couple, and promoted their relationship as a spousal and parental couple.
>
> As well as helping them mark these boundaries, our behavior may have encouraged the couple, through starting together in the session, to be in a stronger position to attend to each other's concerns, and to pick up, in a contingent manner, their shared anxiety about managing intrusion. The question, "how will it be while I'm away?" might then be understood as an expression of anxiety about visiting a mother who was experienced as intrusive, but also to contain a probe about whether it was possible to separate from each other without damage (picked up in my countertransference anxiety about inflicting shame or rejection through holding a boundary).

Intervening through behavior corresponds with the concept of *interpretive action* (Ogden, 1994), where an aspect of transference-countertransference experience is conveyed through behavior, rather than words. Its value is gauged by the degree to which it expands analytic space—the freedom to explore what is happening between people. When focusing on the interaction between partners, the therapist's role may sometimes be akin to providing a kind of video feedback, encouraging couples to see how they are behaving together and review what has happened between them through replaying their interaction, allowing critical moments to be reexperienced, thought about, and then, through contingent and marked mirroring, experienced in a new and potentially more functional light.

Beyond interpretation

Going beyond interpretation engages with Stern's clinical infant in deciding how to interpret representations of relationships that seem not to fit with our perception of reality. Here we encounter the potential for interpretive activity to be Janus-faced: looking forward and backward along the continuum of time. Kohut distinguished between trailing- and leading-edge interpretations in these terms, a flight metaphor that brings to mind associations of drag and lift (Miller, 1985). Trailing-edge interpretations address what the therapist thinks the patient is trying to ward off or unconsciously resist, and are often linked to history; the emphasis is on how past experience continues to influence relationships between self and others. In contrast, leading-edge interpretations focus on what the therapist thinks the patient is trying to maintain or achieve through their behaviour.

Attachment theory encourages us to think teleologically, as well as historically, to consider the function of behavior—especially in terms of regulating affect. Leading-edge interpretations have a positive aspect to them, and may involve working with, accepting and valuing defences rather than attempting to overcome them:

> A wife describes how she scans her husband's face to know what he's thinking and feeling, but is frustrated by the impassive mask he presents to her. They have been to visit a house she's interested in them buying as the family home, and she doesn't know what he thinks about it. So she pushes for a response. When she pushes, he withdraws, sometimes angrily, creating the all-too-familiar experience for her of rejection, so she protests. His dilemma is that he often doesn't know how he feels, and fears her becoming upset with him if he expresses a view that is contrary to her own. He represents relationships in his family of upbringing as being inverted, with him looking after a narcissistically preoccupied mother left by his father to fend for herself. She represents her family history primarily in terms of abandonment, where those who were responsible for her left her to fend for herself. He seeks to know what she's thinking before committing himself to expressing a view, so looks to his wife for implicit guidance. She searches for a reaction from him so she does not feel on her own with her experience. His impassiveness drives her crazy; her craziness drives him away. He defends himself against the onslaught of her feelings by expressing concern about her state of mind and, in extremis, wonders if she needs psychiatric help, as his mother had done. She then confirms his fear by exploding at him.

The trailing edge approach to interpreting this situation might be to link the way he relates to his wife to the way he related to his mother, evoking aspects of this overwhelming dynamic in the transference to his wife and his conflict between complying with what she wants or giving vent to his anger about being eclipsed in his own right (anger that he might be fuelling in his wife through projection). Likewise, one might interpret how his impassiveness revives for his wife memories of abandoning parents about

which she continues to protest. A joint interpretation might home in on how they both contribute to creating a system in which neither feels cared for as persons in their own right.

In contrast, a leading-edge interpretation might emphasize what each partner is trying to achieve in wanting to know about the other's experience, and how by doing so they as a couple are attempting to establish a sense of emotional security within and between them. This, then, becomes an objective that can be represented as something for which they both may be striving, a positive experience in which they can feel together as a couple. The interpretation might be extended to incorporate how they share similar fears about developing a greater intimacy in their relationship, and the dilemma this presents them with in achieving their aims, acknowledging and valuing rather than attempting to resolve their conflict. Leading-edge interpretations are not removed from the province of trailing-edge interpretations: an acknowledgement that emotional security has been fragile for and between couples in the past provides the context for what they are trying to achieve in the future. However, by focusing on future intent, it may be that leading-edge interpretations help provide a safe haven, if not secure base, for the couple and their therapy. They do so by reframing behavior, valuing rather than challenging defences, and facilitating the process of building a therapeutic alliance with each of the partners. Working on the leading edge may open the way for introducing trailing edge interpretations that evoke and challenge a couple's separate and shared assumptions about each other, highlighting the impact of their existing internal working models on themselves and each other, and enabling their unconscious assumptions to be revised and updated. In these circumstances, they provide a prequel to reflective thinking.

Whether going before or beyond interpretation, therapists are challenged to think developmentally about how partners might be attempting to communicate about their affective experience. Thinking developmentally involves being attuned to emotional states within oneself, as well as each of the partners within the context of the intersubjective encounter that comprises the therapeutic process. Perhaps working in the transference can be represented in terms of promoting creative intersubjectivity in the clinical encounter, and not only with the endeavor to remedy dysfunctional strategies operating in the domains of attachment, caregiving, and sexuality. In the process, there will be opportunities to enlarge the therapeutic project beyond exploring the territory of the dynamic unconscious—impulse regulated by defence—to encompass a broader goal of fostering the capacity for empathic knowing, a capacity that is biologically embedded and awaiting development in all close relationships.

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References

Baranger, M. (1993), The mind of the analyst: From listening to interpretation. *Internat. J. Psycho-Anal.*, 74: 15–24.

Beebe, B., & F. Lachmann. (2013), *The Origins of Attachment. Infant Research and Adult Treatment*. London: Routledge.

Bion, W. (1959), Attacks on linking. *Internat. J. Psycho-Anal.*, 40: 308–315.

Bowlby, J. (1973), *Attachment and Loss: Separation*. London: Hogarth Press.

_____. (1988), *A Secure Base*. New York: Basic Books.