A THEORY OF CAREGIVING IN ADULT LIFE

Developing and Measuring the Concept of Goal-Corrected Empathic Attunement

In Two Volumes

VOLUME ONE

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ABSTRACT

This thesis presents a theory of caregiving in adult life. I have used the context of psychotherapy to develop the theory. Within this theory I have developed the concept of goal-corrected empathic attunement (GCEA) which relates to a process of interaction between careseekers and caregivers.

The first part of the thesis introduces the concept and seeks to ground it in research on psychotherapy, on the interactions between mothers and infants, and the theory of attachment. The theory suggests that adult psychotherapy can be understood as an attachment eliciting activity which arouses the dynamics of attachment in clients who come for help. When careseeking is aroused in adults, like infants they require attunement to affect and affect regulation from a sensitive caregiver. In addition, however, they also require an empathic response. When successful, careseeking will shut down and the ever present instinctive exploratory system will resume. In this way the need of the careseeker and the response of the caregiver are goal-corrected.

To test the various elements of the theory I devised a series of three experiments. The results of the first and second experiments supported the idea of GCEA in adult psychotherapy as being interactive and associated with exploration. The third experiment found: (i) a highly significant correlation between two subjective scores for GCEA; (ii) a significant correlation between the objective measure of GCEA and the two subjective measures; (iii) a significant correlation between a score for 'secure attachment' and the objective score for GCEA; (iv) a significant training effect as measured by the objective GCEA score.

A potential drawback of this experiment was that it was conducted in 'artificial' conditions. If similar results could be achieved in practice, this work would have important implications for the selection and training of those joining and working in the caring professions.

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To the memory of my parents

James McCluskey and Maura Browne

Declaration

While the thesis is not based on joint research the preliminary work required obtaining the views of peers and students in relation to excerpts of clinical practice. This work was subsequently written up and published with two colleagues, Derek Rogers and Poppy Nash (McCluskey et al., 1997).

My colleagues were involved in different capacities. Derek Roger was interested to see whether his own research on devising instruments for rating emotional control and detachment would correlate with correct or incorrect identification of affect attunement. Poppy Nash helped in putting the data on the computer, with analysis of the results in conjunction with myself and also helped me with the actual management of the experiment, handling the student groups on the day they identified the excerpts. This work appears in the thesis in chapter 6.

Liza Bingley Miller and Carol-Ann Hooper were involved in a later stage of the research when it came to requiring independent ratings of the main experiment. The work we did together on achieving inter-rater reliability was subsequently written up for publication (McCluskey et al., 1999). I was lead author on this paper and took responsibility for conceptualising the process which we were observing. This is described fully within a theoretical context later in chapter 5.

A third paper based on my theory of caregiving in adult life is currently in press with the APA Journal Group Dynamics (McCluskey, U.)

Overview

This thesis presents a theory of caregiving in adult life. Careseeking is usually the trigger for caregiving. A key concept within this theory relates to a process of interaction between careseekers and caregivers that I have called goal-corrected empathic attunement (GCEA). I have used the context of psychotherapy to develop the theory. GCEA is also found in forms of caregiving outwith the context of psychotherapy. Indeed one of the advantages of the theory is that it seeks to ground the explanation of psychotherapy in psychological theories derived from other fields.

The first part of the thesis introduces the concept and seeks to ground it in research on psychotherapy, on the interactions between mothers and infants, particularly the work of Stern, and the theory of attachment developed by Bowlby and Ainsworth and extended by Heard and Lake. The theory that I am putting forward is that adult psychotherapy can be understood as an attachment eliciting activity which arouses the dynamics of attachment in clients who come for help. When careseeking is aroused in adults, like infants they require attunement to affect and affect regulation from a sensitive caregiver. In addition, however, they also require an empathic response. When successful, careseeking will shut down and the ever present instinctive exploratory system will resume. In this way the need of the careseeker and the response of the caregiver is goal-corrected. It is this process that I call goal-corrected empathic attunement.

The process of arriving at a theory of caregiving in adult life started for me when I first saw the perturbation studies carried out by Murray and Trevarthen. These studies involved mother-infant dyads communicating with each other through a live video link. The videos I saw started off by showing both mother and infant animated and enjoying each other. The live connection between infant and mother was then broken without their knowledge. A video replay of an earlier 'conversation' was inserted

into what had been a live connection. What I noticed was the effect on the infant of losing contact with his or her mother. I was struck by the immediate collapse of animation, the fact that they instantly turned their head away from the video screen, and their look of sadness. These were six month old infants. Equally dramatic was that all activity in terms of expressing oneself and exploring came to an abrupt end. During my many years' practice as a social work educator, I had noticed similar behaviours and expressions to those I had just observed on video. The context for my observations was the teaching of interviewing skills to social work students or working on interpersonal skill development with qualified professionals. I noticed these expressions (albeit in less dramatic form) in those playing clients when the therapist or worker, in my view 'lost touch', 'dropped them' or backed away' from their affect and the particular issue they were trying to communicate. I read Daniel Stern's work on affect attunement and misattunement between mothers and infants and began to wonder whether that was what I had been observing in the adult context. I began to wonder whether it would be possible to catch such behaviours on video if and as they happened between clients and therapists in the real world. I became curious about the nature of the processes I was observing in both infants and adults; what they were and what they meant.

I became interested in whether other therapists, educators, or students noticed the same interactive phenomena that I was noticing. I set up a series of experiments to find this out. In the course of exposing the phenomena to outside observation my understanding of the processes that I had been noticing deepened and became more complex. In reality the experiments and my reading interacted so that I became clearer over time about what I was looking for and how to interpret what I was finding. In practice, the way that I went about opening up the ideas to outside observation made it possible for me to test aspects of the concept of GCEA as I went along, such as its hypothesised link with exploration and interaction. I was able to use the fact that I got measurements of GCEA to test the impact of training and attachment status, and to see whether some students were better than others.

My first experiment therefore set out to see whether affect attunement which had been observed in infant caregiver interactions could indeed be reliably identified in adult psychotherapy. To do this I divided video taped recordings of therapeutic sessions into 1.5 minute segments and asked a panel of experts and students to rate the episodes as 'attuned' or 'not attuned'. The results indicated that there was a high level of agreement between the experts on some of the excerpts shown and not on others. However, the agreement achieved between the students and the experts was no better than chance. Analysis of the data suggested that the experts paid attention to the interaction in making their judgements, and associated empathic attunement with exploration, while the students did neither and appeared more influenced by the behaviour of the therapist.

I then set out to see whether students would do better if given instructions to pay attention to the interaction. I created two matched groups, an experimental group and a control group. I gave each group the same instructions as I gave in my first experiment but in addition the experimental group were given instructions to pay attention to the interaction between therapist and client when making their ratings. I used three excerpts, of which one was judged 'attuned' by 100% of the experts, and another as 'non attuned' by 80% of them. I based my results on these latter two excerpts on the assumption that the experts were 'correct'. The results showed that the experimental group made significantly more correct identifications than the control group. The qualitative analysis revealed that the students who made correct ratings also noted whether the client had engaged in or was prevented from exploration.

The results of the first and second experiments supported the idea of GCEA in adult psychotherapy as being interactive and associated with exploration. I then wished to see if it was associated with the subjective experience of the careseeker and caregiver, and the attachment status of the therapist. In addition I wished to see whether students could improve their ability to interact in an attuned way with training.

In order to achieve the above I designed a third experiment which would take place at two points in time and which would allow me to measure GCEA objectively by an outside observer, and subjectively by both careseekers and caregivers. I would then be able to test whether: (i) I had reliable measures of GCEA which correlated with each other; (ii) these measures correlated with the attachment style of the caregiver; (iii) caregivers provided with training improved more as judged by these measures than those who were not given this training; and (iv) students consistently differed from each other in terms of the measures of GCEA.

To achieve the above objectives I decided to control the conditions under which the experiment took place so that as far as possible (i) the elements under observation were as similar as possible to each other and (ii) the experiment would provide the means to work out an objective rating of GCEA. I therefore chose to use 'role play' instead of 'live' practice and to use social work students and professional actors to play the roles of caregivers (students) and careseekers (actors). This would allow me to: (i) control for scenario - each student would be presented with a similar situation; (ii) control for gender - I could decide which actors to employ on the basis of their gender; (iii) video each interview, thereby giving me as near accurate a record as possible on which to obtain an objective rating of GCEA; and (iv) keep confidentiality issues to a minimum, thus making the possibility of doing the experiment more likely.

On day one of the experiment all students did four interviews with each of four actors. After this first stage I created two matched groups of students; one group received training in GCEA, the other did not. At the end of day two all students completed attachment style questionnaires. The experiment yielded 96 video recordings of GCEA; completed measures of GCEA for all interviews from the students and actors and completed attachment style questionnaires for all the students.

It took two colleagues and me a year of testing and re-testing before we developed a method of rating which gave a reliable measure of GCEA. At the end of this work a correlation of .79 (p=.002) was achieved between the two independent judges based on the average score from a series of 1.5 minute segments from each of 12 video tapes. All 96 interviews were then rated giving me an objective GCEA score for each student (caregiver). This score was then compared to the two subjective scores for GCEA and the attachment score, and analysed for the effects of training.

I found: (i) a highly significant correlation between the two subjective scores for GCEA; (ii) a significant correlation between the objective measure of GCEA and the two subjective measures; (iii) a significant correlation between a score for 'secure attachment' and the objective score for GCEA; (iv) a significant training effect as measured by the objective GCEA score.

A potential drawback of this experiment was that it was conducted in 'artificial' conditions. It remains to test these findings in the real world of practice. Nevertheless, I suggest that I have developed and presented a theory of effective caregiving. The process of Goal-Corrected Empathic Attunement which is embedded in this theory is based on research in the fields of psychotherapy, developmental psychology and attachment. I have transposed these understandings to the adult domain and tested the theory in experimental conditions. The results of my experiments suggest that the concept does have the features that I predicted and that the theory should now be tested in practice.

As far as I know this is the first time an attempt has been made to measure social work students' performance against a theory of effective caregiving and which has related the results to measures of personality style in ways that make sense. If similar results could be achieved in practice, this work would have important implications for the selection and training of those joining and working in the caring professions.

CHAPTER ONE

THE DYNAMICS OF CARESEEKING AND CAREGIVING

We are born with the expectation of being met as a person

(Sutherland, 1993)

Introduction

This thesis presents a theory of caregiving in adult life. This subject has personal significance for me. I have very vivid memories of accompanying my mother when I was in my early twenties to Fitzwilliam Square in Dublin to see a consultant cardiologist about the possibility of her having an operation to replace three malfunctioning valves. She came out from the consultation in considerable distress. From what I could gather she was told she was not ill enough to warrant the risk of the operation. She was very frustrated, depressed and in despair. I do not know whether she conveyed any of this to the cardiologist or whether he had any clue that she saw the operation as her only hope of survival and wanted to have it whatever her chances. From what I know of her she would have been polite, deferential and would have accepted his advice with good grace and a smile, would have thanked him for his time and paid his exorbitant fee. I had come from Scotland where I was working, and my mother had travelled at some inconvenience and distress from the south of Ireland to Dublin for this consultation. It lasted about twenty minutes. Neither of us thought to seek a further word on the subject, to go back into the building and discuss the choices and the risks of having the operation more fully. She died six months later aged fifty five.

This is an account of a desperate attempt to get help in the light of an extremely dangerous medical condition. It is an example of both failed careseeking and failed caregiving. A more skilled careseeker may have negotiated that consultation better, a

more skilled caregiver may have seen behind my mother's elegant, well dressed appearance and gentle manner and seen the desperation of a woman who felt she was losing control of her life. Part of my mother's careseeking style was to support the other's claim to know what was best; an effective caregiver in this instance would have to have had the skills necessary to deflect such flattery, to override the fragility of her physical appearance and tackle her directly about the risks she was willing to take.

> "Should caregivers fail to meet the needs of careseekers, the latter cannot reach the goal of careseeking, and commonly become frustrated and then depressed. What happens when each partner is failing to reach their goals, and what is happening to their careseeking and caregiving systems is increasingly being researched and understood in both non-human primates and in human beings."
>
> (Heard and Lake, 1997, p. 5)

It is with this arena of interaction, that between careseeker and caregiver that this dissertation is concerned.

There were other personal reasons for embarking on research in this area. In the early seventies, after qualifying in social work at Edinburgh University, I worked for five years in an innovative department of child and family psychiatry in Fife. Staff in this department were either trained in psychodynamically oriented therapeutic work or were interested in such work. This meant that there was an emphasis on the meaning of the interactions taking place between therapists and clients. There was an interest in how clients were responding to the therapeutic interventions by the therapists and the impact of such interventions on the clients lives. The relationship formed between therapist and client was seen as a very important aspect of the work.

The relationship was understood to have meaning particularly for the client who was seeking help, and the therapist saw it as an integral part of their job to try and be aware as possible of this aspect of the working relationship. Within a psychodynamic framework for working, attention was paid to the feelings that were aroused in therapists by their clients and thought was given to the possibility that these feelings may be unconsciously projected by the clients into the therapists as a way of communicating aspects of their experience too painful to know about or assimilate.

The work of the psychodynamically trained therapist is to be tuned in to these affects and processes and to try and conceptualise their meaning. The psychodynamically trained therapist understands the process of ongoing therapeutic work to be the unravelling and working through of this material with the client in ways that makes sense to the client and feels helpful. I was very interested in this work and both received and took part in providing psychodynamic supervision for staff, much helped by the writings of Michael Balint, (Balint and Balint, 1961), Janet Mattinson (Mattinson, 1975) and Donald Winnicott (Winnicott, 1958a, Winnicott, 1971a, Winnicott, 1971, Winnicott, 1967, Winnicott, 1958b, Winnicott, 1971b). The clients we were working with were families where the children or adolescents were providing cause for concern either to their parents, school, GPs or other professionals such as probation officers or educational psychologists.

Even though the work was stressful and demanding, the department was a very satisfying place to work. The culture was thoughtful and reflective and the work was subject to constant study and research, much of which was written up. It was in this working context that I came across and worked with other social work professionals dealing with the same client group. The point of contact was often over a referral of one of the families they were working with. It was striking how seemingly unaware they were of the emotional dynamics of the family. It was equally noticeable that this lack of awareness seemed to affect their capacity to consider engaging themselves with the family in resolving their problems in the here and now.

The social workers often seemed to think in terms of two alternatives: refer the family on to another department (such as ours) or place one or more of the children in residential or foster care. The emphasis on separating children from parents often coincided with a lack of awareness that the child and family needed to know what this separation was about, why it was happening, how long it would be for and whether and how they would all come together after the period of separation was over. The idea of the referral to another department or the separation being part of a planned process that the social worker was overseeing, which had a beginning, a middle and an end that anticipated the post intervention period was generally absent. Just as the social workers seemed blind to the meaning of relationships within families and the impact of separation on family members so they seemed equally blind to the impact of their own behaviour on the families who came to social services for help. It seemed hard for them to think that they might mean something to the families or have something to offer in the way of help with relationships.

This happened in the early to mid nineteen seventies. It highlights the difference between organisational structures which support the task of caregiving and which strive to understand the dynamics of careseeking and caregiving and organisational structures which do not. There have been several studies since which support this observation that organisational structures impact on professional functioning and well being and on the capacity of professional carers to collaborate effectively with colleagues and provide a relevant and thoughtful service for their clients, for example, the work of Janet Mattinson and Ian Sinclair, (Mattinson and Sinclair, 1979; and others (Agass, 2000; Brearley, 2000; Woodhouse and Pengelly, 1986). These and other studies demonstrate the crucial importance of understanding the impact of emotionally difficult and disturbing work on the thought processes and behaviour of the professional carers involved.

Starting towards the end of the seventies and continuing through the eighties up to the present day there has been a movement away from the idea that professional

caregivers need certain conditions which support their work towards the idea that social workers and others in the public service need monitoring and evaluating against laid down procedures. It has become as if good practice can be encapsulated in good procedures and the able practitioner need only follow them. The present concept and practice of purchaser and provider in health and social services exemplifies this assumption where the professional caregiver is bought to provide a tightly defined service within strictly defined time limits.

On a recent visit to a social services office in my capacity as consultant to a family therapy team I found the social workers completely demoralised: they were low in numbers in terms both of referrals to their service and in new recruits of staff to their team. Even their own regular members were attending their fortnightly meetings in haphazard fashion. Their description of their most recent reorganisation was that the teams were now so structured that they rarely met their colleagues from other teams; the office was dead at 5 p.m. in the evening, where previously they would have stayed on and chatted with their colleagues - they now do their work and go home.

The work is so compartmentalised that before one sees a client one has to establish a contract for service with them by post and then wait for them to make the appointment at the office - home visits are a rarity. It can take three weeks or longer to actually make face to face contact with someone who has presented to the duty team in an emergency. Most self referrals fall by the wayside - they do not show up for appointments and the view of the social work staff was that they were not getting the immediate face to face contact they required[1].

The sense of alienation from the core of their work, from face to face contact with people wanting help was palpable. And of course what is obvious to the reader from

[1] The experience that we had at Playfield house confirmed that clients sought help reluctantly, rarely followed through on first request for help and needed highly responsive staff who could effect home visits - otherwise these people who generally desperately needed help dropped from the sight of social workers, GPs and others. From what we now know of attachment behaviour (and which is pursued in

the way this service is organised and delivered is that there is a complete absence of the idea (in the minds of the managers) that the dynamics aroused by careseeking might be worth taking into account and paying some attention to and that if careseekers are met by an impersonal response from potential caregivers it might well influence how they feel about pursuing their request for help.

The process of refining and defining procedures for good practice clearly arises from the observation and analysis of past mistakes and has the objective of taking the best practice and ensuring that this becomes the standard. However the need to ensure proper standards of care for sick and vulnerable people should be informed by an understanding of the properties or nature of the relationship struck or formed between careseekers and their caregivers. This relationship is crucial to the communication of the nature of the service required and the provision of that service. It mediates the transfer of information not only from users of social services to social work staff about issues of child care and child protection, but from patients to orthopaedic surgeons about the nature of the pain and disability being experienced, or between patients and nurses about the need for more painkillers.

These and other examples represent careseeking in a context of anxiety, pain, and distress. How the caregiver responds is crucial in terms of whether the careseeker feels understood; feels that their intelligence, sensitivities and imagination are respected as sources of relevant information and therefore can proceed safely to explore more complex dimensions to the issue(s) that they are concerned about: whether that is a recent heart attack and the potential consequences; discovery of abuse of a child by a trusted other; or complex emotional states being explored in psychotherapy.

Caregivers who are working to procedures alone may well give a service that satisfies the auditors and the inspectors of quality controls, but they may not be quite so

this thesis) insecure careseeking styles will tend to be avoidant and avoidant ambivalent in relation to perceived caregivers - so these observations make sense.

focused on the effect of their behaviour or the response they are getting from the careseeker. Indeed they may be oblivious to the fact they are getting less than half the story and losing trust and confidence. This, in the long run, is going to cost time and money, it keeps the unsatisfied careseeker returning in one form or another in order to find the conditions which will support their recovery.

The dynamics of caregiving and careseeking being studied in this dissertation are those pertaining to the actual interactions taking place between the careseeker and the caregiver. The study examines the actual dynamics of that relationship; how we can understand the interactions between careseeker and caregiver which shape that relationship and influence whether it is successful or otherwise.

Origins of interest in attunement in therapy

I first set out to study affect attunement in the context of adult psychotherapy. I did so from a sense that it was an important area of study. I have over thirty years experience of working with people in couple relationships, families or groups and also have considerable experience of working with trainee social workers at post-graduate level.

There is a particular phenomenon that has exercised me constantly over these years. This is the frequency and regularity with which therapists withdraw from the affect being expressed by their clients. Sometimes the affect is expressed verbally by the client; sometimes non-verbally. This withdrawal takes the form of either (i) carrying on as if totally oblivious to the information coming through about the affective state the person is in or the affect they wish to communicate; or (ii) distracting them from the direction they are heading either by asking unrelated questions or introducing a change of subject. In addition, I have noticed, that as the clients bring in what they consider to be affectively significant material they often tend to glance at the face of the interviewer, then look away. This movement I have captured on video many many times. In my view it fits the phenomena of social referencing described by Klinnert

(Klinnert et al., 1983) which describes how a one year old infant placed in an ambiguous situation will check the expression on their mother's face (affect) to determine whether they should proceed in a direction that seems unsafe or stay where they are.

My practice was to stop the therapist at the points in the session where they failed to respond to the communication of affect. I have therefore accumulated a great deal of information about what was happening for the therapist at that time; what they were experiencing and thinking, what they wanted to do and what was getting in the way of them doing it. Questions I would generally ask the therapist were: Did you see the expression on his face just now?; did you notice the tone in the voice? Did you notice the way he looked at her when she said that or he said that? Did you hear what she said just now? I have never had any therapist say to me that they had not noticed what I was drawing their attention to. For some it was less vivid than others; for some they needed me to retrace what had happened and give a verbal description (or if it had been videoed, then a video replay) of the movement or expression of the careseeker but once this happened they were aware they had seen what I was referring to.

Having stopped the session and had a discussion with the therapist about what they had missed, why they had backed away from it, whether they thought if we re-ran that sequence they could pick it up if it happened again and if so how they might do that, I then got to see what happened next. When they changed the way they responded to the client's affect, I noticed three things: a) there was a change in the client's vitality affects; their sense of liveliness and involvement, this was often accompanied by a change of colour and muscle tone in the face; b) the client pursued the conversation in a direction congruent with the affect that they had communicated (even though sometimes this affect was expressed non-verbally, in context, one got a sense of where they were going); c) the therapist became more involved, seemed to be more alive and engaged and purposeful as if engaged in something they experienced as

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real. Those were my observations of the therapist and the effect of a change of strategy. If one thinks about it in attachment terms the change in strategy required the caregiver to shift from behaviour that put distance between themselves and the careseeker to one that promoted emotional proximity between them.

I was also observing the client. What I noticed was that once the therapist had backed away from the client's affect, the client would reorganise themselves, sometimes in such a subtle way that it was hardly recognisable. This seemed to be in the service of going along with the direction being pursued or suggested by the therapist. I have also never seen a client insist that they stick with the affective meaning of what they were saying or suggest it be pursued by the therapist in lieu of the direction being presented to them by the therapist[2]. I am not saying that I think clients never return to their own pathway at some point in the future and that therapists always divert them away, rather I believe clients do make many and many attempts to get the therapist to attend to their deepest emotional concerns and that therapists do in the end mostly respond, but that the process may take longer than it need and not be understood as well as it might.

In the Spring of 1993 I attended a one day conference at the University of York on attachment issues in working with children led by Mary Sue Moore and saw the videos of the perturbation studies carried out by Murray and Trevarthen (Murray and Trevarthen, 1986). These made an enormous impact on me. I saw the process of attunement between mother and infant and I saw the direct effect on the infant of non attunement. I was absolutely riveted by the immediacy with which the infant withdrew eye contact, turned their head away and looked down at the floor or looked away. I began to wonder about the role of attunement in careseeking-caregiving relationships and the effects of misattunement and non attunement on the development of the relationship itself. This prompted me to read the work of Daniel

[2] This observation of the careseeker's behaviour seems to fit the mental organisation associated with the insecurely attached child (Target and Fonagy, 1998). Target suggests that the way that caregivers

Stern (Stern, 1985). For me, Stern's work supported the theory of Ronald Fairbairn (Fairbairn, 1952) with which I was very familiar and which was contrary to the view of child development held by Melanie Klein and her followers. Fairbairn maintained that infants were person-seeking from the start. Stern's review of the literature on infant development and his own research confirmed this thesis .

A few months later I wrote a paper entitled pre-verbal communication: the role of play in establishing rhythms of communication between self and other (McCluskey and Duerden, 1993). I wrote at the end of that paper:

> "To understand what is required in therapy we need to capture the detail of the process of communication between people when they feel they are being understood and communicating well. Maybe like Stern and others we need to film it and play it back in slow motion so that we can examine the detail of the interaction - capture the ebb and flow - amplify and name the processes for ourselves, so that we can recognise and learn them. As social workers or therapists we need to understand more about not only the context of therapy: purpose, predictability, reliability; the processes of attachment, loss, transference and counter transference, but also the mechanics of communication. The work of the naturally good enough mother in Winnicott's phrase needs to be analysed."
>
> (McCluskey and Duerden, 1993, p. 26)

I started this research as a consequence of the work for that paper. That being the case I set out primarily to study attunement in careseeking caregiving situations between adults in a therapeutic context.

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relate to the affective component of the child's experience of reality, corresponds with the caregiver's own attachment status. I return to these ideas more fully in the next chapter.

The preliminary work for this thesis involved getting the views of my peers and students on excerpts of clinical practice: I wanted to know whether they would agree with my judgement that in one instance the therapist was attuned to the client's affect and in the other that the therapist was not attuned. This study was subsequently written up and published with two colleagues (McCluskey et al., 1997) as mentioned in the introduction to this thesis.

Because my understanding of the function of the concept of affect attunement has changed and developed during the course of the research, it provides a particular challenge as to how to write this thesis. My current position, which developed through the reading and empirical work for this thesis, is that the concept of affect attunement that I started off with is insufficient to describe the process of effective caregiving. I developed the concept of goal corrected empathic attunement which I locate within the psychobiological theory of attachment, within earlier research into the process of counselling and psychotherapy and within the field of developmental psychology.

This was not always my position. I started out in my first experiment (chapter 6) with the concept of affect attunement as defined by Stern (1985): "Affect attunement..is the performance of behaviours that express the quality of feeling of a shared affect state without imitating the exact behavioural expression of the inner state" (p. 142). The definitions of affect attunement that I used for my first experiment were: "attunement is a way of communicating to the other that one has recognised the affect they are experiencing. Attunement conveys to the other that one has a feeling sense inside of what it feels like to be them right now". By the end of that experiment I understood that the activity of affect attunement on its own was insufficient to describe the processes that facilitated exploration. I understood that in addition to affect attunement an empathic response was also required.

However I did not always find myself updating my terms even when my understanding of the concept had shifted. For some time into the study I continued to use the term 'affect attunement' when in fact I should have been using the term 'empathic attunement'. As far as this thesis is concerned I use the term 'affect attunement' in chapter six when I describe my first experiment. I shift from using the term 'affect attunement' to using 'empathic attunement' in chapter 7, when I describe my second experiment.

Having set out some of the changes in the ways that I have understood and used the term 'affect attunement' it is now time to describe the structure of the thesis itself.

Structure of the thesis

This thesis presents a theory of caregiving in adult life. As already described the central concept in the thesis is the concept of goal-corrected empathic attunement. I developed this concept in response to devising a reliable system for rating the interaction between the actors and the students as videoed in experiment three. It became clear to me in the course of the research that empathic attunement is goal-corrected. This means that when the caregiver attunes successfully to the communication of the careseeker, then careseeking behaviour temporarily shuts down and the instinctive exploratory system functions normally. I locate empathic attunement as a necessarily component of effective caregiving - attunement to affect without empathy is insufficient.

The first four chapters provide the building blocks for constructing and presenting the concept of goal-corrected empathic attunement. They draw particularly on attachment theory, studies of interaction between parents, infants and children and concepts of empathy. However they also cover some of the more general research in psychotherapy.

The following three chapters present the empirical studies designed to identify the elements and processes involved in the concept of goal-corrected empathic attunement and test various hypotheses. They are concerned to see whether (i) the phenomenon of affect attunement could be identified in adult psychotherapy; (ii) it referred to an interactive process and was associated with exploration; (iii) the attachment status of the students affected their ability to attune engage in goal-corrected empathic attunement (GCEA); and (iv) students who were given training would improve their performance in GCEA. Chapter 10 presents the results of this experiment.

The final chapter, chapter 11, reflects on the theoretical and empirical results of the thesis and possibilities for future work.

In more detail, the thesis is set out in 11 chapters of which this is the first.

In **chapter two** I explore in brief the contribution of research into the psychotherapeutic relationship to helping us understand the processes of interaction seen as important and beneficial in the helping relationship.

In **chapter three** I examine the research on careseeking-caregiving interactions in infancy in order to build up a profile of the dynamics aroused by these transactions.

In **chapter four** I transpose my understanding of the processes of careseeking and caregiving in infancy into the adult context. I draw on the work of attachment theorists to elucidate the dynamics involved in the careseeking-caregiving process.

In **chapter 5** I present the theoretical underpinnings for the concept of goal corrected empathic attunement. This chapter describes the thinking involved in developing this concept and locates it within a theory describing the dynamics of attachment in adult life.

In **chapter six** I set out the design and the results of my first experiment. This experiment was set up to see whether the phenomenon of affect attunement could be identified in adult psychotherapy

In **chapter seven** I describe my second experiment. This was devised to test whether empathic attunement was interactional. I wished to see whether one could judge it by looking at the behaviour of the therapist alone or whether one could only judge it in the context of what was happening between the two interactants - how each was responding to the other. This chapter presents the design and the results of the experiment. It also includes detailed analysis of the qualitative findings.

In **chapter eight** I present the design for the third experiment. I was testing three things: (i) whether goal-corrected empathic attunement (GCEA) could be reliably rated in careseeking caregiving situations; (ii) whether caregivers who had a secure attachment style would get a better score for GCEA than those who had an insecure attachment style and finally (iii) whether one could improve GCEA through training. **Chapter nine** is devoted to the work involved in establishing a reliable score for GCEA.

In **chapter ten** I present the results from the third experiment. I developed three measures for GCEA - two subjective measures and one objective measure. I explore the relationship with measures of attachment and the training the students received.

In **chapter 11,** I discuss the design of the study, the results and suggestions for future work.

CHAPTER TWO

RESEARCH ON THE PROCESS OF INTERACTION IN ADULT PSYCHOTHERAPY

> "To good old British empiricists it has always seemed self-evident that the mind, uncorrupted by past experience, can passively accept the imprint of sensory information from the outside world and work it into complex notions; that the candid acceptance of sense-data is the elementary or generative act in the advancement of learning and the foundation of everything we are truly sure of. Alas, unprejudiced observation is mythical too. In all sensation we pick and choose, interpret, seek and impose order, and devise and test hypotheses about what we witness. Sense data are taken, not merely given: we *learn* to perceive."
>
> (Medawer, 1962, p. 133)

Introduction

On the whole psychotherapy is a private treatment paid for out of personal income. Because of its relative under-representation in the public services there have been few large scale publicly funded research projects into its effectiveness. Most notable of these was the work of the Chicago group in the 1940s and 50s of which Carl Rogers was a leading figure. More recently in the United Kingdom, the Department of Health commissioned a review of psychotherapy research driven by the current interest in evidence based provision of services. This was published by Roth and Fonagy (1996) under the title 'What works for whom?: a critical review of psychotherapy research'.

The review by Roth and Fonagy reflects what is actually happening in the field of psychotherapy. The picture that emerges is not that of a unitary form of treatment.

Rather there are a cluster of psychotherapies, psychodynamically oriented therapies, cognitive behavioural therapies- interpersonal, systemic, integrative, group, family and so on. I quote at length from Roth and Fonagy's introductory chapter to show the scale of the problem and the issues involved.

> "..there is considerable cross-fertilisation between treatment approaches, in terms of both theory and technique. Currently, for example, there is a degree of convergence among clinicians rooted in psychoanalytic practice and those whose interests lie primarily in cognitive-behavioural techniques. While the latter are increasingly interested in non-conscious processes and the impact of the psychotherapeutic relationship, the former have shown more concern about the nature of knowledge representation and the significance of cognitive factors that may account for slow progress within psychotherapy. Ultimately, theoretical orientations will have to be integrated, since they all approximate models of the same phenomenon: the human mind in distress. For the moment, however, integration may well be counterproductive, as theoretical coherence is the primary criterion for distinguishing false and true assertions in many psychotherapeutic domains."
>
> (Roth and Fonagy, 1996, pp. 11-12)

In practice, integration is not common, psychotherapy research is generally small scale, conducted by a few researchers collaborating together in universities. Sometimes this is done in conjunction with clinically active colleagues who are motivated to understand why what they do seems to work or fail to work. For this reason the literature on psychotherapy is rather diverse. What we know is that there are a vast range of different psychotherapeutic paradigms. The register of the United Kingdom Council of Psychotherapy recognises eight distinct psychotherapy sections (e. g. psychoanalytic and psychodynamic psychotherapy section, hypnotherapy section, family, marital, sexual therapy section) between them representing in the

region of 60 organisations each with their own particular orientations to theory and practice.

While I understand the reasoning behind the statement of Roth and Fonagy quoted above, I find their reluctance to seek general theories unsatisfactory. It seems to me that the essence of psychotherapy is an effective response provided by one or more persons to another human being in distress who is seeking help. Psychotherapy is a response to careseeking. For each individual the dynamics of careseeking and caregiving go back to infancy. A theory of careseeking and caregiving is most naturally grounded in research in this area (infancy). A key concern of this thesis is to see whether such a theory can be provided.

As a beginning this chapter sets out to see whether traditional psychotherapy research has looked to the field of infant development to help understand the processes involved in the early careseeking caregiving relationships in order to elucidate careseeking caregiving behaviours in adult life. I am also interested in whether the researchers have considered the possibility that an understanding of the dynamics of careseeking and caregiving would help to understand the process of psychotherapy itself.

At the same time I am interested in what psychotherapy researchers have discovered about the process that goes on between careseekers and caregivers. This is a traditional concern in the field of counselling and psychotherapy, where those who study what is known as 'process' are interested in the interaction between therapist and client and the relationship formed between them. Process is a word that carries several meanings. It sometimes refers to interaction, sometimes to relationship, sometimes to both verbal and non-verbal sequences of behaviour, sometimes to only one dimension of interaction. This chapter, presents the work of key researchers in this rather broad field over the past 50 years.

The literature on this question is vast so I have selected my sample based on the following criteria:

i) eminence and contribution to the field;
ii) research that covered the major traditions of counselling, psychotherapy and psychoanalysis;
iii) major centres of funded research.

I will start with the work of the Chicago school of psychotherapy research. I will then examine the work of Carkhuff and Berenson who represent a more counselling tradition. Finally I will look at the work of Lester Luborsky who comes from a psychoanalytic background. He has taken the concept of transference and developed ways of exploring its manifestation and resolution in the therapeutic process. The idea of transference comes as we know from early experiences of relationship and how these experiences are projected onto others. Early experience of relationship clearly arises in the context of careseeking and caregiving.
The work of these authors cover a time period of about 50 years and can be located within different decades. I will present them chronologically starting with the Chicago group continuing with Carkhuff and Berenson, and end with the work of Luborsky.

The work of the Chicago group 1940-1960

Carl Rogers is often seen as a proponent of counselling (he tends to use the word counsellor where others would use the word therapist) and as being outside the more traditional psychoanalytic schools. I include his work under psychotherapy because his definition of the goal of therapy includes change at the level of the structure of the personality.

> 'during therapy the concept of self is revised to assimilate basic experiences which have previously been denied to awareness as

> threatening, the person becomes more realistic, he integrates previously denied experience.'
>
> (Rogers 1953, p. 419)

Awareness of and integration of previously excluded material would certainly fall within the goal of psychotherapy.

In 1942, Rogers published a complete account of a tape recorded counselling process. All interventions by client and counsellor were marked and all interventions by the counsellor were annotated by Rogers. What is clear from the account itself, the annotations and the remarks made by him is that Rogers sees the response of the therapist as crucial in terms of facilitating or inhibiting the clients exploration of his feelings and concerns. For example:

> S10 "I have a good ear for harmony then. But when I'm blocked, I seem to lose that, as well as my dancing ability. I feel very awkward and stiff.
>
> C11 M-hm. So that both in your work and in your recreation you feel blocked.
>
> S11 I don't want to do anything. I just lie around. I get no gusto for any activity at all.
>
> C12 You just feel unable to do things, is that it?
>
> S12 Well, I actually feel pressure on me just like that (pointing to abdomen) as near as I can refer to it, uh-pressing right on my dynamo, as you might say.
>
> (Rogers, 1942, p. 269)

Rogers annotated this sequence thus: "C11, C12. Good instances of entirely non-directive responses which simply recognise the feeling being expressed, make conversation easy, and enable the client to continue to explore his attitudes." While

Rogers notes sequence, he is basically concentrating on the nature of the therapist's response. He also picked up on the importance of the atmosphere created between therapist and client and attributed this to the therapist. He writes there are four definite qualities which 'characterise the most helpful counselling atmosphere':

(i) a warmth and responsiveness on the part of the counsellor which makes rapport possible, and which gradually develops into a deeper emotional relationship;

(ii) permissiveness in regard to expression of feeling - the client comes to feel that all feelings and attitudes may be expressed;

(iii) a clear structure in terms of time boundaries and what types of actions are permitted during the session;

(iv) freedom from any type of coercion or pressure.

(These four points are taken from pp. 87-89, Rogers (1942))

While atmosphere is something that one would normally assume to be the product of interaction; Rogers puts it down to the behaviour of the therapist, how the therapist is conducting him or herself, and the setting of structure in terms of time boundaries.

Fred Fiedler (1953) also took the view that the dominant party to the therapeutic encounter is the therapist:

> "the relationship is created by the therapist; all psychotherapies have as their effective core the interpersonal relationship rather than specific methods of treatment; and the therapist's conveyed feelings rather than his methods are the prerequisites to the formation of a therapeutic relationship."
>
> (Fiedler, 1953, p. 297)

Fielder's study was carried out on a sample of 16 cases and looked at several hours from the beginning, middle and end parts of therapy. Some cases extended into the hundredth or two hundredth hour of treatment (see page 311). Given this broad range of sampling, Fiedler found that the patient is almost immediately aware of the

therapist's feeling towards him. He also found that "in order to have a patient who expresses his feelings freely, one must be a therapist who has favourable attitudes towards his patient" (p. 313).

His observations of 'successful' and 'unsuccessful' therapists led him to the view that the differences between therapists, were not necessarily intellectual, but could also be based on emotion, in terms of their feelings for their patients. He explored what feelings are found in 'good' therapists and what feelings are found in 'bad' therapists. He found that 'good' therapists see their patients as more like themselves and assume their patients are more similar to themselves (see Fielder, 1953, pp. 296-315).

Fielder carried out various studies that suggested that he saw the therapist as the pivotal figure in the therapeutic process. For instance he carried out a study on whether the therapeutic relationship is primarily a function of the therapist's competence or of the therapist's method and orientation. He also set out to challenge the assumption that therapists' trained by different schools create different kinds of relationships (better/worse)[1].

Fiedler (1953), goes on to provide further evidence that 'the therapist plays the determining part in shaping the relationship' (p. 302). He got judges to rate therapists working with different patients and also had them re-rate the therapists with the same patient but using a different therapeutic session. His findings suggested that therapists are quite stable from patient to patient and are not affected by differences in the content of the hour or differences between patients.

[1] He explored this by asking a number of therapists of various degrees of reputed competence from different schools to take part in a project involving a Q sort of 'what they considered to be the ideal therapeutic relationship'. Two different sets of statements were used and three different types of therapists co-operated. The therapists were drawn from the psychoanalytic, non-directive, and Alderian schools, as well as some who considered themselves to be eclectics; several non therapists also co-operated. He found that (i) therapists of different schools see the same elements in the relationship as important and differences in school and method do not lead them to attempt the creation of a relationship which differs in essence from those which therapists of other schools seek to create; (ii) non therapists described the ideal therapeutic relationship in terms no different from those of therapists, indicating that the therapeutic relationship is not unique to psychotherapy but can be found - or at least imagined by those who have never experienced therapy; (iii) therapists who were reputed to be experts agreed more highly with experts of different schools than with non experts within their own school.

Rogers and Dymond describe a massive programme of research into Client-Centred Therapy undertaken at the University of Chicago in the early 1950s.

> 'It studied the progress of 80 individuals - clients, "drop-outs" and controls over a period ranging from a few months to four years. It involved the administration of a six-hour battery of tests on more than two hundred occasions to these individuals, the recording of well over a thousand therapeutic interviews, and the transcription of many of these interviews for further research and analysis.'
>
> (Rogers & Dymond, 1954, p. 413)

It is interesting that in spite of this detailed attention to *interaction* Rogers seemed to stick with the idea that the process was predictable and the outcome inevitable provided the therapist behaved in certain ways.

> "whether by chance, by insight into personality, by scientific knowledge, by artistry in human relationships, or by a combination of all these elements, we have learned how to initiate a describable process, which appears to have a core of sequential, orderly events and which tends to be similar from one client to another. We know at least something of the attitudinal conditions for getting this process under way. We know that if the therapist holds within himself attitudes of deep respect and full acceptance for this client as he is, and similar attitudes towards the client's potentialities for dealing with himself and his situations; if these attitudes are suffused with sufficient warmth, which transforms them into the most profound type of liking or affection for the core of the person: and if a level of communication is reached so that the client can begin to perceive that the therapist understands the feelings he is experiencing and accepts him at the full depth of that

> understanding, then we may be sure that the process is already initiated.'
>
> (Rogers, 1953, pp. 44-45)

Rogers maintained that there was a predictable pattern to the way in which issues were presented for exploration and that this pattern was affected by the therapist's response to the client.

An example of research focusing on the processes operating *within* the psychotherapeutic session is work on the changing levels of client defensiveness during the progression of therapy. Seeman and Raskin (p. 213) refer to a 'measure of defensiveness', developed by Hogan (1948) and applied by Haigh (1949). Apparently, Haigh compared the defensive behaviour of the first and second halves of therapy and found a decrease in defensiveness in the latter half of therapy. When the measure of defensiveness was compared with positive measures for the same group of cases (e.g. self acceptance, insight), the correlations between the measures indicated that, on the average defensiveness reduces as statements of self acceptance and insight increase.

It is interesting that researchers were noticing that when therapy was successful the level of client defensiveness in relation to the therapist lowered in the second half of therapy. A reduction in defensiveness was linked with an easing up in attitudes to self and others. I would suggest that a reduction in defensiveness must indicate that the therapist is relating in a way that does not arouse defensiveness in the client or that they can respond to the client in such a way as to make it less necessary for the client to defend themselves.

There is interesting research from the field of child development which throws light on defensiveness which I will return to in the next chapter of this thesis. I will also suggest in that chapter that the effect of process in potentially strengthening and

affirming a sense of self is something that can be achieved outside psychotherapy in the interaction of mother and infant. Rogers himself felt no need to derive his conclusions from such a developmental hypothesis. Instead he pursued a purely inductive approach:

> "We endeavour to describe, study, and understand the basic process which underlies therapy, rather than warp the process to fit our clinical needs or our preconceived dogma or the evidence from some other field."
>
> (Rogers, 1953, pp. 45)

Given such views, it was never likely at this point that psychotherapy research would have looked to ethology, biology, information processing or general systems thinking to make sense of the processes being observed. They were more likely to be influenced by the research going on in psychology at that time, which among other things was concerned with deriving valid measurements of various individual characteristics (such as defensiveness, self acceptance, self perception etc.).

In conclusion therefore one can say of the early researchers of the Chicago group that they were highly attentive to process and outcome, and the individual characteristics of the therapist that facilitated a positive outcome. The researchers were interested both in the process of change and in the nature of what was being changed - i.e. personality structure. In addition they also developed measures for rating the outcome of therapy. However while they were studying interaction they tended (i) to study the individual behaviour and personality characteristics of the therapist as the dominant person and not interaction per se and (ii) they were decidedly against locating the study of therapeutic process outwith the therapeutic encounter itself and therefore by definition had no interest in seeking to understand the dynamics of psychotherapy by examining the processes involved in the interactions taking place between infant careseekers and their caregivers.

From a focus on the individual to a focus on interaction 1960-1980.

I have chosen to concentrate in this section on two main authors, Carkhuff and Berenson, one of whom, Carkhuff is a major name associated with psychotherapy research of this period.

These researchers took the view that all helping interactions had a 'for better' or for worse' effect upon the person being helped. Like Rogers[2] they thought that what facilitates these interactions in the direction of 'for better' are the existence of certain core dimensions attributable to the person who is helping, which were: a) empathic understanding; b) positive regard; c) genuineness; and d) concreteness or specificity of expression. They saw these rather than techniques as the keys to success.

> "We find, for example, that the helper's final, not his initial, level of empathic understanding is related to patient improvement in therapy...the implication is that ultimately the helper's effectiveness is related to his continuing depth of understanding rather than his ability to 'technique it' during early phases of therapy. Indeed too much empathy too early in therapy may have a deleterious effect upon patient development because it may create too much tension and anxiety in the helpee."
>
> (Carkhuff and Berenson, 1969, cited in cited in Carkhuff and Berenson 1977, p. 8)

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[2] The core conditions necessary for successful psychotherapy according to Rogers:

i) The presence of a relationship - 'two persons are in psychological contact';
ii) The state of the client - the client should be in a state of vulnerability or anxiety - incongruence;
iii) The state of the therapist - the therapist should be within the confines of this relationship, a congruent, genuine, integrated person;
iv) The therapist must experience acceptance of the client;
v) The therapist must experience empathy for the client;
vi) The client must experience the therapist's empathy and acceptance.

(Rogers 1957 in Kirschenbaum & Henderson 1990, p.224)

They worked out five levels of therapist behaviour for each of these core dimensions, expressing the view that level 3 was the 'minimally facilitative or effective level of functioning'. The five levels actually demonstrate a deepening process of communication and interaction that they feel is necessary to facilitate change. They track the reciprocal interaction between therapists and clients and they identify the nature and variety of the affective communication between clients and therapists.

Carkhuff and Berenson put a primary emphasis on the helper's capacity to facilitate exploration. They make the point that exploration is not an end in itself but without it nothing else meaningful can happen.

> "We need to be able to train helpers to respond fully to the helpee's frame of reference. These responses need to be a great deal more than simple-minded reflections. The helper's ability to respond must take him fully into the helpee's experience, not only to facilitate helpee exploration but also to teach the helpee how to explore."
>
> (Carkhuff and Berenson, 1977, p. 153)

That Carkhuff and Berenson were tuned in to interaction is evident from the following quotation:

> "The accuracy of the helper's responsiveness is dependent upon the helper's listening skills. The level of the helper's listening skills is dependent on the helper's observation skills and the level of the helper's observation skills is dependent upon the helper's attending skills. Responding is much much more than a verbal exchange. Responding incorporates the complexities of attending:

attending involves physical, emotional, and intellectual attending, observing and listening."

(Carkhuff and Berenson, 1977, p. 155)

While interaction is clearly the vehicle of the exploratory process the dominant focus is on the skill of the therapist.

Carkhuff and Berenson produced valuable work in terms of addressing the process of change and also examining what facilitates change. They build on the work of the Chicago group. What they offer in addition to the work of the early researchers is a much more carefully thought out review of the elements of affect intensity, empathy and responsive interaction. The communication of affect from the therapist to the client and the client to the therapist is highlighted.

What these researchers notice is the fact that the way the therapist responds to the expression of affect affected the level of exploration that developed between them. They note the effect of the level of affect intensity displayed by the therapist in *response* to the client's presentation of affect (see pages 8-18, Carkhuff and Berenson 1977). They do not seek a theoretical explanation to account for why this should be so. Again, however, I would suggest that these researchers point us to the fruitfulness of researching infant caregiver interactions. The communication of affect is largely non-verbal and therefore reaches back to the earliest forms of communication in infancy. This is not a route that the researchers took themselves, instead they concentrate on detailed analysis of interaction and the effect of therapist responsiveness on the client's exploratory process (see appendix 1) .

I will now turn briefly to the work of psychotherapy researchers during the past twenty years noting in particular the work of Lester Luborsky.

Psychotherapy research 1980-2000

In the 1980s there was a return to the study of the therapeutic relationship to see what in the relationship itself contributed to clients getting better or getting worse, following a period of therapy (see McLeod, 1994, p.142). During this period there has been a proliferation of research instruments designed to measure the psychotherapeutic process itself.

McLeod (1994) lists the problems with the study of psychotherapeutic process, starting with the fact that the word itself means different things to different researchers. According to him there are at least four definitions of the term process in use:

(i) Process is a general condition that exists in a therapeutic relationship, for example, an emotional climate of warmth and acceptance:

(ii) A process consists of a sequence of behaviours or actions engaged in either by the counsellor, the client or both together;

(iii) Process refers to aspects of the experience of either the client or the counsellor;

(iv) Process refers to contractual aspects of therapy such as frequency, length or number of sessions. (p142)

McLeod (1994) concludes,

> "However process is understood or defined, there is a general agreement that it comprises a highly complex and elusive set of phenomena." p. 143

Lester Luborsky (Graff & Luborsky, 1977; Luborsky & Crits-Christoph, 1988), developed the concept of 'The Core Conflictual Relationship Theme', as a result of trying to trace the basis for his clinical judgements. He came to the view that most of his judgements were based on attending to the patients' accounts of narratives of interaction either with him/her self or with other people. He then noticed that there was a recurring theme to these interactions. He identified three components to these narratives - a) what the patient wanted from the other person; b) how the other person reacted and c) how the patient reacted to their reactions. Luborsky linked his perception of pattern with the presence and manifestation of transference phenomena. In his 1994 paper he describes the method he arrived at for gaining reliable ratings of the CCRT. His aim was to use the system to test Freud's propositions in relation to transference. He used judges to rate transcripts, the transcripts were marked off in relation to the units being analysed and the units themselves were rated in line with pre-defined categories.

Luborsky's work has been very influential and much referenced, (Allison, 1994).His work is aimed at testing hypotheses which inform his clinical diagnosis and intervention. The theoretical framework informing the research is steeped in an object relations interactional model of personality development. As such it is highly relevant to my thesis. Luborsky is examining the way transference presents over time. He sees transference as having its origins in the past. I will suggest in chapter three that there is now ample research from the field of child development to cast light on the interactive patterns that develop between infants and their caregivers and the variation of these patterns based on caregiver sensitivity and responsiveness. .

Finally in order to conclude this section I will quote briefly from another contemporary researcher who I consider representative of much current work in this field in that he is using modern technology to observe and record the verbal and non verbal process taking place between therapist and client. His work is in the area of

affect attunement which I will introduce into the thesis in the next chapter; it is highly associated with infant caregiver interactions.

Anstadt and his colleagues in Germany, (Anstadt, Merten, Ullrich, & Krause, 1997) completed a rigorous study of 11 brief therapies carried out by therapists of different modalities - cognitive behaviourist, psychodynamic, client centered[3]. They used Luborsky's concept of the Core Conflictual Relationship Themes (CCRTs) as a baseline for judging outcome and used the instruments developed by Friesen & Ekman, (1984, 1986) - Facial Action Coding System - (see also Ekman, 1975, 1993) to assess the expression of emotion by both parties. They found that therapists who compensate for emotional expression have better outcomes. Such a therapist might, for example, respond with an expression of surprise, or sadness, or distress to an account which the client produced without much emotion.

This seems to imply that the therapist who can catch the underlying emotion and surface it, or who can bring in the emotions of surprise or curiosity, is more effective than one who responds with the same affect that is being expressed by the patient. This also links with the work of Berenson and Carkhuff referred to earlier. For example, these researchers stress the need to raise arousal levels on some occasions and lower them on others (see the charts in appendix 1) and again is something that has been researched by developmental psychologists which I will introduce in my next chapter.

While this work (Anstadt et al 1997) in particular is aware of the research on infant caregiver research (such as the interplay of facial emotional expressions between caregivers and babies on the developing relationship between them) they do not look to the infant caregiver relationship to provide a paradigm for understanding the

[3] The therapists were required to have worked with at least 150 cases, have five years experience and training responsibilities in their field. All treatments were video recorded using a split screen technique. The researchers were testing the hypothesis that affective facial behaviour of therapists and patients in terms of whether the therapist mirrored the expression of affect presented by the patient or compensated for the affect in the first session would be predictive of treatment outcome.

processes involved in caregiving careseeking relationships in adulthood of which psychotherapy is one form. They do not conceptualise adult psychotherapy as a careseeking caregiving process which activates the dynamics of attachment and thereby all the associated secure, insecure and turbulent relationship patterns that such a context is likely to elicit.

Conclusion

What all studies on process have in common is a wish to try and get at what are the important features of therapy, how does it work, what do clients say or remember they found helpful[4], what kinds of issues come up and is there a pattern to their resolution that relates to therapist or client behaviour. What all of them do is to get right into the detail of the interaction taking place between therapist and client. Between them they represent a vast amount of careful and detailed work that takes as its reference point the unit of interaction itself or concepts related to the interactive process such as the effect on here and now interaction of experiences of relationship in the past.

Between them these researchers point to the importance of (a) the process of interaction between therapist and client; (b) enabling the client to explore their concerns; (c) responding appropriately to the level of affective arousal in the client; (d) empathic response maintained and deepened over time; and (e) the way in which relationships experienced in the past are acted out in the present in relation to the therapist so that the therapist is responded to as if they had the same attitudes and feelings towards the client as someone from their past.

What McLeod (1994) says is needed is a

[4] I am thinking of the work on significant moments (Hardy, Shapiro et al 1998)

'theory that will allow the interactions between these phenomena
to be understood' (1994, p.150)

He reaffirmed this view in 1998 in his chapter on the current state of psychotherapy research (p. 343)

I agree with McLeod and suggest that what has been missing in psychotherapy research is a theory of interaction. I suggest that what we need now is a theory of interaction that takes account of the biological nature of careseeking and caregiving processes and the particular dynamics aroused between caregivers and careseekers when careseeking is presented in less than straightforward ways in adult life.

There are a number of aspects of the research quoted in this chapter which I make use of in chapter five in constructing the concept of goal-corrected empathic attunement. For example I make use of (i) the observations of attunement to affect, and affect regulation; (ii) the quality of empathic response; (iii) the role of defensiveness in relationship; (iv) how experience of relationships in early childhood both filters what one sees and responds to in the here and now, and affects how one processes that information. But before I do this I need to set the research covered in this chapter in the larger context of developmental processes in infants and young children and set these in context of an instinctively based biological theory of attachment between caregivers and careseekers.

It seems to me that most psychotherapy research has not had a theory of caregiving based on an understanding of developmental processes and that this information was not available to the profession until recently. An exception has been research based on the ideas of Freud. He had his own theory of personality development from which he evolved therapeutic technique and practices. This aspect of Freud's work has, however, had much less influence on research than on practice. Much of the work

since his time has focused on aspects of therapeutic technique, dimensions of psychotherapy or outcome.

Much of dynamic psychotherapy has been based on reconstructed accounts of early childhood development, based on what adults remember, and what they present as problems and concerns. We now have a wealth of research on what actually happens interactively between caregivers and careseekers at the earliest stages of development. It seems plausible to assume that a better understanding of the processes that lead the human infant to seek help from another person and what happens to the growth of that infant when this process goes well or badly may be relevant to the processes we observe in the adult domain when a distressed adult seeks help in a psychotherapeutic context.

In my next chapter I will present evidence from the world of infant research to support a theory of effective caregiving within adult psychotherapy based on infant caregiver-interactions.

CHAPTER THREE

INFANT CAREGIVER-INTERACTIONS: THE PROCESS OF AFFECT IDENTIFICATION, COMMUNICATION, AND REGULATION

"although psychoanalysis is avowedly
a developmental discipline it is nowhere weaker, I
believe, than in its concepts of developmental"

(Bowlby, 1988, p. 66)

Introduction

Psychodynamic psychotherapy has traditionally seen a link between experiences of relationship in early life, and problems with relationships or dysfunctional relationships, in adult life. The centrality of the relationship between therapist and client in terms of personality change and development have been confirmed. However as we have seen, few researchers have taken seriously the nature, purpose and function of the dynamics of interaction between careseekers and caregivers.

During most of the time that research was being conducted into the adult psychotherapeutic process little was done on researching the actual happenings that take place between infants and their caretakers. Bowlby was one of the few practising adult psychoanalysts and child psychiatrists who was researching this area. He made connections between the *actual experience* that children have with those who look after and care for them, how they process that experience, and the effects on later relationships in adult life.

Some psychotherapists have now become interested in attachment theory as a paradigm for psychotherapeutic practice and research. However most still rely on the theoretical constructions of experienced clinicians who have formed their views on human development from working with children or adults who have suffered abuse and or neglect in childhood. Even though most psychotherapeutic trainings now require a pre-clinical year or more, devoted to 'normal' infant observation; understanding of these observations is still influenced by the theoretical paradigm favoured by the particular training institute in question. The most influential of the psychoanalytic frameworks used by training institutes in general, whether they be adult or child focused, is the work of Melanie Klein. While Roth and Fonagy (1996) take the view that each individual psychotherapeutic paradigm needs to be theoretically coherent, there is currently an interest in something like a theory of interaction which would go some way to making sense of the helping relationship.

This chapter sets out to explore the interactions that take place between infants and their caregivers and the effect of these on the developing pattern of relationship established between them. I start with a paper by Gyorgy Gergely. In this paper Gergely who is himself a developmental psychologist provides a bridge from the world of psychoanalysis to the world of observation and experiment. He basically points out the impossibility of the position of either Klein and Mahler, both prestigious figures in the field of child and adult psychotherapy, in relation to their understanding of child development.

Not all psychoanalysts shared Freud's or even Klein's view of infant development. Ronald Fairbairn (1952) and others saw the infant as person seeking from the start of life and presumed the development of a dynamic mental structure in response to actual experience with caregivers. The work of the object relationists is supported by the psychobiologists and infant researchers who explore amongst other things the regulation, and communication of affective states, and the way that this process is embedded in infant caregiver interactions. This work reflects Bowlby's requirement

that theory should be bedded in what actually happens in infancy and a theory of interaction in adult life that could inform the psychotherapeutic process.

From deduction to construction - from Melanie Klein to Gyorgy Gergely

> "The image of the biological newborn needing 'socialisation' to become a person does not apply when attention turns to evidence for complex psychological expressions in the responses of contented healthy newborns to people who take them as persons with intentions and feelings of companionship, and who feel pleasure when the infant responds."
>
> (Trevarthen, 1998, p.16)

Over the last twenty five years there has been an explosion of research into infant development. This work has relied on observation and experiment often in the infant's natural environment and has used cine video and audio equipment including sonographs to get at the fine nuances of interaction, verbal and non verbal taking place between infants and their caregivers. This work has produced evidence that contradicts previously held beliefs within such diverse fields as psychoanalysis and cognitive psychology about the way that infants make sense of the world and the way they relate to and respond to people and inanimate objects. A title of a recent book 'The Scientist in the Crib" by Alison Gopnik et al (Gopnik et al., 1999) captures the way that infants are now regarded.

In 1992 Gyorgy Gergely published a remarkable article which bridges the world of adult psychoanalysis and infant research. In it he considered the difference between Mahler and Melanie Klein in relation to their understanding of the origins of defensive splitting and projection and discusses the scientific evidence for both concepts. Klein believed that children were born with an innate death instinct from which they were continually threatened by destruction; in response to which they split off these

aggressive impulses and projected them into an external object; this object or objects then become target(s) of feared fantazised persecutory attacks. Mahler did not believe in an innate death instinct. She located the origin of defensive splitting in a much later phase of development; in what she termed the rapprochement crisis, which starts somewhere between 18 months and two years. The mother is seen as "all good" or "all bad" in relation to the dual experiences of both longing for the mother and fearing engulfment[1].

Gergely devotes most of his article to outlining the assumptions about child development inherent in the concept of defensive splitting and projection. Because this work gets to the heart of the difference between theoretical reconstructions of childhood experience and experimentally derived information about the process of development, I will summarise Gergely's observations and use his work as a bridge from which I can bring in some of the relevant research on infant development.

To arrive at the formulation of defensive splitting and projection, Gergely suggests that both Klein and Mahler imply a differentiated representation of self and other as:

1. separate physical objects;
2. causal agents or recipients of actions;
3. separate minds with non-identical intentional states:
4. objects that retain their identity while being represented as objects of different (and ambivalent attitudes).

(Gergely, 1992, pp. 18-19)

According to Gergely, for Klein's theory of defensive splitting to hold up the newborn infant would have to be capable of all the above. While Mahler by locating the origin of defensive splitting later in the child's development avoids these particular assumptions, according to Gergely she holds that

[1] See page 16 of article for a full description.

> "during the first weeks of life, the infant is surrounded by a 'quasi-solid stimulus barrier', an 'autistic shell which [keeps] the external stimuli out' [Mahler et al, 1975]."
>
> (Gergely, 1992, p. 15)

Though Mahler and Klein differed from each other in the way that Gergely outlines, they both represent a significant influence on the way individual dynamics are still understood by adult psychotherapists and group analysts in the United Kingdom. They also both differ from the object relations school of psychoanalysis spearheaded by Ian Suttie (1935, 1988) and expressed most fully by Ronald Fairbairn (1952). What distinguished Fairbairn and his followers from other psychoanalytic theorists of the time (and now) was that he saw the infant as *person seeking* from the start of life as opposed to pleasure seeking or seeking relief from unpleasant instinctual drives. What has emerged through the studies of the developmental psychologists is that the view of the infant engaging with the world of people from the start is a more accurate picture of infant development than Klein's.

What all theorists in the adult domain have in common is a wish to understand the mechanisms by which disturbed adults tend to replicate patterns of relationship with other people across a variety of situations and contexts irrespective of the passage of time, and how they seem to maintain the character of these relationships in spite of finding them unsatisfactory in one form or another. Psychotherapy, as discussed in the last chapter is sought out primarily as a response to distress. The expectation is that understanding something about the origins of behaviour and the mechanisms which support the repeating pattern might free one from its repetition and compulsion. All object relation theorists share the view that the origin of present difficulties in relationship are located in the past and that the mechanism by which these difficulties are maintained in the present is through the process of internalising

the experience of self in these many and diverse relationships in the form of internal working models.

In other words early relationships are internalised in such a way that they act as dynamic structures within the person: these are activated by and influence the pattern of current relationships. Depending on the severity of the pain involved in the original gestalt of relationships as experienced by the person they are more or less open (permeable) to influence and change based on current experience of relationships. Fairbairn (1952) called these dynamic relationship structures 'internal objects'; Bowlby (1979) called them 'internal working models' Heard and Lake (1997) call them 'internal working models of the experience of relationships' in order to differentiate them from the fact that we create internal working models of all experience; Daniel Stern (1985) calls them 'experiences of relationships that are generalised'. What these dynamically orientated psychotherapists have in common is a view that the person is a surveyor of their experience of relationship from the start, that images of the self and other operating together are stored and remembered for their predictive and adaptive value and used to guide and interpret subsequent relationships. They understand interpersonal behaviour as based and predicated on experience. This is what accounts for repetition of disturbed relationship patterns across the life cycle.

What the developmental psychologists are able to do is to provide the evidence for the way in which young infants relate to the world of people and objects and how they actively participate in responding to and regulating not only their own and others' affective responses but the way in which they apply reason and logic to the manipulation and perception of physical objects. Before examining the role of affect attunement in the identification, regulation and communication of affective states and the way that it is embedded in infant caregiver interactions, I will present a short account of two experiments designed to show how infants make sense of the

expression of affect, expect some order and consistency to its expression and expect affect and behaviour to be congruent.

Gergely and Peter Fonagy (1998) developed an Emotion Action Task which involves presenting one year old infants with video images of adults relating to an object. The infant is exposed to several different sequences. The first one involves a picture of the adult being pleased to see the object and then reaching out for it and drawing it towards her. The actor holds the affect for a few moments so that the infant can absorb it, before reaching for the object. The test involves several variations on this scenario.

The sequences the infant sees are: (1) positive emotion followed by congruent action; (2) positive emotion followed by incongruent action; (3) negative emotion followed by congruent action; (4) negative emotion followed by incongruent action. So for example the last video sequence is the actor showing displeasure towards the object to the point of displaying an expression of disgust, and then following this by reaching out to the object, hugging it to them and displaying pleasure. What Gergely and Fonagy have found is that the infant categorises the person as irrational if the gestures are incongruent with the emotion in the voice *if the congruent display comes first in the sequence of viewing*. They gauge this on the basis of the span of attention given to the different episodes by the infant and the infants expressions of puzzlement and confusion. Gergely (1996) provides evidence that non verbal infants are aware of lack of congruence between the affect being displayed on a person's face and the emotion that they are experiencing.

Affect regulation is linked with caregiving from the start of life.

> "The emotional expressions of the infant and their caretaker function to allow them to mutually regulate their interaction."
>
> (Edward Z. Tronick, 1989, p. 112)

In 1983, Hofer wrote

> "hidden within the interactions between infant and mother, we and others have found a number of processes by which the mother serves as an external regulator of the infant's behaviour, its autonomic physiology, and even the neurochemistry of its maturing brain."

(Hofer, 1983) provides evidence from numerous animal studies which show that vital physiological systems which the young are unable to regulate themselves, are regulated by contact with the parent and that the physiological effects of separation from the parent are likely to be some of the cause of the distress expressed on separation.

> "Many of the more slowly developing separation responses may thus be due to withdrawal of the previous regulation supplied by the mother rather than being part of the acute emotional response to disruption of attachment."
> (Hofer, 1983, p. 199)

Later work by Schore (1994, 2000) suggests that the early social environment

> 'mediated by the primary caregiver, directly influences the evolution of structures in the brain that are responsible for the future socio-emotional development of the child.'

(Schore, 1994, p. 62)

His argument is that attachment patterns between infants and caregivers take place during the phase of development when the infant is dependent on the other for the regulation of their biological and neurological systems.

> "The resulting variety of affective interactions between the caregiver and the infant is imprinted into the child's developing nervous system. Different types of stimulation are embedded in these 'hidden' socio-affective interactions, and they elicit distinctive psychobiological patterns in the child. In response to such socio-environmental experiences, hormonal and neuro-hormonal responses are triggered, and these physiological alterations are registered within specific areas of the infant's brain which are undergoing structural maturation during a sensitive period.

Siegel (1999) suggests that a

> "child uses a parent's state of mind to help organise her own mental processes. The alignment of states of mind permits the child to regulate her own state of mind by direct connection with that of her parent... The study of emotion suggests that non-verbal behaviour is a primary mode in which emotion is communicated, facial expression, eye gaze, tone of voice, bodily motion and the timing of response are each fundamental for emotional messages."
> (Siegal, 1999, p. 121)

Mechthild Papousek (1994) found that certain characteristics of infant directed speech (the form of which is culturally specific in the sense of being adapted to the structure

of the language of the host country) do not vary across cultures and has at least four functions:

i) to regulate arousal and affect in infants;

ii) to draw attention to caregiver's speech;

iii) to guide infants in practising communicative subroutines;

iv) to mediate linguistic information.

Caregivers use tone, pitch and rhythmic modulation (melody) of their voice to regulate the affective arousal states of their infants. Other research confirms that infants are highly responsive to caregiver affect as expressed on the face and that their own arousal levels are affected by the interaction between them and either an emotionally available and attuned caregiver (Segal et al., 1995) or an emotionally absent (depressed) or non attuned caregiver (Stern, 1985).

Correct identification of affect by the caregiver affects the infants developing sense of self.

Susan vas Dias, a child psychotherapist trained at the Anna Freud Centre and with over twenty years as a consultant child psychotherapist suggests that what is *also* going on (in addition to regulation) is that the mother is making the baby's internal emotional world intelligible to the baby. She builds on the fact that because affect is always accompanied by visceral arousal, the *experience* of affect is located in the body, therefore the infants direct understanding of self is through the experience of affective states. She suggests that by attuning to the infant's feeling state and framing it in words "Their [the caregiver's] tone will mirror the baby's affective state, the baby will feel attuned with and emotionally held, and their inner state/self validated. The labelling of the feeling state will facilitate the infant's ability to be familiar with, know, and scan how he or she is feeling. ... *and (he or she) will be able to build upon this to develop their own self-narrative and internal dialogue*" (my italics). (Vas Dias, 2000 p. 161). Of course when the infant's affective state is not validated, but

distorted, mocked or humiliated, the later clinical presentation according to Vas Dias, is of someone who has little self narrative, and does not experience their emotions - in other words does not have access to their core self. Such people present their silence for treatment (see Vas Dias, 2000).

Confirmation for the hypothesis of Vas Dias (that because affect is always accompanied by visceral arousal, the *experience* of affect is located in the body therefore the infants direct understanding of self is through the experience of affective states) comes from the work of Meltzhoff and his colleagues. This contrasts with Piaget who took the view that infants can only begin to know themselves and others after they have acquired the ability for symbolic play - somewhere between 18 and 24 months (in other words, that they access their sense of self primarily though their cognitive function), Nadel 1999, p.18. Andrew Meltzhoff (Meltzoff and Moore, 1977, Meltzoff, 1983, Meltzoff, 1992, Meltzoff and Moore, 1995, Meltzoff, 1999a, Meltzoff et al., 1999b)discovered that infants have the capacity to know that another person is like themselves within minutes of being born.

Meltzhoff's, (1983) work on imitation (infants as young as forty two minutes imitate facial expressions) shows that in order to imitate, the baby must understand the similarity between an internal feeling and an external face that they see. "Imitation is a behavioural measure indicating that newborns, at some measure of processing no matter how primitive, can map actions of other people onto actions of their own body." (Meltzoff, Gopnik & Rapacholi, 1999b, p. 18). Gopnik et al (1999) suggest that this behaviour indicates that "from the time we are born, we know quite directly that we are like other people and that they are like us" (p. 30). Meltzoff and Moore (1977) proposed that *when babies imitate they are linking the visual appearance of other people to their own internal kinaesthetic and proprioceptive feelings, connecting the visible bodily actions of others and their own internal states* (my italics).

Field et al (1982) have shown how consistently two to three day old babies can frown, smile, look surprised, imitating the expressions adults show to them. When, for example, new-born babies scan live faces, they show more fluid physical movements (of their arms, legs, hands and feet) and they use their voices (Brazelton, 1974). The Papouseks (1979) have filmed mothers and neonates greeting one another with smiles and direct eye contact. What is striking is that when the mothers were asked by the researchers to close their eyes for a period of two minutes following this type of greeting, their babies first of all looked puzzled, then distressed, then looked away.

Rovee-Collier & Fagan, (1981) and Field (1981)have demonstrated that infants have the capacity to remember and anticipate consequences of their own actions. The cross cultural work of the Papouseks' (1979), has indicated that infants are programmed to interpret a range of emotional expression on the human face and that parents are programmed to interpret the emotional response on the face of their infant.

By three months

> "babies co-ordinate their own expressions, gestures, and voices with the expressions, gestures and voices of other people."
>
> (Gopnik et al 1999, p. 31)

Judy Dunn (1999), when discussing the ways that infants develop a sense of who they are, suggests that in the early interchanges between infant and caregiver the caregiver takes both sides of the conversation with explicit comments on what the baby wants or feels: "Oh, you are feeling hungry, I know!" or "Oh all right, we know what you want!" (1999, p. 231) According to Dunn, parents frame the beginnings of intentional communication for the baby in order to make the world more intelligible to the baby and the baby more intelligible to them.

What these studies show is that infants have direct access to their own and others' affective states right from the start of life and that they respond to lively interested interaction with fluid physical movements, expressions of pleasure and vocalisations. Infants who have first witnessed congruency between actions and emotions do not engage with (withdraw from)subsequent incongruent behaviour.

> "At the age of two to three months, infants begin to give the impression of being quite different persons. When engaged in social interaction, they appear to be more wholly integrated. It is as if their actions, plans, affects, perceptions, and cognitions can now all be brought into play and focused, for a while, on an interpersonal situation. They are not simply more social, or more regulated, or more attentive, or smarter. They seem to approach interpersonal relatedness with an organising perspective that makes it feel as if there is now an integrated sense of themselves as distinct and coherent bodies, with control over their own actions, ownership of their own affectivity, a sense of community, and a sense of other people as distinct and separate interactants. And the world now begins to treat them as if they are complete persons and do possess an integrated sense of themselves."
>
> (Stern, 1985, p. 69)

How caregivers communicate to infants that they understand their affective state: the process of affect attunement

Stern (1985) refers to affect attunement as "the acts and processes that let other people know that you are feeling something very like what they are feeling", p. 138. "How can you get 'inside of' other people's subjective experience and then let them know that you have arrived there, without using words?", p. 138. Caregivers communicate to their infants that they are on their wavelength so to speak through what Stern (1985) calls cross-modal attunement.

> "For there to be an intersubjective exchange about affect, then, strict imitation alone won't do. In fact, several processes must take place. First, the parent must be able to read the infant's feeling state from the infant's overt behaviour. Second, the parent must perform some behaviour that is not a strict imitation but nonetheless corresponds in some way to the infant's overt behaviour. Third, the infant must be able to read this corresponding parental response as having to do with the infant's own original feeling experience and not just imitating the infant's behaviour. It is only in the presence of these three conditions that feeling states between one person can be knowable to another and that they can both sense, without using language, that the transaction has occurred. "
>
> (Stern, 1985, p. 139)

This is attunement to vitality affects. It is done in such a way that for instance, the tone and pitch of an infant's vocalisations are matched by the rhythm and intensity of the mother's hand movements. A sense of vitality and enjoyment communicates itself to observers; the pair are clearly in tune. At the other end of the scale, Stern provides examples of misattunement or non-attunement. These are painful to watch and involve either a lack of awareness of the baby's affect and intention as in the case of a psychotic or extremely depressed caregiver or a lack of willingness to engage with the baby for other reasons.

Stern describes observing an encounter which induced a feeling of angry tension in the observers, as the mother carried on with excited play (more in tune with her own needs), unaware of her infant's reluctance (Stern, 1985, pp. 197-8). What the observers saw the infant doing was mis-time her responses by a fraction; or use brief gaze aversion, just at the highest pitch of her mother's excitement. What is particularly significant is that the infant's strategy was to respond to her mother, rather than to initiate movements

herself. The interaction had no quality of creativity to it, as understood by the caregiver-infant mutually contributing to the play. In Stern's observation, the infant was following the mother.

Stern suggests based on observations of many such infants over time that when they are alone one of two things seem to happen. "They cut short their potential positive excitement, most likely by activating a disregulating mother as the evoked companion, or they show freer access to their own pleasurable excitement and can wallow in it, as if they inhibited or somehow prevented the activation of the RIG." p. 195-6

> "We do not know why some infants seem able to regulate their excitement so much more successfully when alone than when interacting with a disregulating parent. Whether we are talking about inhibited evoked companions or selective generalisations, it would appear that those children who are more successful at escaping the evoked presence of a problematic parent when alone gain the advantage of being able to utilise more of themselves. At the same time, they are dealt the disadvantage of living more alone in the world."
>
> (Stern, 1985, p. 196)

Beebe and Lachmann (1988) (quoted in Kiersky and Beebe, 1994) argue that "these mutually regulated bi-directional interactions between infant and caretaker provide the basis for an infant's pre-symbolic representations of self , other, and self with other." They suggest that "these 'interaction structures' provide a way of determining what 'being in tune with' the mother might feel like to the infant as well as what being misattuned might feel like... in this conceptual framework, the state of the other is perceived and expressed through moment-by-moment changes in time, space, affect, and arousal. Thus, the *timing* of communication between caretaker and child, the changing *spatial* relationship between the participants, and the degree of affective

stimulation and proprioceptive *arousal* are the significant dimensions of early social exchange." (Kiersky & Beebe, 1994, p. 390)

Stern, p. 197, gives an example of intolerable under-stimulation. He describes the case of Susie, 'a normally spunky infant, well endowed with all the capacities to appeal to and elicit social behaviour from any willing adult, plus a lot of persistence to keep trying at the faintest hint of success." Susie's mother however was depressed, preoccupied with a recent divorce and had not wanted Susie in the first place. Stern describes the situation where Susie was unable to spark enough so that her mother ever took over the up-regulation of excitation. In other words whatever Susie did or however vivacious she was her mother never responded in any way that would either match or increase her level of excitation. While in Susie's case her mother never actually took control of the down-regulation of excitation, Stern suggests that "her lack of responsivity acted as a drag on Susie's attempts to up-regulate."

> "The actual and fantasised experiences with a self regulating other are essential for encountering the normally expected range of self-experiences, and without the other's presence and responsive behaviour, the full range simply does not develop. There is a maturational failure, a 'self-regulating-other-deficiency disease.' This is just another way of stating that only a selected portion of the whole spectrum of self experiences of excitation may get exercised during this period resulting in a permanent influence during this sensitive period upon what experiences become part of the sense of a core self."
>
> (Stern, 1985, p. 198)

Affect attunement is the process by which one human being communicates to the other that they are on their wavelength. "Vitality affects therefore must be added to affect categories as one of the kinds of subjective inner states that can be referenced in

acts of attunement. Vitality is ideally suited to be the subject of attunement because it is composed of the amodal qualities of intensity and time and because it resides in virtually all behaviours one can perform and thus provides a continually present (though changing) subject for attunement. Attunements can be made to the inner quality of feeling of how an infant reaches for a toy, holds a block, kicks a foot, or listens to a sound. Tracking and attuning with vitality affects permits one human to be with another in the sense of sharing likely inner experiences on an almost continuous basis. This is exactly our experience of feeling-connectedness, of being in attunement with another. It feels like an unbroken line. It seeks out the activation contour that is momentarily going on in any and every behaviour and uses that contour to keep the thread of communion unbroken" (Stern, 1985 p. 55)

Stern video-taped many mother/infant pairs at two, four, six, nine, eighteen, twenty-four, and thirty-six months. He found that on showing these tapes to new or experienced groups of students they were inevitably struck by 'the sense that the two individuals are conducting their interpersonal business in a similar and recognisable fashion throughout', (Stern, 1985, p. 186).

Infants' responsiveness to affective interaction with caregivers and their response to loss of contact with caregiver

One of the first experiments carried out to test the hypothesis that infants (7 months) and mothers are actively engaging in meaningful communication is what have become known as *perturbation studies.* These studies were carried out by a number of people (Brazelton et al, 1974); (Trevarthen and Hubley, 1978); (Trevarthen, 1979a); (Tronick et al., 1977); (Tronick, 1989); (Oster et al., 1992); (Gergely, 1996). I will describe the original research carried out on this subject by Lynne Murray as part of her doctoral thesis in Edinburgh. She studied perturbations in infant (6-12 weeks old) caregiver interactions. Perturbation studies show that infants are distressed when 'out of contact' with a person with whom they have been experiencing pleasurable affective commerce. They show conclusively that infants are

communicating and that their smiles and other facial expressions are not just due to the passage of wind or the fanciful imagination of devoted mothers or fathers.

Murray set up three experiments:

i) the first involved interrupting a period of normal communication between an infant and their mother by the arrival of a researcher into the room and engaging the mother in conversation in such a way that the mother turned away from her infant;

ii) the second perturbation required the mother to stop communicating with her infant and adopt a 'Blank' face - while continuing to look at the infant;

iii) the third perturbation took place in the context of the mother and infant communicating with each other through video contact. This perturbation took the form of the researchers changing the images and sounds that the mothers and infants had of each other so that they were seeing and hearing each other out of 'real' time.

The outcome of these three perturbations has been described at some length by Lynne Murray in a recent article (Murray, 1998).

Before I describe the infants reactions to the perturbations I will quote Murray's own description of the way the infant and mother were communicating before the interruptions.

> "During the periods of normal interaction the infant's gaze was directed to the mother's face almost all the time, and the infant

> smiled, made active gestures and 'prespeech' tonguing movements
> and wide shapings of the mouth."
>
> (Murray, 1998, p. 131)

In her analysis of the infants' reactions to the three perturbations described in the previous paragraph, Murray noticed the following:

1 With the first perturbation, the infant's communication subsided and signs of positive excitement were reduced. There was no increase in signs of negative affect or in the incidence of displacement behaviours such as fingering the clothes, or sucking the fist. "Although the infant gazed less at the mother this seemed not to be a function of active avoidance of her, but rather reflected the infant's interest in the researcher."

2 When the mother presented a 'Blank Face', "the infant very quickly appeared disturbed. An initial form of response frequently occurred that suggested protest...active prespeech movements were at first sustained, if not intensified and frowning increased, and these behaviours occurred while the infant looked at mother. This phase of apparent protest was typically followed first by signs of distress, such as grimacing, or displacement activities of the hands, and subsequently by withdrawal, with the infant's gaze being averted from the mother's face and the head drooping."

3 "In the closed-circuit television experiment...when confronted with the replay sequence there was a rapid change in behaviour that in some respects resembled the response to the Blank Face perturbation. Gaze was largely averted from the mother and was interspersed with short, darting glances at her, and there were also signs of distress such as frowning and grimacing, and fingering of the clothes and face. However, unlike the response to the Blank

Face disruption, 'prespeech' tonguing and wide open mouthing occurred less often, and the impression was not so much one of protest, but rather one of puzzlement or confusion." Further analysis revealed that frowning and looking away were associated with the video replay while frowning and looking at the face were associated with the Blank Face perturbation.

Confirming the function of affect communication, work by Campos et al (1983) found that when 10 month old infants were exploring the surface of the visual cliff they will look to their mothers to see if they should proceed. If the mothers signal fear or anger most infants will not cross, but if the mothers present a joyful expression the infants will proceed. Infants react similarly to voice tone as to facial expression. The experiment showed that infant's regulate their own behaviour especially when presented with an ambiguous situation, by 'reading' the caregiver's face or tone of voice - this is what is known as social referencing behaviour. It confirms the work on voice tone and facial expression just referred to.

Bretherton, (1990) draws on a range of research which describes the way in which mothers differ in their sensitive responsiveness towards their infants during the infant's first three months. These interactive patterns were predictive of how the mother and infant were found to be communicating at the end of the infant's first year and were linked with secure and insecure attachment patterns.

As we have seen from research quoted earlier in this chapter, face-to-face interactions between infants and adults starting as young as three months are bi-directional (mutually regulated). Infants modify their affective displays and behaviours on the basis of their appreciation of their caregiver's affective response - they respond to turn taking signals cued by the caregiver (Cohn, 1987). This mutually regulated co-ordinated behaviour has led to interaction between infant and caregivers being described as reciprocal, synchronous or coherent. Brazelton and Cramer (1990) identify synchrony, symmetry and contiguity which organise into entrainment (i.e.

long sequences of anticipated responses) as associated with attunement and security. Such reciprocal behaviours have the quality of autonomy, play, and flexibility as one and then the other contribute to the sequence of events.

Caregiver-infant interactions: the patterning of relationship

In his 1989 paper Tronick describes two infant -parent interacting dyads each playing peek-a-boo.

In the first, the infant abruptly turns away from his mother as the game reaches its "peek" of intensity and begins to suck on its thumb and stare into space with a dull expression. The mother stops playing and sits back watching her infant. After a few seconds the infant turns back to her with an interesting and inviting expression. The mother moves closer, smiles, and says in an exaggerated voice, "Oh, now you're back!" He smiles in response and vocalises. As they finish crowing together, the infant reinserts his thumb and looks away. The mother again waits. After a few seconds the infant turns back to her, and they greet each other with big smiles.

In the second scenario, the infant turns away and does not look back at her mother. The mother waits but then leans over into the infant's line of vision while clicking her tongue to attract attention. The infant, however, ignores the mother and continues to look away. Undaunted, the mother persists and moves her head closer to the infant. The infant grimaces and fusses while she pushes at her mother's face. Within seconds she turns even further away and continues to suck on her thumb.

According to Tronick, in both instances turning away and sucking is the infants way of calming themselves down and regulating their emotional state. In the first example the mother is able to wait until her infant has 'recovered', in the second the mother pursues the infant in an intrusive manner, is unable to respond to the signals from her infant to move away giving rise to increasingly negative affect from the infant. If this patterns persists and becomes typical of the interactions between these dyads one

would predict that the first pair would have a happier more open and straightforward relationship and the second would be more fraught.

The second sequence of interactions is very similar to one described by Kiersky and Beebe (1994) referring to work carried out by Beebe and Daniel Stern in 1977. They describe a sequence of "chase and dodge":

> Looking at a sample of approximately six minutes at the beginning of a videotape play session, we observed a complex and rapid sequence in which mother 'chased' and infant "dodged." The mother chased by following the infant's head and body movements with her own head and body, pulling his arm, picking up to adjust his orientation or attempting to force his head in her direction. To every maternal overture, the infant could move back, duck his head down, turn away, pull his hand from her grasp, or become limp and unresponsive. The infant exercised a virtual "veto power" over her attempts to engage him in a face to face encounter.
>
> (Kiersky and Beebe, 1994, p. 41)

Tronick (1989, p. 113) has labelled *self directed regulatory behaviours* as: looking away, self comforting, and even self stimulation. He also gives an example of an infants goal-directed behaviour. He describes an infant reaching for something outwith its grasp. After each unsuccessful attempt he pauses, sucks his thumb, gets angry. The mother sees what he wants to do and brings the object just within his reach. The infant grasps the object and smiles. One can see what the infants experience might be if the mother was not paying attention (was not psychobiologically attuned) or for some reason (maybe depression, fatigue, illness) failed to respond so that the infant had repeated experiences of failure in reaching his or her goals and of having their affective intentions disregarded. The infant would begin to learn that his affective

message did not seem to impact on other people. "Other-directed and self-directed regulatory behaviours are part of the infant's normal repertoire for coping with sadness, uncontrolled anger, and the extremes of positive affect, which can turn into distress. They enable the infant to control the potential disruptive effects of these emotions and their extremes on his or her goal-directed activities." (Tronick, 1989, p. 114).

Patterns of affect attunement associated with effective caregiving

Tronick & Cohn, (1989) found that normal interaction between infants and caregivers was characterised by moves from affectively positive, mutually co-ordinated states to affectively negative, miscoordinated states and back again on a frequent basis. In his 1989 paper Tronick summarises his earlier observations (published in 1980) of infants who chronically experienced miscoordinated interactions. "These infants repeatedly engaged in self regulating behaviours (e.g., they turned away, had dull looking eyes, lost postural control, orally self comforted, rocked and self clasped). Cohn & Tronick (1990) came up with very interesting associations between caregiver behaviour and infant expression of affect (the infants were 7 months). For instance, mothers who were disengaged had infants who expressed more protest, mothers who were intrusive had infants who tended to look away more; mothers who were positive had infants who expressed more positive affect. Tronick (1989) sums up the situation in what Stern would call misattuned infant caregiver partnerships as "the participants are stuck in affectively negative miscoordinated interactive states, and their messages calling for change are disregarded." (p. 116)

The interactional states that characterise normal good enough interaction are ones which move from positive affect to negative affect and back to positive. Tronick (1989) would argue that such experience would enable the growth of more complex abilities in the infant, namely the "experience of having negative affect transformed into positive affect would enable the infant to elaborate his or her other-directed affective communicative and self-directed regulatory capacities and to use them more

effectively - to be able to maintain engagement with the external environment in the face of stress...From this experience, the infant develops a representation of himself as effective, of his or her interactions as positive and reparable, and of the caretaker as reliable and trustworthy." (p. 116)

It is clear from the studies quoted and the examples given that infants respond to what they are experiencing in ways that regulate their own affective states and that they seek out and enjoy positive affective interaction with caregivers. It is also the case that as they develop an interest in their physical environment they have a wish to influence it. Infants behaviour toward people and things can be described as goal-corrected. In terms of achieving a sense of competence in their interactions with people or things, infants are dependent on help from their caregiver to interpret accurately what they communicate or signal. Failure to reach their goals causes distress and provides a void in the area of competence. It is also the case that normal interaction moves from positive to negative to positive so that good interactions can be described as a process of rupture and repair. I return to these points as a major building block for my theory of goal-corrected empathic attunement in chapter 5. It is my view that *the self regulatory behaviours that we observe in infants are the beginnings of the instinctive goal corrected system for self defence*. I will also return to this idea in chapter 5. I now move on to explore whether affect attunement alone is sufficient for effective caregiving or whether something more is needed.

Affect attunement and empathy

Daniel Stern (1985, pp. 145) suggests that affect attunement is different from empathy as it occurs mostly automatically and largely out of awareness. Empathy on the other hand, involves the mediation of cognitive processes. What the two concepts share is emotional resonance. On the basis of his review of the literature on empathy, Stern suggests that empathy consists of at least four distinct and probably sequential processes:

(1) the resonance of feeling state;

(2) the abstraction of empathic knowledge from the experience of emotional resonance;

(3) the integration of abstracted empathic knowledge into an empathic response;

(4) a transient role identification.

While Stern agrees that what empathy and affect attunement share is the initial spark as he puts it, of emotional resonance, "..attunement takes the experience of emotional resonance and automatically recasts that experience into another form of expression. Attunement need not proceed towards empathic knowledge or response. Attunement is a distinct form of expression in its own right" (p.145). In my view this definition of attunement, i.e. "attunement takes the experience of emotional resonance and automatically recasts that experience into another form of expression" is the clearest definition that Stern offers of the act and process of attunement. It separates it from emotional resonance alone and defines it essentially as the giving of expression to the affect of the other in a way that the other can recognise as originating in and belonging in themselves.

Resonance, on the other hand, to my mind, involves accessing similar feelings to the other inside oneself that one may or may not have been conscious of. Resonance can take place intra-personally or interpersonally. This process happens almost out of consciousness and comes from being in attunement to the affective state of the other.

Affect attunement comprises two stages: stage one requires being in resonance[2] with the feeling state of another; stage two activates a desire to communicate one knows the affective the state of the other (cross modal matching of vitality affects, rhythm and shape) in such a way that the infant knows one knows their experience. Misattunement is the process whereby the other captures the infants experience

[2] Resonance may or may not activate the instinctual systems for careseeking or caregiving.

enough for the infant to know they are on their wavelength and then uses this connection to divert the infant towards another affective state, e. g. from wakefulness to sleep; from not feeding to feeding; from physically or emotionally calm to distressed.

Stern thus summarises mother-infant attunement as involving some form of matching, where what is being matched is the other person's emotional state and where the matching is cross-modal (i.e., is not dependent upon using the same mode of verbal or non-verbal communication by both interactants).

What Stern shows conclusively is that we pick up the affect of other people, what we do with it, how we interpret it and how we respond to it is another matter and largely dependent on our empathic capacity, how secure we feel and our level of arousal and well being. Empathy can be understood as our capacity to move away from ourselves as the locus of our reference for understanding emotion and sensation and see these phenomena as they might be experienced by another person, given *their* context and the information coming to them from their senses and cognition. It involves the capacity to read another's mind and put oneself in his or her shoes.

When caregiving is benign and attuned the language that accompanies the interactions between caregiver and infant, is described by Lynne Murray as 'motherese' (Murray and Trevarthen, 1985). It is clearly understood by both, is a source of enjoyment, stimulation and arousal and is interactive and goal directed (as demonstrated by the perturbation studies described earlier). What that experiment showed was the level of distress induced in the infant when they were given the 'pretend mother' or the 'absent mother' to relate to having enjoyed the experience of live contact. Anyone who has seen the spilt screen video images of this experiment cannot fail to be convinced that 'motherese' is a powerful form of communication to which both are equally contributing.

What these studies are helping us to see is that careseeking and caregiving is an interactive process of great complexity. Affect regulation in the very young infant is clearly important to keep physiological arousal levels within manageable and comfortable limits. In addition, affect attunement, misattunement, non attunement and empathy are clearly involved in the process of establishing reciprocity in the caregiving relationship. Affect attunement that is not followed by empathy will lead to distrust and defensiveness. Affect attunement that *is* followed by empathy should support a feeling of being able to trust one's affective experience and feel secure in the relationship.

> Thus, an infant's distress becomes a resonance motivating an empathic caregiver to contact the infant tenderly and to keep making changes until the infant is comfortable; i.e., the distress becomes a basic form of infant communication which says 'please change what is happening" (Emde, Gaensbauer, and Harmon, 1976, pp. 85-87). Conversely, the infant's pleasure becomes a process of resonant pleasure which reinforces (rewards) an empathic caregiver's maintenance and /or repetition of ongoing conditions and becomes a basic form of infant communication which says. "Keep up what you are doing, I like it, [please continue]" (Emde et al, 1976, p.87). Stated in another way: empathic care favors interruption of the infant's distress but opposes interruption of the infant's pleasure."
>
> (Weil, 1992, p.41)

Summary

Infants are clearly communicating with their caregivers prior to the onset of language. The pattern of communication developing between them and their caregivers is beginning to be established before the addition of speech. We now have a better idea of how the infant self is developed, and the sense they are making of congruence and

incongruence between feeling and behaviour. We also know that the way infants are communicated with, the consistency predictability reliability and congruence of the affective messages they are receiving from their caregiver and the way their own communications are received are determining factors in the infant's sense of a coherent self and their expectations of interactions with others.

We can conclude from these studies that in the course of the first year infants understand three major components of emotion:

i) that the expression of emotion is intentional and meaningful;

ii) that people can respond to one's expression of emotion and validate one's internal experience;

iii) that one can infer the meaning of behaviour and actions from the emotional expression of others.

It is my hypothesis, to be elaborated later, that as the infant moves into the verbal domain, (and even before) affect attunement from an unempathic caregiver leads to profound distress when the infant is in careseeker mode. Affect attunement which is devoid of empathy gives rise to defensiveness (self regulatory behaviours) and inhibits exploration.

The complexity of affect attunement it seems to me (and I am not aware of Stern writing about this) is it can be experienced by the person being attuned to as a precursor to empathy. This is wonderful if the infant then experiences an empathic response. However this may not be the case. Infants as we have seen from the studies described in this chapter will learn quickly if affect attunement is followed by painful misattunement or non attunement and will take steps to defend themselves. In addition to these two possible scenarios one has the person who has mixed experience - sometimes attunement is followed by motherese and later when communicating

verbally by empathic responses, but other times, the access allowed by attunement is used by the caregiver to attack and hurt. The infant quickly learns adaptive strategies to cope with the various responses he or she receives to expressions of careseeking.

It seems to me that attachment theory with its focus on the biological instinctive systems of caregiving and careseeking provides an excellent conceptual framework to help make sense of diverse careseeking and caregiving patterns and for helping understand the processes set in trail when caregiving is dysfunctional, neglectful, ineffective or abusive.

> "It would be reasonable to assume that
> an understanding of the role of attachment difficulties
> in psychopathology should have implications for
> therapeutic interventions."
>
> (Rutter, 1995, p.565)

In this chapter I have brought together evidence from the field of infant research which supports the view of Fairbairn and other object relations theorists that the infant is person seeking from the start of life and is not a bundle of instincts and drives from which he or she seeks relief and assuagement. The pattern of relationship that develops between infants and their caregivers is clearly influenced by the way in which each interacts with the other and seems to persist in its original pattern of organisation over time.

In my next chapter I locate caregiving in psychotherapy and allied professions in the context of attachment theory.

CHAPTER FOUR

PATTERNS OF CARESEEKING CAREGIVING RELATIONSHIPS:

RESEARCH INTO ATTACHMENT BEHAVIOUR IN INFANTS AND YOUNG CHILDREN

> "Overall, attachment history does seem to contribute to the prediction of anxiety, anger, and empathy during childhood. Children with resistant attachment histories seem to be more likely than children with other histories to have problems with anxiety, perhaps in response to the constant vigilance they have developed in their early attachment relationships. Children with avoidant or disorganised/disoriented histories are most likely to show hostile, aggressive behaviour, both with parents and with peers, perhaps as a response to chronic rejection and insensitivity from their caregivers. In contrast, children with secure histories seem to have acquired a foundation for empathy from their early relationships; they take to new relationships the ability to be sensitive to another's emotional cues, as well as a pattern of dyadic affect regulation in which the one who is not distressed helps to regulate the other."
>
> (Weinfield et al., 1999, p. 79)

Introduction

In the last chapter, I drew attention to the way in which infants are psychobiologically dependent on their caregiver for basic regulation of their affective states. Research into infant development provided evidence that infants know that

they are like other people within moments of birth and can match expressions on others faces with their own internal bodily states. Infants, when they are not hungry, tired or ill, enjoy communicating with an attuned adult who vocalises and matches, raises or lowers their level of vitality. Infants expect congruence between behaviour and emotion and are puzzled and distressed when this does not happen. When removed from contact with an adult with whom they have been sharing pleasurable affective experience they withdraw into themselves. When adults relate in unattuned and misattuned ways the infant will do what they can to protect themselves, even if all they can do is avoid eye contact. Non attunement to affect between caregivers and infants is extremely distressing to watch as is affect attunement that is followed by unwanted misattunement.

In addition we saw that patterns of interaction get established between infants and caregivers and noted briefly that these patterns were predictive of how the mother and infant were found to be communicating at the end of the infant's first year and that they were linked with secure and insecure attachment patterns (Bretherton 1990). I ended the chapter noting and raising the issue of affect attunement in careseeking and caregiving and that affect attunement, misattunement and non attunement can contribute to complex patterns of careseeking caregiving interactions. The next step is to explore the literature on attachment theory with a view to understanding the processes of careseeking and caregiving.

My aim in this chapter is to present a brief overview of attachment theory, to show the way that attachment behaviour has been assessed, its persistence and stability; its link with affect attunement; its transgenerational transmission from parent to infant; the patterns of caregiver-careseeker interactions associated with secure and insecure attachment status (particularly in relation to how the dyads interact while playing and how they communicate about emotion).

I will discuss the work of researchers such as Ainsworth (Ainsworth and Wittig, 1969, Ainsworth et al., 1978, Ainsworth, 1991; Main, 1985, 1991, 1995; and Crittenden, 1995).

Attachment theory

Attachment theory, developed by John Bowlby (1969, 1973, 1980, 1982) describes the function of attachment behaviour (survival), the situations under which careseeking behaviour is activated (fear, distress, illness and anxiety) the object of attachment behaviour (protection through proximity with a preferred caregiver) and the conditions under which attachment behaviour is assuaged. Bowlby also introduced the concept of set goal into attachment theory. As well as acknowledging the existence of finite set goals such as orgasm, Bowlby saw attachment behaviour as an example of a behavioural system that had a continuing set goal. In the area of attachment behaviour the goal was a certain sort of relationship to another specified individual.

Internal working models of the experience of relationship

In Bowlby's view individuals build up a set of mental representations of how their attachment seeking behaviour has been received and responded to by their attachment figure and these are stored as templates of experience. Bowlby described them as internal working models. Heard and Lake (1997) describe them as 'internal models of the experience of relationship (IMERS). This way of describing internal models allows for the fact that individuals have different experience of the same person - in different moods for example - so that different templates for the experience of that person are stored as predictors and guides of their present and future behaviour.

The reorganisation of these internal working models of relationship in the light of reality is the challenge for most psychotherapies. Bowlby, (1991) identified communication as the key issue that psychotherapists have to struggle with, and argued, on the basis of scientific evidence that a major block to communication intrapsychically and interpersonally is the way an infant's emotive signals have been responded to by their primary caregiver. These findings have been supported and

corroborated through the work of Ainsworth (1978, 1991); Grossmann et al., (1985, 1988); Grossmann and Grossmann, (1991a, 1991b); Fonagy et al., (1995a, 1995b); Main, (1991, 1995, 1999); Crittenden (1995) and Emde, (1990a, 1991), amongst others. .

Attachment classification: stable and persistent over time

Mary Salter Ainsworth (Ainsworth and Wittig, 1969) first noted in her Ganda study the different way in which mothers communicated with their children - the way that they held them talked to them, sang to them touched and stroked them - the whole way that they regarded and interacted with their infants. It was during her time with the Ganda tribe that she put forward the concept of the *Secure Base*. She also noted that the ways that children used their secure base (mother) was different depending on the quality of interaction that had been going on between them. Later in Baltimore USA when she set out to study attachment behaviour she incorporated home visits into the design of her research in order to capture the quality of interaction between infant and caregiver. Through her observations of infants and mothers Ainsworth noticed that effective caregiving - caregiving that would assuage careseeking was much more than simply providing proximity to the caregiver as Bowlby had suggested, it had to include the interactional style in which caregiving is provided (in other words what we were discussing in the last chapter).

In order to study attachment behaviour Ainsworth devised what has become known as the Strange Situation Test. This is a 20 minute test consisting of eight episodes. Mother and infant are introduced to a laboratory playroom, where they are later joined by an unfamiliar woman. While the stranger plays with the baby, the mother leaves briefly and then returns. A second separation ensues during which the baby is completely alone. Finally, the stranger and then the mother return. Ainsworth found that the infants explored the toys and the playroom more vigorously when in the presence of their mothers than after the stranger entered or while the mother was absent. Ainsworth's stroke of genius was not just to observe what the infants did

while mothers were absent but to notice that they differed in their response to her when she returned. She went on to classify their responses on reunion into secure, insecure ambivalent and insecure avoidant.

The largest group were the secure, accounting for two thirds of her sample and the smallest group was the ambivalent. The insecure group have been further classified (Main, 1985) into insecure avoidant, insecure ambivalent and disorganised. These classifications have been shown to be stable over time[1] and persist into adulthood (see Cassidy and Shaver, 1999 for a full account of research into attachment behaviour and clinical implications, also Main, 1988, 1991, 1995; and Bretherton, 1991). Summaries of research findings on the three types of infants (Campos et al., 1983) and research on the general population (Hazan and Shaver, 1987) confirm that the secure group account for about 60% of the studied population.

Ainsworth found that sensitive mothers had children who were securely attached at one year: *that maternal sensitivity was the primary determinant of quality of attachment: sensitive mothers have secure children, inconsistent mothers have ambivalent children and interfering /rejecting mothers have avoidant children.* Sensitive handling refers to the caregiver's ability and willingness to perceive the infant's communications as reflected in his behaviour, emotional expression, and vocalisations, to see and interpret them from the infant's point of view, and respond to them promptly and appropriately according to the infant's developmental and emotional needs.' (Ainsworth et al., 1974, 1978)

The adult attachment interview

In 1985 George, Kaplan, Goldwyn and Main piloted what has become known as the adult attachment interview (AAI). This is an hour long semi-structured interview

[1] Klaus and Karen Grossmann (1991) confirm these findings drawing on two major prospective studies that they carried on in 1976 and 1980. The 1976 study comprised newborns, the 1980 study had infants from 11 months old. They tested all their infants on the Ainsworth's Strange Situation test at 12-18 months.

which asks for a description and evaluation of early relationships with each parent. (Main, 1995) describes how this interview yields four central classifications of the state of mind of the person being interviewed. When administered to parents it has been found that each classification corresponds to a pattern of infant response to the parents in the Ainsworth Strange Situation. "Parents who are coherent and collaborative in discussing their histories(classified as secure/autonomous parents) tend to have *secure* infants, parents *dismissing* of their own experiences tend to have *avoidant* infants, parents *preoccupied* by their own parents tend to have *resistant* infants, and parents suffering lapses in reasoning or discourse during the discussion of traumatic events (classified as *unresolved/disorganised parents*) tend to have *disorganised/disoriented* infants." (pp. 408-9)

Main (1995) cites studies by Hamilton (1995) and Waters et al (1995) who found a correspondence between the classification of adult status and the classifications made during the Strange Situation done 16 to 20 years previously, giving evidence for the stability of these patterns over time. A study by Fonagy et al., (1991, 1992), showed that classifications of parental adult attachment status corresponded with the attachment status of their children, providing evidence for transgenerational transmission. Nevertheless, the most striking and uplifting fact to come out of the AAI studies is that adults who can give a fluent, coherent and reflective account of their childhood attachment relationships (whatever those relationships were like) have children of their own who are classified as secure. This, finding, to my mind, has great significance for psychotherapy and relationship focused social work. The psychotherapeutic medium must be *par excellence* the medium through which a person can develop some level of metacognition in relation to the experiences they have had in earlier life and are having now.

Careseeker-caregiver dyads: communication patterns in relation to affect

The Grossmanns (1991a, 1991b) describe two major prospective studies carried out in 1976 and 1980. They re-analysed the videos they had of the Strange Situation Test (carried out with all the participants) to examine the communication patterns operating between infants and caregiving figures. They looked at the emotional communication of the infants and how the parents responded. What they found was that infants classified as securely attached were more direct in terms of communicating their distress to the parent and more successful at gaining comfort and support. Infants who were impaired in their mood and play behaviour during the two separations and who had an avoidant attachment to the parent present communicated less directly to the parent on their return.

I consider that these findings are enormously interesting and offer a focus for examining interaction in adult one to one psychotherapy. It may be that secure and insecure therapy dyads develop particular patterns of communication in relation to discussing affectively laden material.

Two further tests carried out by the Grossmanns revealed that children reacted differently to a play sequence involving changing emotional expressions on the part of the person playing with them (e.g. from happy to interactive to sad) if in the presence of a parent with whom they were judged secure than if in the presence of a parent with whom they were judged insecure. The play partner is dressed as a clown and goes through a series of activities with the infant in the presence of one or other parent. These activities include being happy, wanting to play with the infant, and finally crying (Grossmann and Grossmann, 1991b). When they were with the 'secure' parent they were able to reflect back the different emotions, promptly and accurately. When they were in the presence of the parent with whom they had been classified as 'insecure' the infants' response was neither prompt nor accurate. What this work shows is that infants who feel secure with their attachment figure are more

autonomous, more emotionally coherent and fluent and more flexible in terms of monitoring and responding to affect in others.

In the adult context such a pattern of communication between therapist and client should indicate that the dyad is secure and exploration is under way.

Careseeker-caregiver dyads: interaction patterns in relation to play

The Grossmanns (Grossmann and Grossmann, 1991b) also report on interactions they observed taking place between parents and infants (again 12-18 months) in a free play situation. They found that infants classified as secure communicate more subtly, with soft vocalisations, whereas infants in insecure dyads initiate interaction more often with toy presentations and loud vocalisations. They also addressed parental sensitivity in terms of reacting to the infant's emotional state and independent play activity. They found that how parents responded to their infant while the infant was playing depended on whether they had classified that parent and child couple as secure or insecure. In 'secure' couples when the child was playing happily the parent stayed away from them and observed; if their child became bored or started to lose interest or became distressed they would intervene and offer a toy or suggestion. This usually led to a resumption of play with high interest and energy.

In contrast, in couples classified as 'insecure' the parent rarely offered a toy, stayed away from their infant when he or she showed low interest in play or was in a poor mood but did initiate many play activities when the infant was already playing with high interest. In addition they found that mothers of avoidant infants withdrew from their infant specifically when the infant seemed sad. This usually resulted in the child ceasing to play and becoming uncertain and distressed.

It seems to me that these are extremely important observations, depicting a combination of a lack of affect attunement and empathy. In the adult context of psychotherapy where the 'third' element between the two people is not 'play' but

discussion of emotional concerns it struck me that to monitor the interaction pattern between the careseeker (client) and the caregiver (therapist) could provide interesting clues as to whether the interaction is contributing to the maintenance of defensive careseeking.

Careseeker- caregiver dyads: interaction strategies based on secure or insecure relationships

I present the following work from Crittenden to show the coherence of the strategies developed for coping with misattunements and impingements. This work lends weight (by providing more detail) to the observations of the Grossmanns just recounted.

According to Crittenden (1995), sensitive caregiving not only ensures security in the infant but also teaches them that their behaviour is meaningful and that it has predictable effects on others. In contrast, infants classified as avoidant at one year of age will typically have experienced maternal rejection when they displayed affective signals indicative of a desire for closeness with their mothers. If these infants protest they often experience maternal anger. If caregivers are consistent in what they do however rejecting, infants will develop an organised strategy for dealing with their attachment figure (see (Main, 1995). On the other hand, "When infants cannot predict their caregiver's response they become anxious and angry ... Without a strategy for changing the probabilities of caregiver behaviour, however, these infants remain unorganised with regard to attachment." (Crittenden 1995, p. 371)

Crittenden argues that by one year, infants who are labelled secure have learned the predictive and communicative value of many interpersonal signals; they have made meaning of both cognition and affect. Avoidant infants, on the other hand, have learned to organise their behaviour without being able to interpret or use affective signals; that is they have made sense of cognition but not affect. Ambivalent infants have been reinforced for affective behaviour but have not learned a cognitive organisation that reduces the inconsistency of the mother's behaviour. Infants

classified as ambivalent are also referred to as resistant, because of the way that have been observed to resist approaches from mother on her return, during the reunion phase of the Strange Situation Test.

Main, (1995, p. 419), describes the behaviour of the resistant infant during the 'strange situation' as follows: "mother's absence leads to exhibitions of marked distress, so that separation episodes are quickly terminated. Mother's return to the room fails to settle the baby, however, and consequently he is still crying, whining or fussing at the end of each reunion episode. To the observer, the behaviour of resistant infants can be unsettling, since neither the baby's distress nor his preoccupation with mother's whereabouts is affected by her actual return. In addition the baby may alternate between seeking to be held by mother and angrily pushing her away." It is for this reason that this pattern of behaviour has been termed both 'insecure resistant' and 'insecure ambivalent'.

"Ainsworth's home records showed that mothers of the four resistant infants in her sample were unpredictable, discouraging of autonomy, and insensitive to infant signals and communications. Most displayed some warmth and involvement at times...Unlike the mothers of avoidant children, most considered themselves highly invested in mothering. They differed from the 'avoidant' mothers by not physically or verbally rejecting their children...Face to face interactions with their babies were marked by lack of contingent pacing and they were observed to be 'tender and careful' in how they managed their babies in only 2% of observed episodes." (Main, 1995, p. 420). Main is quoting from her knowledge of the original Ainsworth study.

These 'organised' strategies will keep the insecure avoidant child at a distance from the caregiver and thereby unable to reap the benefit of full attentive supportive care and will keep the insecure ambivalent/resistant child in a state of hypervigilence for affective cues that might signal what is going to happen next. Both types of children

suffer hyper-arousal[2]. As I understand Main and Crittenden, both patterns of insecure attachment depict organised if restricted responses to attachment figures. Persons in all classifications are subject to becoming disorganised if their attachment figure becomes frightening, threatening, physically or sexually abusive.

Mary Main (1995) in an extensive review of the findings from the Strange Situation points out that "only (that majority of) infants whose mothers had been 'sensitive and responsive to infant signals and communications' in the home had shown the expected behavioural patterning. For infants whose attachment behaviour had been consistently rejected; threatening conditions (mother's absence during the strange situation), failed to activate attachment behaviour. For infants whose mothers had been unpredictable, in contrast, mother's presence failed to terminate it. Insecure infants, then, either failed to exhibit attachment behaviour in threatening conditions and actively avoided mother on reunion or else, remaining preoccupied with mother throughout the separation, failed to explore in conditions of safety." (p. 449)

Main points out that because the attachment behavioural system is conceptualised as being continually alert and context sensitive, the primary propensity to seek proximity in response to threat and to terminate proximity-seeking in conditions of safety must still be active[3]. "In this conceptualisation, then, the infant's conditional strategy (avoidance or preoccupation) is understood to be imposed on a still-active primary strategy. Maintenance of a "minimising" (avoidant) or "maximising" (resistant) behavioural strategy is therefore likely eventually not only to become dependent on the control and manipulation of attention but also eventually to necessitate overriding or altering aspects of memory, emotion and awareness of surrounding conditions." (p. 451)

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[2] The heart rates of the apparently avoidant infants are as elevated as those for secure infants during separation and pre-to-post Strange Situation rises in cortisol are somewhat greater for avoidant than for secure infants. See Main 1995, p. 418).

[3] Conditions listed by Bowlby well known to activate attachment behaviour are: I) occurrence of alarming events; 2) rebuffs by other children or adults" (1969 p 259).

I consider this to be an enormously important statement by Main and one which is outwith the scope of this thesis to address fully. However, what it makes me think is that insecure attachment style imposes a huge strain (fatigue) on the psychobiological system and that psychotherapeutic help attuned to the complexity of careseeking behaviour could have physical as well as psychological effects. I consider that adults are likely to present with their particular careseeking style when they approach psychotherapeutic help and to maintain or return to that style if they feel anxious or threatened.

I wish to look now at research by Haft and Slade (1989 which suggests that attachment security in the caregiver corresponds with the capacity to attune to a range of emotion in careseekers, thus facilitating effective caregiving. This work supports that of Tronick, (1989), Crittenden McKinsey (1995), Main, (1995), and Fonagy et al., (1991) amongst others and I use it as a major building block in my construction of a model of effective caregiving within the psychotherapeutic domain.

Effective caregiving: attunement to a range of affect

Haft and Slade (1989) reported the results of a study in which they found that the nature of a mother's internal affective experience powerfully influences the affects she acknowledges and attunes to in her child. They set out to see whether differences between mothers in their ability to access a variety of their own affects and experiences will influence the kinds of affects and experiences they can acknowledge in their babies.

The researchers classified attunement into low order attunement and high order attunement using the affect attunement scale devised by Stern (unpublished). Using the scale the mothers attunements were rated along a continuum from negative attunement (a score of -2 or -1) to comments or communications (a score of zero) to positive attunements (a score of +1 or +2). In addition each rater rated the quality of the attunement , i. e. the degree to which the mother entered into or shared in the

infants' subjective experience. A response with a score of 1 was labelled a low order attunement - here the mother combined her desire to share in the baby's affective experience with an intention to teach or otherwise alter his experience. On the other hand a score of 2 (rated as high order attunement) was one where the intention was purely to share in the baby's affective experience. Responses scored in the other direction -1 or -2 indicated mother's entry into the affective experience, but with the intent to mock or scorn the baby.

They found:

i) Securely attached mothers' (rated on the AAI) responded to a broad range of affective experiences and could correctly assess their baby's affect, whether it was positive or negative. They evinced little psychological need to distort their babies' affect in order to protect a particular state of mind regarding attachment and attuned with an even hand to their babies' expressions of initiative, effort, exuberance, frustration, anger and need for closeness. When they did misattune, it was not in any systematic way with a bias in favour of one kind of affective experience over another.

ii) In the preoccupied group a pattern of selective misattunement was discovered. For example the mothers did not attune or validate their babies expression of initiative and exuberance during play. They either totally ignored these type of expressions in their babies or misattuned to them. Ambiguous situations seemed to provoke confusion and anxiety - when the babies signalled to the mothers that they needed to know what to do the mothers tended to become anxious at their own inability to understand their babies persistent requests for clarification. There was an unpredictable area of distortions and misattunements that occurred pervasively, in the context of both positive and negative baby affect.

iii) The dismissing group distorted their babies affect by misreading it primarily when it was negative and did so most consistently when the baby directed the negativity towards them and not at an object. In marked contrast to the relatively unpredictable pattern of the preoccupied group dismissing mothers distorted and misattuned consistently, following a pattern that was defined by the type of baby affect displayed. Dismissing mothers were most comfortable attuning to their babies expression of exuberance, especially in the context of mastery at play. The babies' expression of autonomy and separateness seemed most comfortable for these mothers and were the preferred state for affective sharing. They seemed to reject bids from their babies for comfort and reassurance. The first line of approach was typically to use comments to override the baby's affect, as if trying to make it go away. If this was not successful and the baby continued to be distressed or angry, a misattunement would often follow. There was often a sadistic quality to these misattunements and comments.

The authors conclude that with the insecurely attached mothers there are real limitations on the kinds of subjective experiences that can be experienced and shared.

Summary

In chapter three I set out the way in which infants arrive in the world ready to meet other people, interact with and enjoy them. We saw that the infant cannot do this on his or her own and that in order to achieve this goal he or she needs help from an attuned, sensitive and empathic caregiver who is willing to search out what the infant is communicating and then make sense of it. When the infant does not get this response he or she develops defensive strategies to cope with the emotional disturbance aroused. In the face of continued lack of attunement or deliberate or accidental misattunement or non attunement the infant develops distinctive patterns of relationship with self or others which maintain their equilibrium.

When the goals of careseeking have not been met then defensive behavioural strategies will be apparent in the interaction. Attachment theory helps us to understand the central place of affect regulation in the experience, monitoring and negotiation of relationships.

> "By locating attachment as a primary motivational system within the person, with its own function, purpose and behavioural sequences, which are activated and terminated within particular environmental conditions we now have a language that makes sense of the experiences of "feeling protected or unprotected, helpless or helped, valued or dismissed, anxious or secure."
>
> (Lieberman et al., 1991)

Such a view makes it possible to consider the ways in which careseekers in psychotherapy sessions may experience the interaction between them and their therapist and offers pointers for how to understand the process of this relationship.

During the course of this chapter I have remarked on different occasions about the implications of particular pieces of research into infant-adult dyads for later manifestations of careseeking in adults, particularly within a psychotherapeutic context. I wish to summarise them here before proceeding to my next chapter.

The Grossmann's work indicated that secure and insecure infant-parent dyads develop particular patterns of communication in relation to discussing affectively laden material. For example infants, in infant-parent dyads classified as 'insecure', when exposed to different displays of affective expression, their response to the affect was neither prompt nor accurate.

Crittenden's observations suggested that the three main types of insecurely attached infants have different ways of managing affective and cognitive information:

(i) Avoidant infants learn to organise their behaviour without being able to interpret or use affective signals.

(ii) Ambivalent infants have been reinforced for affective behaviour but have not learned a cognitive organisation that reduces the inconsistency of the mother's behaviour.

(iii) Disorganised infants those who cannot predict their caregiver's response; become anxious and angry. That without a strategy for changing the probabilities of caregiver behaviour, these infants remain unorganised with regard to attachment.

On the other hand infants who feel secure with their attachment figure are more autonomous, more emotionally coherent and fluent and more flexible in terms of monitoring and responding to affect in others.

Such observations suggest to me that in the adult context, therapeutic work geared at effecting change in the way in which the client experiences themselves and others needs to be attuned to the complexity of the careseeking pattern itself and the many ways in which it disguises and deflects the self and other from experiencing certain affects.

In my next chapter I present the work of Heard and Lake (1997) who have developed the construct of the attachment dynamic to account for the way that adults use different instinctual motivational systems to maintain well being and social and interpersonal competence. I use their work to elucidate the process of effective caregiving within psychotherapy and explain why I call this process goal-corrected empathic attunement. My next chapter, therefore, which builds on the last chapter and this one will conclude the theoretical section of this thesis.

CHAPTER FIVE

PRESENTING THE CONCEPT OF GOAL-CORRECTED EMPATHIC ATTUNEMENT:

EFFECTIVE CAREGIVING WITHIN PSYCHOTHERAPY

> "Should caregivers fail to meet the needs of careseekers, the latter cannot reach the goal of careseeking, and commonly become frustrated and then depressed. What happens when each partner is failing to reach their goals, and what is happening to their careseeking and caregiving systems is increasingly being researched and understood in both non-human primates and in human beings."
>
> (Heard and Lake, 1997 p. 5)

INTRODUCTION

> The documented findings that the orbitofrontal system is involved in 'emotion-related learning' (Rolls, Hornak, Wade & McGrath, 1994) and that it retains plasticity throughout later periods of life (Barbas, 1995) may also help us to understand how developmentally-based affectively-focused psychotherapy can alter early attachment patterns....Attachment models of mother-infant psychobiological attunement may thus be used to explore the origins of empathic processes in both development and psychotherapy, an reveal the deeper mechanisms of the growth-facilitating factors operating within the therapeutic alliance.
>
> (Schore, 2000, p. 39)

In this chapter I will show how I transpose the research on careseeker-caregiver dyads to the context of adult psychotherapy. In order to set the context for relating the work on attachment in infants to the adult context of psychotherapy I will start with the work of Heard and Lake, practising psychoanalytic psychotherapists who have extended the theoretical base of attachment theory to take account of the problems that clients bring to therapy. Heard and Lake (1997, 2000) have extended attachment theory to include three instinctive motivational systems other than careseeking and caregiving (sexuality, interest sharing and self defence) and which in my view fit the reality of relationships post infancy. I will then move on to show how I have put together the concept of goal-corrected empathic attunement; why I locate it in the interpersonal system of caregiving and careseeking and why I think it makes sense to locate it within the extended view of attachment theory - the theory of the attachment dynamic (Heard and Lake, 1997)

The attachment dynamic

According to Heard and Lake the instinctive goal-corrected complementary systems of careseeking and caregiving described by Bowlby are insufficient to describe the complexity of motivational states that inspire and direct human beings. In 1986 in a paper entitled 'The attachment dynamic in adult life' Heard and Lake argued that companionable interest sharing was a major motivational force that brought human beings together into relationship with one another. In addition to interest sharing they included a further two systems; the affectional sexual system and the system for self defence. In 1997 in their book 'The Challenge of Attachment for Caregiving' they elucidate the way in which these five goal-corrected systems interact with one another to form what they term the attachment dynamic and provide the research basis for their hypothesis.

Heard and Lake's (1997) theory of the dynamics of attachment conceptualises the self as a system of interacting systems which has relationship with others at its core. The self is conceived as interpersonal, experienced through relationships with others or

through the process of defence against the pain of relationship. Experience of relationship with attachment figures is coded within the self in the form of 'relationships as experienced' (IMERs - internal models of the experience of relationships). The concept of IMER captures the infinite variety and impact of all attachment relationships and their effect on the functioning of the self.

The five systems within the attachment dynamic are therefore:

(i) the careseeking system;
(ii) the caregiving system;
(iii) the interest sharing system;
(iv) the sexual system;
(v) the system for self defence.

These systems operate interdependently in order to develop and maintain a sense of well being and competence. When the goals of one or more of the five systems within the attachment dynamic are not met (particularly the careseeking system) then various levels and degrees of the following can occur:

(i) a sense of well being diminishes;
(ii) there is a neglect of self care and care for others;
(iii) exploration is inhibited;
(iv) the person operates from the system for self defence and *in extremis* will choose survival of the self at any cost.

Any system within the attachment dynamic can fail to reach its goal by being overridden by other systems within the dynamic. For example, the caregiving system is activated when help is sought from a careseeker; however if the careseeker presents in a way that stimulates anxiety in the caregiver the caregiver may retreat into self defence and or experience or start exhibiting careseeking behaviours themselves. This process is described by Heard and Lake (1997, 2000).

If the careseeker fails to have their careseeking needs met, the behavioural patterns which accompany careseeking cannot shut down and the system for careseeking is infiltrated by the activation of the personal defence system. In this way careseeking is then expressed by whatever behaviours have been found to evoke in the caregiver responses that assuage the pain of not reaching careseeking goals. When the caregiver is activated to provide caregiving, frustration of this goal to give care is also likely to cause distress. When the needs of the caregiver and the careseeker are met, there is satisfaction and relief in both parties.

The attachment dynamic describes an interpersonal process which takes place through two different kinds of social exchange which present usually in mixed form. These two kinds of social interactions are (i) supportive companionable and (ii) dominant versus submissive. A supportive companionable interactive stance will generally support exploratory behaviour in whichever system is activated within the attachment dynamic. A dominant versus submissive type of social interaction will generally lead to intermittent incomplete and unsatisfactory exploratory processes at the individual and interpersonal level.

The system for exploration

The system for exploration is not included within the attachment dynamic. Exploration is not activated by attachment behaviour. The exploratory system is conceptualised as always active unless overridden by the dynamics of attachment. The exploratory system has both an intra-individual and inter-personal component. The intra-individual component refers to all that we do which involves creating personal meaning, the interpersonal component refers to interest sharing with peers (Heard and Lake 1997, 2000). In addition, while the exploratory system is not part of the attachment dynamic, Heard and Lake (2000) conceptualise it as part of the caregiving system. In other words, when caregiving is aroused, it is the caregiver's exploratory system that seeks to understand what the careseeker needs and work out

what might meet those needs. A caregiver whose exploratory system is not activated to understand the needs of the careseeker will not provide effective care.

I will now present my own work on developing the concept of goal-corrected empathic attunement.

Goal-Corrected Empathic Attunement: a process involved in effective caregiving

> "An earlier paper (Emde, 1988) reviewed how current infancy research points to the centrality of the infant-caregiving relationship experience and of emotional availability in the context of that experience for establishing both continuity and the potential for later adaptive change. Moreover, linking infancy research with psychoanalytic clinical theory generated a proposal about motivational structures. The proposal is as follows. Early-appearing motivational structures are strongly biologically prepared in our species, develop in the specific context of the infant-caregiver relationship, and persist throughout life. I have since realised that more can be said. These motivational structures can also be regarded as fundamental modes of development. As such, they are life-span processes that can be mobilised through empathy in the course of therapeutic action with adults."
>
> (Emde, 1990b, p. 883)

As we have seen, attachment behaviour in very young children according to Bowlby (1969) is activated in the context of fear, distress, illness and anxiety and results in the infant seeking proximity with their caregiver. The function of attachment behaviour is to ensure survival. Attachment behaviours continue throughout the life cycle and are activated under certain environmental conditions. Individuals build up a set of mental representations of how their attachment seeking behaviour has been received and responded to by their attachment figure and these are stored as templates of

experience. Bowlby described them as internal working models. Heard and Lake as mentioned earlier describe them as internal models of experience in relationship (IMERs). The basic idea is that experience of self in relation to attachment figures is stored as models of how such relationships have worked in the past and as a basis for predicting how they might work in the future.

The idea of internal working models of self in relationship is critical for helping us to understand the nature of the psychotherapeutic relationship. In this relationship the careseeker (the client) brings to the experience their various templates of how their relationships with their earlier attachment figures have worked and this will both influence their behaviour in the therapeutic relationship and their experience of what actually happens.

Careseeking is always directed towards a caregiver, and will only cease when the goal of careseeking has been met, i. e. when the caregiver gives the required response. Failures on behalf of the caregiver to adequately meet the needs of the careseeker will result in the attachment behaviour of care seeking failing to shut down. Instead it will remain active but in less visible or complete sequences of behaviour. In the therapeutic relationship one would expect to see the careseeker exhibiting attachment behaviours, demonstrating particular attachment styles and also expressing behaviours which indicate their expectations of the responses of the therapist. Psychotherapy offers the opportunity to identify these complicated presentations of attachment behaviour and to respond in ways that will assuage careseeking and promote the exploratory system.

The psychotherapeutic relationship: an account of interactional sequences using the concept of goal-corrected empathic attunement

Careseeking behaviours will be activated in the context of psychotherapy and the careseeker (client/patient) will be motivated to have their careseeking needs met by the caregiver (therapist) who will be perceived in the therapeutic context as 'older and wiser'. One would also expect the caregiver to be activated to meet the needs of the

careseeker. A failure in this regard one would see as a failure in the caregiving system. More precisely, what is failing here is the exploratory component of caregiving (Heard and Lake, 2000[1]). It is the exploratory aspect of caregiving that is paying attention to the meaning of the many presentations of affect by the careseeker or the meaning of the lack of affective presentation, as in the work described with extremely emotionally abused adults by Susan Vas Dias (2000).

In the adult context, if the caregiver does not attune to the affect of the careseeker, careseeking will not be assuaged but even more importantly the careseeker will have no evidence on which to base their confidence that the caregiver would be able to support them in their exploration, discovery and potential action. In this context, affect attunement requires resonance to the feeling state of the other, and a willingness to engage with and regulate the other's state of arousal so that the careseeker is optimally placed for exploration. In addition to affect attunement the adult caregiver working with an adult careseeker must also convey they *understand* where the other is headed and have some resources in addition to what the careseeker has to help them get there.

Attachment theory proposes that exploratory behaviour in individuals is dependent on the accessibility of a safe base, one that can be relied on to be supportive and educative in times of crisis or threat. This is as true for the Antarctic explorer as it is for any of us going about our daily business knowing that there is somebody somewhere who could help pick up the pieces if we get into real trouble.
The other building block for the concept under discussion is empathy. For the operation of therapeutic work, attachment theory on its own is insufficient as it fails to address the nature of the support offered back at base. The instinct to survive can get a child or adult to return to a safe place when necessary. However, the reception one gets at base will determine whether one actually gathers further resources or

[1] The exploratory system is not part of attachment (careseeking) behaviour. The exploratory system is a separate system which is always active *unless* overridden by careseeking.

simply recovers and resuscitates the ones one already has. What makes the difference is whether one is greeted with:

(i) an attuned response to one's internal state of arousal;

(ii) whether the person attending to you not only does that but stays long enough with you in order to address that arousal state[2];

(iii) whether the person responds empathically.

This brings into the frame another person who can offer support. It also brings in a *relationship* with another person. This is very different to having to rely on one's own resources, as happens when all that is offered is skilled attunement. Attunement and empathy as described are not sufficient. Skilled empathy will take the other near the domain of experience and thinking of the other person, but the process of helping the other access their own competence requires the helper to move beyond just putting the other in touch with what they know already. It requires that they help them access that which they are on the edge of knowing.

This process requires that the helper use their own intelligence to think about the situation of the other including what they might be thinking about and engage to the limits of their own intellectual capacity without fear of losing to the other that which belongs to them. This is an act of emotional, imaginative and intellectual generosity which goes beyond appreciating the situation the other is in, it joins with and engages with them in opening up for exploration ideas and courses of action that neither may have articulated in quite this manner heretofore.

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[2] This means dealing with it in such a way that one is helped restore one's own internal balance (see Weil. 1992). If this is done properly with sensitivity and care then one is able to access one's cognitive and emotional intelligence, (i.e. the process of affect regulation I discussed in chapter 3). This alone is very useful because it puts one back in charge and in touch with one's own personal competencies.

This fine tuning of emotion, intelligence and imagination on the part of the therapist requires that they monitor the effect of their input on the client and adapt, adjust and arrange their responses to the verbal and non verbal feedback they are getting. Therapists working in this way elicit feedback to their input and check what is happening for the other. They do not just rely on verbal and non-verbal signals which can be ambiguous and open to misinterpretation. The process I am describing is active and interactional. It is a process of regulation and adjustment.

The behaviours of caregiving and careseeking are complementary so one would expect to be able to observe an interactional sequence of behaviours where they both, in their respective roles of caregiver and careseeker seek to influence each other to have their respective goals met. At the conclusion of a successful sequence of interactions one would expect to observe some relief and satisfaction for both parties.

In therapy what is communicated non-verbally by the careseeker reaches back to the earliest forms of the self, the self that was communicating and making sense of how they and others fitted together and understood each other long before language was available, and at a time of extreme physical dependence. It is into this domain that the therapist enters through empathic knowledge. Empathy is a crucial component of effective caregiving.

> "The empathic process in which therapists steep themselves in the world of the other attempting to understand how others see and experience themselves and their worlds, putting this into words and checking their understanding, appears to us to be curative. Empathy is a process of co-constructing symbols of experience. Clients' process of symbolising their experience in awareness promoted by empathic responding to their internal experience appears to us to be a universal core ingredient of the therapeutic process. Being able to name an experience first makes the previously implicit explicit, thereby

> providing an improved sense of facilitation and comprehension of how one knows what one is experiencing. This in and of itself provides some clarity and relief from earlier confusion."
>
> (Bohart and Greenberg, 1997, pp. 5-6)

Based on the idea that attachment behaviour is always active until assuaged (cf. Bowlby, 1969, Main 1995 described earlier, and Heard and Lake, 1986, 1997) the theory of goal corrected empathic attunement therefore that I am putting forward refers to the activity whereby one person (the client) seeks to engage the other person (the therapist) in attending to their emotional and practical concerns in such a way that they can understand themselves better and manage their interactions with others more effectively. The therapist has to convey that they grasp the significance of the material being brought, the context within which it has arisen, the meaning it has for the client, and the direction and manner in which the client wishes to pursue it. The therapist needs to respond with attunement and empathy, plus ideas and concepts which are held together within a theoretical framework that add a dimension that the client can use to gain another perspective on themselves and what they have brought. The principles on which goal-corrected attunement work are open systems of communication between the two parties concerned, which are regulated and directed by feedback.

The therapist (caregiver) has first to manage the emotional arousal (affect regulation) of the client (careseeker) so that they are in the best state possible to think about and explore their problem. This the caregiver does though attuning to the presenting affects - the vitality affects as described by Stern (1985). This may involve tuning down the clients' affects in such a way as to bring them within manageable levels so that the client can think clearly. Or it may involve 'tuning up' and amplifying the client's affect so that they can begin to access their own affective experience. This can be long painful work taking many months even years with those who have had the extremes of misattunement hinted at earlier (see Vas Dias 2000; Truckle, 2000, &

Mollon, 2000). Secondly, the caregiver has to relate to the content so that the careseeker can re-examine their concerns from the advantage of a meta perspective. This is achieved through empathy.

The process of goal-corrected empathic attunement that I am presenting locates caregiving in the psychotherapeutic context within the theory of the attachment dynamic, (Heard and Lake, 1986, 1997).

What happens when careseeking is activated is that the exploratory system is overridden. In order to engage the client in exploratory work careseeking must be assuaged by effective caregiving. In other words, in the therapeutic context, assuagement of the careseeking system will provide the conditions necessary for the exploratory system to function. There are distinct vitality affects associated with the three stages to this process: 'relief when careseeking needs are met; enlivenment when in the process of exploration and well being when in touch with competence to act', (Heard, 1997a).

Goal-corrected empathic attunement therefore involves an open system of communication between two parties engaged in a psychotherapeutic endeavour. This in turn involves a wish to be understood and helped on the one hand and a capacity to attune to affect, regulate arousal levels, empathise, provide thoughtful ideas and responses and a flexible response to non-verbal and verbal feedback on the other. The goal of empathic attunement is to facilitate the functioning of the client's exploratory system. If the blend of empathy, affect attunement and regulation of arousal levels has been successful then the exploratory system will 'kick in' signalling that the goal of the interaction has been met.

The processes that one would expect to take place are as follows: an expression of concern by the careseeker is matched by the caregiver for emotional intensity and vitality (Stern's cross modal affect attunement); this is followed by further revelations

by the careseeker, which are responded to in such a way by the caregiver (as described in Bohart's definition of empathy quoted earlier) that the careseeker's meaning as well as the feeling they have about the content are being understood; this leads the careseeker to raise further concerns; which is then responded to by an expression of affect attunement by the caregiver; this leads to visible assuagement on the part of the careseeker and a sense of satisfaction in the caregiver. At this point the careseeking system shuts down temporarily until a further careseeking behaviour is activated.

I would expect from the attachment literature and my own observations referred to in chapter one, that most stages of this process will be accompanied by social referencing behaviours as described by Emde (1983, 1985) and Kiersky & Beebe (1994) where the careseeker scans the caregiver's face for cues on which they make a judgement as to whether it is safe to proceed.

> "Social referencing is a process whereby an individual, when confronted with a situation of uncertainty, seeks out emotional information from a significant other in order to resolve the uncertainty and regulate behaviour accordingly. In our experimental social referencing paradigms we have constructed situations of uncertainty that involve an unfamiliar toy robot, an unfamiliar person, or a glass-topped crawling surface with an apparent drop-off (the so-called "visual cliff"). When an infant, in the course of exploration, encounters the uncertainty situation (e.g., the apparent drop-off surface) he looks to mother's face. If she signals fear or anger, the infant ceases exploration or withdraws; if she signals pleasure or interest, the infant continues exploration."
>
> (Emde, 1990b, 893)

The hypothesised process of goal-corrected empathic attunement is represented in the following chart.

GOAL-CORRECTED EMPATHIC ATTUNEMENT WITHIN THE CONTEXT OF PSYCHOTHERAPY

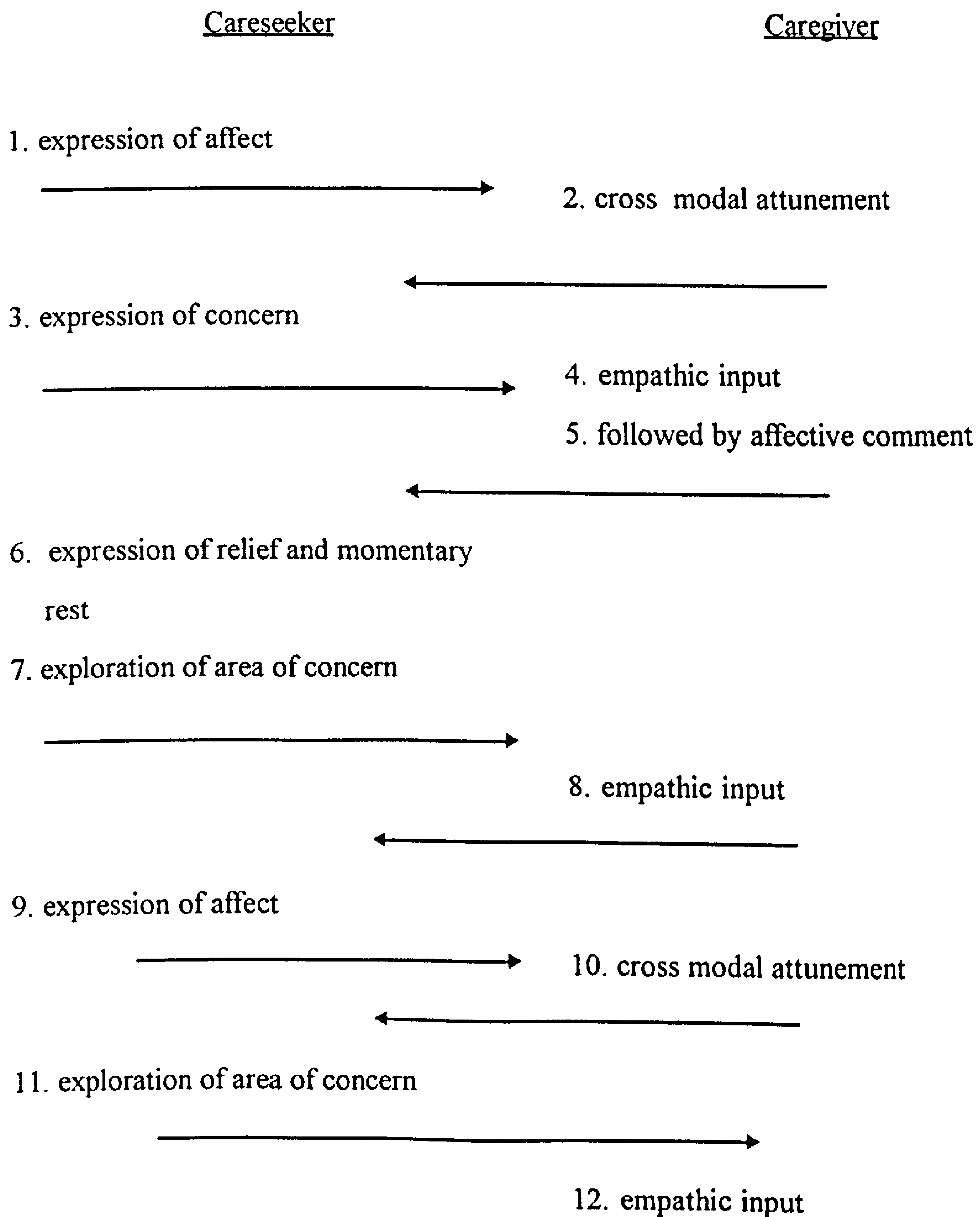
BEHAVIOUR OF CARESEEKER	CAREGIVER'S RESPONSE	IMPLICIT GOAL OF CAREGIVER'S BEHAVIOUR WITHIN A THERAPEUTIC CONTEXT	FUNCTION IN ATTACHMENT TERMS OF CAREGIVER'S BEHAVIOUR	VITALITY AFFECTS WITHIN A SYSTEM OF RESPONSIVE INTERACTIONS BETWEEN CARESEEKER AND CAREGIVER
expression of concern or distress	affect matching for intensity and vitality	settle initial anxiety: affect regulation	signals emotive message are understood and accepted	relief
displays concerns	empathic response	influence internal working models of relationship	signals the competence of the caregiver	relief
raises further concerns or shows further distress	attunement to the affect combined with empathic input	regulate arousal levels, signal intended continuing proximity and a benign cognitive appraisal	signals the range of material that it is safe to explore in this context	relief
exploration of concerns	attunement to affect, affect regulation and empathy	facilitate a sense of continuity with past experience	survival, integration and development	enlivenment and well being

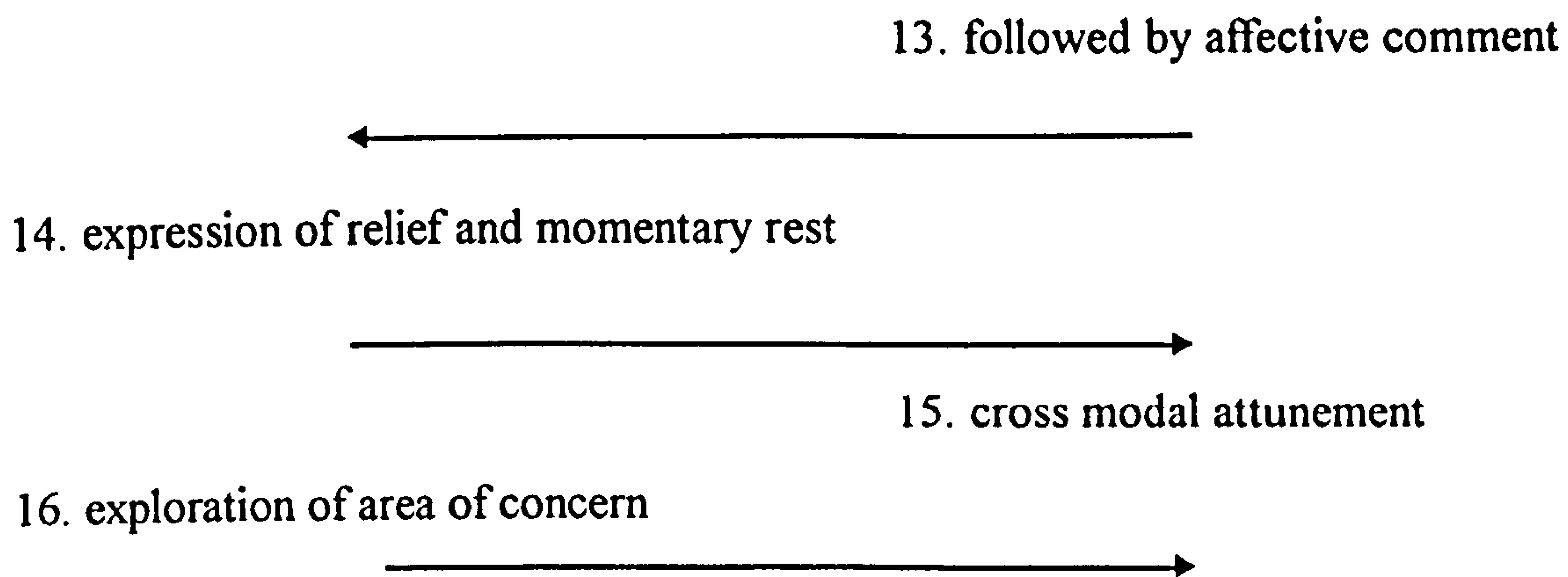
While affect attunement is expressed cross modally, empathic attunement is expressed verbally, it is an intuitive grasp of the underlying emotional state of the other that draws on empathic knowledge and is an acknowledgement of an emotional state e.g. a therapist says to the client: 'You are showing me your despair." There is acknowledgement of the correctness of the fit between the experience and the explanation by non-verbal and possibly verbal gestures of relief.

In line with the previous diagram I suggest that it may be possible to identify a sequence of behaviours in therapeutic situations which can be tracked.

I set this out in a diagram to indicate the possible flow and direction of interaction, though many variations are possible.

The Deepening Spiral Of Goal-Corrected Empathic Attunement.





The above sketch illustrates that the process of exploration of deepest concerns is fluid and dependent on checking the response of the caregiver to see whether it is safe enough to proceed. As will be noted in the diagram, sometimes empathic input from the therapist on its own will trigger affect in the careseeker (see 8 and 9). Slight hitches in the responsiveness of the caregiver will throw the careseeker back into careseeking behaviour and inhibit exploration. This process characterises psychotherapy as a careseeking-caregiving partnership in which each party has their own set goals.

In short the interaction between therapist and client is part of a goal-corrected sequence governed by biologically based instinctive goal-corrected systems.

Where have we come so far?

The concept of goal-corrected empathic attunement is based on the idea that in situations arousing attachment issues, careseeking will be activated and remain active until assuaged, at which point the exploratory biological instinctive system will engage.

In this chapter I have used the context of psychotherapy to explore the dynamics of careseeking and caregiving. I did this because in the main it is the medium we have

elected to address the aetiological roots of failed and successful caregiving. However careseeking is not only aroused within the psychotherapeutic context.

I started in chapter one with an account of my mother's consultation with a cardiologist and suggested that the consultation might have taken another form or at least that she would have come out from the consultation feeling differently about it, if she or he had been able to get beyond her particular careseeking style.

It is crucial in the process of medical consultations that one's exploratory faculties remain active so that one can discuss all aspects of the problem to one's satisfaction. This is not going to happen if careseeking is aroused. Unfortunately the sheer context of medical consultations invites careseeking.

It seems equally plausible to me to think that careseeking can be aroused in a multitude of contexts but particularly in consultations with social workers, care staff, nurses, and others in the 'caring professions'. This thesis is based on the assumption that the processes explored in psychotherapy have relevance to other situations involving human interactions in times of crisis and distress.

For their part psychotherapists have traditionally been aware of the crucial importance of the therapist's attitude, empathy, communication skills, attention to verbal and non verbal clues, and attunement. It therefore made sense to begin an exploration of these concepts with research in this field.

In chapter two I drew attention to the contribution made by those who have researched the psychotherapeutic process. In particular I commented on their understanding of the importance of process for the development of a sense of self, and of the relationship between defensiveness and self acceptance. They also drew attention to the importance of affect matching and intensity and the role of empathic response. Carkhuff and Berenson particularly drew our attention to the importance of

the quality and depth of empathy not just at the start of therapy but over time as the therapeutic process developed between client and practitioner. We noted the research into Luborsky's concept of the "Core Conflictual Theme' and its links with early experience of relationship. Finally we noted research into the quality and nature of affective response from the therapist and its role in regulating arousal levels (Anstadt).

I concluded chapter two with the argument that psychotherapy was in need of a theory of interaction between careseekers and caregivers that would help to understand the psychotherapeutic process between adults. In particular I felt that:

(i) research on interaction between infants and caregivers could throw light on the processes occurring in psychotherapy which have been identified over many years as being of critical importance.

(ii) psychotherapy could be understood of as an attachment eliciting activity which arouses the dynamics of attachment in the clients who come for help;

In chapter three I focused on the findings of developmental psychologists who 'discovered' that infants were not just 'gas bags, full of wind', neither were they bundles of instincts born ready made with a theory of mind and able to attribute persecutory intent to other people. In contrast, in support of the psychoanalyst Ronald Fairbairn, researchers found that from within a few hours of birth infants were ready to meet other people, interact with and enjoy them. We saw that the infant cannot do this on his or her own and that in order to achieve this goal he or she needs help from an attuned, sensitive and empathic caregiver who is willing to search out what the infant is communicating and then make sense of it.

I ended chapter 3 with the suggestion that attachment theory offers an explanation of the interactive roots of this phenomena and the biological basis for it.

In chapter four, I located the interactive patterns developed between infants and caregivers within the context of attachment theory as developed by John Bowlby and extended by Ainsworth and Heard and Lake. The fine nuances of intrusiveness and deliberate misattunement on the one hand and affect regulation sensitive attunement and empathy on the other were found to be associated with secure, insecure and disorganised patterns of attachment.

In addition we saw from the work of the Grossmanns' that sensitive attuned responsive interaction from a caregiver when the infant was exploring, maintained and enhanced exploration, while intrusive interaction from the caregiver when infant was exploring stopped the infant in their tracks. Non responsiveness from the 'caregiver' when the infant was flagging simply left the infant to their own devices in a state of non exploration.

While it is enough, (in fact essential), for infants to get an attuned and empathic response from their caregivers which is basically communicated at a non verbal level[5], such is not the case for adults. I consider, that post infancy, (in other words after the infant has acquired language and can communicate with other's who are not their primary attachment figures), the sharing of vitality states in situations where the dynamics of attachment have been aroused, leads the careseeker (toddler, adolescent or adult) to *expect empathy*. I formed this view on the basis of thinking that the experience of attunement in these circumstances can give rise to the feeling of being known - of one's emotional state being understood. In this case when the person does not get an empathic response[6] he or she develops defensive strategies to cope with the emotional disturbance aroused (the pain of failed careseeking).

[3] See Weil, 1992, for a discussion of the connection between deprivation of empathy and severe emotional abuse.
[4] In practice, the two go together, caregiving is always exploratory. However in practice I think it may be possible to talk of primitive and more mature forms of caregiving. For example an instinctive form of caregiving might include indulging in soothing activities to lull a child to sleep, which is very different from caregiving that actively seeks to understand an infant's behaviour.
[5] Which is not to say it is devoid of sound.
[6] See Weil, 1992, for a discussion of the connection between deprivation of empathy and severe emotional abuse.

At this point I began to put together ideas about I considered essential for understanding the dynamics of careseeking and caregiving between adults when the dynamics of attachment are aroused.

Based on my reading of infant development and attachment processes and the empirical work about to be described in the next three chapters, it became clear to me that what facilitated exploration was empathic attunement. Empathic attunement is what is sought by the careseeker and offered by the caregiver. When it 'works' or is provided with sufficient skill the careseeking system shuts down and the exploratory system goes into action. In this way the process is goal-corrected.

In situations which have triggered the dynamics of attachment, a careseeker who has experienced attunement from the caregiver and then does not receive an empathic response will according to the theory, experience distress - in the form of anger, sadness or despair. It should be possible to track what happens between careseekers and caregivers when this happens. This is not *just* about tracking sequences of behaviour, facial expression, intention movements and the whole array of verbal and non verbal responses, it is about noticing, (i) whether the *pattern of interaction* changes when there is a lack of empathic response, and (ii) the accompanying affect.

I have identified goal-corrected empathic attunement as a process within the instinctively based careseeking and caregiving systems which contributes to the delivery of effective care. Effective care is that which assuages the careseeker so that the careseeker has the subjective experience of their careseeking goals being met. When this happens the instinctive system for careseeking will shut down and the exploratory system within the individual will have more energy to engage with the problems of living. The concept of goal-correction means that the delivery of effective care is a dynamic, responsive interactive process - not something that can be fully anticipated in advance or fully planned for.

The idea of goal-correction operating between two people shows how dynamic and creative the process of careseeking and caregiving is. Both parties are engaged in bringing about the desired result and using all their ingenuity to achieve it. The research quoted in chapter 3 shows just how interactive and responsive this process is. We saw that when an intrusive adult wanted contact with her infant the infant who was very young still dodged her attentions and tried to escape as best he could. While held in her arms - the infant used what was available - the ability to move his head.

The concept of goal-correction takes us away from the notion of 'getting it right'. 'Getting it right' is clearly what it is all about, but this cannot be judged on the basis of verbal or non-verbal behaviours and affects considered in isolation from each other or from behaviour and affects of the other party.

The concept of goal-correction directs us to think in terms of *the state of correction* as it were and how we know when that state is reached. The beauty of attachment theory is the simplicity of the answer to this question. As said before, there is a behavioural and an experiential dimension to this. Some behaviours shut down and others emerge. The person who has the experience of something being triggered inside themselves knows that that trigger is no longer active and that they feel calmer - the experience is relief - of feeling settled.

In summary therefore, my thesis is that when the dynamics of attachment are aroused, the caregiver needs to be alert to *the meaning of the behaviours being presented by the careseeker in attachment terms.* Attachment theory provides a framework *for monitoring the interaction process itself* between careseeker and caregiver. In addition attachment theory suggests that when the goal of the system is

met, this is experienced and known subjectively. The person themselves experiences whether the goals of the instinctive system for careseeking have been reached or not.

Such a view of the process of interaction between careseeker and caregiver was not available to me when I started out on this research as explained in chapter one. The ideas were developed during the course of the research that I am about to describe in the next three chapters. I started out to test my hypothesis that affect attunement by the therapist was associated with whether or not the client explored or was inhibited from exploring. The first step in this process was to see whether affect attunement could be identified. My next chapter describes my first experiment: the identification of affect attunement in adult psychotherapy.

CHAPTER SIX

FIRST EXPERIMENT:

THE IDENTIFICATION OF AFFECT ATTUNEMENT IN ADULT PSYCHOTHERAPY

> ..the activity that is characteristically scientific begins with an explanatory conjecture which at once becomes the subject of an energetic critical analysis. it is an instance of a far more general stratagem that underlies every enlargement of general understanding and every new solution of the problem of finding our way about the world. The regulation and control of hypotheses is more usefully described as a *cybernetic* than as a logical process: the adjustment and reformation of hypotheses through an examination of their deductive consequences is simply another setting for the ubiquitous phenomenon of negative feedback."
>
> (Medawer, 1962 p. 154)

INTRODUCTION

As stated in chapter 2 the overall aims of my empirical research were:

1 To obtain a measurement of affect attunement.

2 To see whether students who were given training directed at encouraging them to attune to client affect would subsequently do better at attuning to affect than those students who were not

3 To see whether the attachment status of the students affected their ability to attune to client affect

As a first step I needed to see whether the concept of affect attunement which had been developed in the infant domain (Stern, 1985) fitted the adult domain and in what ways it might need developing to meet the needs of the adult context. Once having established a definition of the concept I needed to see whether it could be reliably rated. I then needed to see whether what I was rating had any validity within the area that I was studying - could I relate the measure to other related measures? Finally I needed to see whether I could train people so that they were better able to attune.

The research design

I conducted three experiments. The first took place in the summer of 1995. I prepared six 1.5 minute videoed extracts of clinical material and had them rated for affect attunement by senior clinicians and students. The basic aim was to see how far attunement, as I defined it, could be identified by both groups.

The second experiment took place in June 1996. Building on experiment one, I now had a clear example of affect attunement and a clear example of non attunement. I prepared three videoed extracts of clinical material and had them rated by two groups of students. Both groups were given definitions of affect attunement. However one group of students were given indicators to help them judge the extract and the other group were not given indicators. The aim was to see whether the additional indication improved the students' ability to identify attunement.

The third experiment also took place in the summer of 1996 and consisted of role plays designed to elicit the dynamics of attachment. I involved professional actors as the careseekers (clients) and students as the caregivers (social workers/therapists). The role plays were videod and the students rated by the actors on prepared scales. The students also rated their own performance.

The students were then divided into two groups. One group was given training, the other group was not. Two weeks later both groups then interviewed the actors again. The role plays were videod as before and the students work was again rated by the actors and by themselves.

At the end of the second day of working with the actors all the students completed three self report attachment style questionnaires. The aim was to see whether attunement could be identified and measured by an external observer. Whether this measure and the students and actors self reports related to their attachment status, and whether training improved performance on all these measures.

First experiment

My first experiment therefore concerned the initial exploratory attempts to identify and define affect attunement in the adult context.

As a first step, I started with seeing whether my colleagues in the field of psychotherapy and social work could agree with me and with each other about whether an interactive sequence between client and therapist was attuned or not. At the stage of devising my first experiment I was not as clear as I am now about the difference between affect attunement and empathy - I had blurred them in my mind to mean empathic attunement and the reader will see this when they read the design of the experiment. Nevertheless, it was a first step in clarifying the concept .

I set out to see whether:

i) it was possible to identify affect attunement in adult psychotherapy;
ii) to get a clearer understanding of the processes involved in affect attunement in the adult context;

iii) to see whether students were equally good at identifying affect attunement as expert clinicians.

The study was based on excerpts from psychotherapy sessions which had been classified by practising therapists as attuned or non-attuned, and in each case a detailed account was obtained as to the reasons for the judgements which were made. These excerpts were then shown to a sample of social workers in training, to discover whether their assessments would correspond to those made by the expert panel. It was intended that detailed analysis of the responses by both therapists and students would show which particular features of the interaction were used to make judgements about the degree of attunement, including the degree to which observers used behaviour of both therapist and patient to arrive at their judgement.

In summary, the study was aimed at assessing (a) the extent to which experts could agree on the attunement or non attunement in video-taped excerpts from therapy sessions, (b) the extent to which their judgements corresponded with those made by relatively inexperienced students, (c) what cues experts and students used to arrive at their judgements.

Materials and procedure

Six excerpts, each lasting one and a half minutes, were selected from a corpus of video-taped psychotherapy sessions. Five of the excerpts were from sessions by two senior therapists, while the third was obtained from a BBC programme on counselling.

The excerpts were selected to reflect an initial judgement of attunement or non-attunement made by myself and a colleague (Dr Derek Rogers[1]), both of us have extensive clinical experience. The six excerpts were divided into two groups of three which, in our opinion, showed either attunement or non-attunement by the therapist.

[1] Reader in Psychology, Department of Psychology, University of York

The initial judgement thus provided a baseline for the study, with excerpts 1, 4 and 6 (therapist A) representing attunement and excerpts 2 (therapist C), 3 and 5 (therapist B) representing non-attunement.

Copies of the tape were sent to the nine experts, who were blind as to the attunement status of the excerpts. The instructions included a definition of attunement which stated that "attunement is a way of communicating to the other that one has recognised the affect they are experiencing. Attunement conveys to the other that one has a feeling sense inside of what it feels like to be them right now." They were asked to view each tape twice, stopping after each excerpt on the first viewing and simply rating it as to whether, in their view, the therapist was attuned or not. On the second viewing they were asked to rate each therapist again, but also to make notes giving the reasons for their judgement.

Based on the judgements made by the experts, a second tape was created for the students comprising just three excerpts - one which the experts had unanimously classified as non-attuned (excerpt 5), one which 8 out of nine experts had judged to be attuned (excerpt 6), and one where the experts were divided in their judgement (excerpt 1). Excerpts 1 and 6 were recordings of the same therapist, and to control for this and for ordering effects the excerpts were presented in counterbalanced sequence[2] to the groups of students using three versions of the tape. The students were all asked to provide a written definition of an attuned therapist before being given the definition used for the experts. The students then viewed one of the three counterbalanced tapes in groups of three or four. The tape was stopped for 30 seconds after each excerpt to allow students to record a score based on a 6-point scale. Scale labels classified points 1 and 2 as attuned, 3 and 4 as undecided, and 5 and 6 as not attuned. The students then viewed the tape for a second time, with a pause between each excerpt to allow the reasons for the judgement to be recorded.

[2] I prepared three video tapes of the six excerpts. Each tape presented the excerpts in a different order. This minimises the effects of order on the results. As a favourable or negative attitude towards a

Subjects

There were two groups of subjects. The first comprised nine senior psychotherapy clinicians: three consultant psychiatrists who held posts in psychotherapy, three social workers who held senior practitioner posts, and three research academics who had extensive clinical experience. The second sample comprised 31 students from a two-year post-graduate social work training programme, all of whom volunteered their participation (see appendices 2 & 3). The students were divided approximately equally between the first and second year of training, and the sample included four men and 27 women with an overall mean age of 31.5 years (SD 6.3) Thirty-nine percent were aged between 26 and 30 years, and an equal percentage had between 4 and 6 years social work experience prior to training. A further 13% had no experience, 29% had between 1 and 3 years and the rest (19.5%) had between seven and 15 years experience prior to training.

Results

Descriptive analysis of the data showed that the experts were agreed that excerpt 6 (therapist A) was attuned and with one exception, that (therapist B) as not attuned. The judgements of excerpts 1, 2 and 4 were more mixed, and overall there was relatively little change from the first to the second viewing. Some caution needs to be preserved in terms of using these results as a benchmark. The results are summarised in Table 1.

therapists' work is likely to depend on which of her excerpts one saw first it is also relevant in this regard.

TABLE 1: RATINGS OF EXCERPTS GIVEN BY THE EXPERTS (N=9)

		Non-attuned	Attuned
Therapist A	(excerpt 1)	5 (55.6%)	4 (44.4%)
	(excerpt 4)	3 (33.3%)	6 (66.7%)
	(excerpt 6)	0 (0%)	9 (100%)
Therapist B	(excerpt 3)	8 (88.9%)	1 (11.1%)
	(excerpt 5)	8 (88.9%)	1 (11.1%)
Therapist C	(excerpt 2)	3 (33.3%)	6 (66.7%)

The students' judgements of the attuned and non-attuned excerpts were in sharp contrast, with only 36% agreeing with the experts that excerpt 5 was non-attuned and only 19% agreeing that excerpt 6 was attuned. Indeed, over two-thirds (68%) were undecided as to whether excerpt 6 was attuned, whereas the experts had been unanimous in judging it to be so.

These findings are summarised in Table 2.

TABLE 2: RATING OF EXCERPTS BY EXPERTS AND STUDENTS

STUDENTS' JUDGEMENT	EXPERTS' JUDGEMENT	
	Not attuned	Attuned
Not Attuned	11(36%)	4 (13%)
Undecided	13 (42%)	21 (68%)
Attuned	7 (23%)	6 (19.3%)

Further inspection of the data showed that only three of the students made judgements of both attunement and non-attunement which corresponded with those made by the experts. The 'undecided' category only applied to the students as the experts had been asked to select between 'attuned' and 'non attuned'.

Creating two groups of students whose judgements corresponded with the experts' judgements of attunement or non-attunement and comparing them with the unsuccessful students by means of one-way analyses of variance for unequal samples also yielded non-significant results. There was also no relationship between the accuracy of the trainee's ratings and measures of age, sex, previous experience in social work or experience in counselling.

The reasons given by the experts for their judgements of the excerpts were examined by coding their responses, which yielded four primary characteristics in each of the categories of attuned and non-attuned therapists.

These were:

ATTUNED THERAPIST			
Engrossed	Modulates response	Provides empathic input	Facilitates exploration

and

NON-ATTUNED THERAPIST			
Distracted	Non-modulated response	An absence of empathic input	Stopping exploration

The first two categories seem primarily concerned with the management of feeling and the second two with the management of content. This classification of the responses of attuned and non-attuned therapists is outlined below:

An attuned therapist

Examples of an attuned therapist as given by the experts	Characteristics of an attuned therapist derived from data from the experts	Behaviour of therapist
"Attentive listener, still body posture etc."	Engrossed	Management of feeling
"The therapist seeks, either voluntarily or involuntarily, to match the feeling of the other through their tone of voice, facial expression, hand or body movements etc."	Modulates response	Management of feeling
"Appropriate comment. The therapist offers something in the form of an idea or a feeling in the same general area that the client is working in which the client seems able to take up, build on or pursue."	Provides empathic input	Management of content
"Client discusses/pursues what matters to them in response to something the therapist does."	Facilitates exploration	Management of content

A non-attuned therapist

Examples of a non- attuned therapist as given by the experts	Characteristics of a non- attuned therapist derived from data from the experts	Behaviour of therapist
"Therapist is nervous; not comfortable; self conscious; patient's response makes therapist agitated." "Both fidget, a lot of physical irritation; both looked bored."	Distracted	Management of feeling
"Although the therapist listens to what the patient is saying there is no response or feeling."	Non modulation of response	Management of feeling
"uses question and answers"; "Therapist tries to cut short some of client's comments."	Non-empathic input	Management of content
"Stops exploration - uses voice tone and closing remarks such as 'that's all right then?' to shut down exploration of particular subject."	Stops exploration	Management of content

Applying a similar analysis to the students whose judgements of attunement and non-attunement corresponded to those of the therapists gave a broadly similar classification. Sample responses were "Therapist gave full attention" for the engrossed category, "Much quicker response by client to therapist's comments , as if agreeing that therapist has described how they are feeling" for the facilitates

exploration category, and "Therapist seemed unable to get a sense of client's feelings, except by asking questions directly of client" for the non-empathic input category.

The gender of patients and therapists was not systematically varied in the study - indeed, all three therapists were women, and with the exception of excerpt 5 the patients were also all female. However, excerpts 3 and 5, which had the same female therapist but different sex patients, were both judged by the experts to be unambiguously non-attuned. At least in the case of this particular therapist, there is no evidence that gender differences in the patients affected the experts' judgement of attunement.

Discussion

I had expected that the students' judgements of attunement would correspond to some degree with those of the experts, though moderated perhaps by professional experience and other attributes such as personality. In fact, the judgements made by the two groups of subjects were very different, and the degree of disagreement between experts and students raised a number of interesting questions. It might be argued that the students' judgements were confounded by the introduction of an "undecided" category into their rating scales, but even if this category is omitted from the analysis there is little consistency with the experts' ratings.

The coding of the therapists' behaviour as managing feeling or managing content helps to shed further light on the question. The characteristics of the therapists judged to be attuned by the experts convey development and progress, a regard for the importance of what the patient is saying and a willingness to interact and respond to it, whereas non-attunement suggests a lack of rhythmical interaction, boredom with what is being spoken about and a lack of synchrony between therapist and patient. The usefulness of the proposed classification is strengthened by the fact that similar categories were identified in the coding of those students whose judgements were similar to those made by the experts.

The students whose judgements did not agree with those of the experts fell into two groups: those who thought the experts' non-attuned therapist was attuned, and those who thought the experts' attuned therapist was not attuned. In both groups, the students paid insufficient attention to the sequence of interaction. For example, those who thought the non-attuned therapist was attuned were aware that the therapists asked questions but failed to notice that she did not pick up on the answers, changed the subject or looked as if she were bored with the answer. Students who thought the experts' attuned therapist was not attuned commented on the therapist's didactic approach but failed to notice that the client was not affected by it. Thus both types of failure to agree with the experts involved not looking at the sequence, but while in the one case the answer lay in observation of the therapist, in the other the answer lay in the interaction between therapist and patient.

In addition to the findings in relation to the experts and the students, the experiment suggested new ideas about the nature of the concept under investigation. I had started with the intention of finding out whether Stern's understanding of affect attunement was relevant to the interaction that occurred between two adults in a careseeking caregiving context. I wanted to see whether a therapist who mis-attuned to a client's affect would inhibit the exploratory process in much the same way as a parent who misattuned to their infant would stop the infant in their exploring. To illustrate the process that I am referring to in infancy I will present the observations of Stern (1985) and his team:

> "In the videotape of an initial play period. a nine-month-old infant is seen crawling away from his mother and over to a new toy. While on his stomach, he grabs the toy and begins to bang and flail with it happily. His play is animated, as judged by his movements, breathing, and vocalisations. Mother then approaches him from behind, out of sight, and puts her hand on his bottom and gives an animated jiggle side to side. The speed

> and intensity of her jiggle appear to match well the intensity
> and rate of the infant's arm movements and vocalisations,
> qualifying this as an attunement. The infant's response to her
> attunement is - nothing! He simply continues to play without
> missing a beat."
>
> (Stern, 1985, p. 150)

Stern then instructed the mother to carry on doing as she was doing but to 'misjudge' her baby's level of animation, to pretend that the baby was somewhat less excited than he appeared to be and to jiggle accordingly. "When the mother did jiggle somewhat more slowly and less intensely than she truly judged would make a good match, the baby quickly stopped playing and looked around at her, as if to say "What's going on?" This procedure was repeated with the same result. ...When the mother was to pretend that her baby was at a higher level of joyful excitement and to jiggle accordingly..the result was the same." (p.150).

It seems to me from the result of the experiment being described in this chapter is that those who correctly judged the misattuned excerpt notice a process of affect attunement which is then followed by a lack of empathy. The attunement to affect is accurate but there it no empathic response.

The capacity to attune to affect as I said in chapter 4 is largely a pre-verbal and non verbal facility. It happens largely out of consciousness and we seem to be born with it. We pick up and resonate to the other's emotional state. Empathy is quite a different matter. It is a metacognitive capacity which seems to involve the ability to (a) translate the information from affect attunement into an appreciation of the other's experience, (b) locate this information in the context of the other's life and times and (c) put this understanding into words in a way that the client gets the feeling of having been understood.

Affect attunement or attunement to the affect of the other appears to be as suggested by Stern (1985) a state of 'being in the rhythm of the other' - the rhythm of their vitality affects - whether that is the affects associated with despair, joy, depression, sadness fear, anger or boredom. What this experiment brought home to me was attunement on its own was not enough. Two quotations may help make my point.

> "Therapist is nervous; not comfortable; self conscious; patient's response makes therapist agitated."
> "Both fidget, a lot of physical irritation; both looked bored."

In these examples the therapist and patient may be seen as being 'in rhythm' with one another. However this attunement on its own seems to maintain the status quo. It does not impact positively or negatively in affecting the other's state.

There is another way in which being in rhythm seemed to be not helpful.

> "Although the therapist listens to what the patient is saying there is no response or feeling evidence of attunement from the nods. She just seems to be making sure the patient is happy with the situation."

> "Does not notice disjunction between verbal and non-verbal behaviour of client which may indicate he/she is not pursuing something he/she may want to pursue."

In these examples what is criticised is not the lack of rhythm but rather a failure of understanding.

Along with mis-attunement to affect, for example, "Therapist moves physically away from client; uses question and answers", this process was linked in the raters minds with inhibiting the client's exploration of their concerns.

"Stops exploration - uses voice tone and closing remarks such as 'that's all right then?' to shut down exploration of particular subject."

"Therapist tries to cut short some of client's comments."

We can see therefore that the process of affect attunement as described by Stern is not on its own sufficient to capture the complexity of adult to adult interaction in psychotherapy. Substantial misattunement to affect may well inhibit exploration but attunement to affect on its own does not promote exploration. What is required in addition is empathic input.

Summary

The agreement between the students' judgements and those of the experts, were little better than should have occurred by chance, even amongst those students who had prior experience. One of the features of the judgements made by students which did not match those of the experts was their emphasis on the therapists' behaviour to the exclusion of the patient's response.

It seemed from the first experiment that students were influenced primarily by the behaviour of the therapist and were not paying attention to how the client was responding to the therapist and vice versa. It seemed to me that I needed to construct an experiment to see whether if students were pointed in the direction of interaction they would increase their chances of making a correct judgement. I also wanted to explore in more depth their perception of the interactive process between therapist and client. A second effect of the experiment is that I decided that the concept that I was investigating was more accurately described as empathic attunement.

In my next chapter I will describe the experiment I designed to fit these purposes.

CHAPTER SEVEN

SECOND EXPERIMENT:

IS EMPATHIC ATTUNEMENT INTERACTIVE?

INTRODUCTION

As explained in the last chapter I wanted to test the hypothesis that experts in comparison with the students had paid greater attention to the interaction between therapist and client. If so, this would provide a reason for seeing empathic attunement as goal-corrected and requiring close attention to how the other responds. One would also expect that if the students were given training in attending to interaction they would improve their level of agreement with the experts.

Hypothesis

My hypothesis was:

> Students who are given instructions to pay attention to the interaction between therapist and client will produce more accurate ratings of empathic attunement than those who are not given such instructions.

Overview of experiment

The design of the experiment consisted of creating two matched groups. The groups were matched on three grounds:

i) whether they had rated the material previously

ii) sex

iii) whether they were in year one or year two of training

Each group rated the same videoed clips of clinical practice. Both groups were given written definitions of affect attunement. One group, in addition to the definitions was given written instructions on what to pay attention to while viewing the extracts. Each of the participants attended a de-briefing session where they were asked to respond to two questions. The de-briefing session was tape recorded.

Methodology

Subjects

I wrote to all first year and second year students on the two year postgraduate master degree course in social work; explained briefly the nature of the project, the time commitment involved and the sum of money I was willing to pay for their participation (see appendices 2 & 3). Sixteen students in all agreed to be involved. 14 of these agreed to be involved in both parts of the project, the first part involved the identification of attunement on tapes of clinical practice (the subject of this chapter and which I am calling experiment 2) and the second part involved taking part in interviews on two separate days with professional actors (the subject of the next chapter, experiment 3).

Of the sixteen students who responded two had taken part the previous year, in the summer of 1995, when I had conduced the original experiment. Even though they had previous exposure to the material I decided to take them into the research. I did this for statistical purposes. I needed two groups as I wanted to test a difference; at best I was only going to have eight students in each group.

Method of allocation to groups.

The aim was to create two matched groups; matched for previous exposure to the material, gender, and year of training. I matched the students as far as possible on this criteria and then allocated them to one or other group on the toss of a coin.

Table 3 illustrates the final allocation of students to each of the two groups.

TABLE 3 The Experimental Group and the Control Group

	Experimental Group	Control Group	Total
previous exposure to test material (in 1995)	1	1	2
Male	2	3	5
Female	6	5	11
Year one	5	5	10
Year two	3	3	6

I allocated the extra man by tossing a coin, "Heads' he went into the 'experimental group', 'Tails' he went into the control Group. By this method the extra man went into the control Group, I therefore allocated the extra woman to the experimental Group.

Confidentiality

The project was passed by the ethics committee in the psychology department. In addition each individual student signed a consent form which allowed them to withdraw from the project at any time they so choose. A copy of the consent form is attached as appendix 4. No student withdrew from the project. Two failed to complete as they were called for job interviews on the last day of the main experiment.

Materials and practical arrangements

I selected three 1.5 minute extracts from the clinical material used in the first experiment. I chose three out of the six original extracts on the basis that one clip was rated unambiguously as attuned by the experts; the other clip was rated not-attuned by 80% of the experts and the third clip got a mixed rating - half thought it was

attuned and the other half thought it was not-attuned. I myself considered that this clip demonstrated the process of 'tuning in'. In this experiment therefore, clip one demonstrated tuning in; clip two demonstrated non-attuned interaction; clip three demonstrated attuned interaction.

In terms of organising the experiment I employed the help of a colleague. For practical reasons it was better if all the students could rate the excerpts at the same time. I hired the audio visual studio for a morning and had the audio visual material projected on to a large screen. The fact that they were all going to view the tape simultaneously created practical problems in terms of the two tests that I was conducting. I did not want the students to know at this stage that they were being given separate instructions. My colleague and I decided to organise the chairs in the room in such a way that we had two groups of chairs in front of the screen sufficiently separated from each other so that those sitting on them would not be able to see each other's materials and instructions. As the students arrived at a pre-set time we ushered them into the appropriate groups. We explained to them the programme for the morning and just before they were about to rate the clips we handed out the written materials.

Programme and instructions

We explained the following points:

1 The nature of the experiment (to rate three excerpts from clinical practice as either attuned or not attuned), the terms of confidentiality applying to their participation, and to seek their signed agreement to participate.

2 The process of rating these extracts. The fact that the excerpts would be shown twice. On the second viewing we would stop after each clip for sufficient time to allow them to make their ratings.

3 We wanted them to attend a debriefing session after the rating session where we would show them the extracts through again and ask them why they had rated the way they had.

4 To explain that fourteen of them were going on to the next stage of the experiment and it was vital that they did not discuss any aspect of this experiment with each other or anybody else until the work of all experiments was completed which would be in one months time.

Rating instruments.

I designed two forms, one for the experimental group (appendix 5) and one for the control group (see appendix 6)

The form for the Control Group had the two working definitions of attunement that I had used in the experiment described in chapter two. These were:

The definitions being used for the purpose of rating the excerpts are as follows:

1 Attunement is a way of communicating to the other that one has recognised the affect that they are experiencing

and

2 Attunement conveys to the other that one has a feeling sense inside of what it feels like to be them right now

The form for the Experimental Group in addition to the above definitions also had the following typed instructions:

In making your decision, it may be useful to keep in mind the following indicators:

i) The therapist conveys a regard for the importance of what the client is saying along with a willingness to interact and respond to it

ii) The therapist appears to be engrossed in what the other is saying, they modulate their

response in relation to it, they provide input
and they facilitate exploration

The process of rating the clinical extracts

Having gone through the order of play and explained to the students exactly what was going to happen, we handed out the forms to each group and gave them the instruction to read their forms and to place a tick (√) in the appropriate box in order to indicate whether they thought the therapist was attuned or not.

Sample

	Excerpt 1	Excerpt 2	Excerpt 3
Attuned			
Not-attuned			

Conducting the experiment

We then started the experiment. One of us managed the video player and the other the lights. As I was at the back of the room doing the lights it was possible for me to observe the students' response to the instructions while they were supposed to be reading them. Some students seemed to read them thoroughly, some scantily and one that I saw simply put them unread on the floor. Noticing this I reminded the students to read the instructions for rating before we turned out the lights; this had no effect whatsoever on the participant that I had observed.

After the experiment we collected the rating forms and gave out the timetable for the de-briefing sessions

De-Briefing

My colleague debriefed 7 students and I debriefed 9. We each followed a similar format and each student was debriefed individually:

1 Checked with the student how they had rated the clips and that the form was filled in correctly

2 Explained that we would go through each clip again separately on the monitor; that we would stop after each excerpt and ask them two questions.

3 Explained that we would tape their answers

The questions we asked were:

a) why did you rate the therapist as attuned or not attuned?

b) what did you see that made you decide the therapist was attuned or not attuned?

The mechanics of the debriefing.

The students were seen on their own and told the discussion was going to be taped. The interviewer then checked their form with them to make sure that they had filled it in correctly and then went through each excerpt on a video monitor in turn. Each excerpt was shown through and before it started the interviewer checked with the student which way they had rated the excerpt, attuned or not attuned. As will be seen later on, some students wanted to change their rating following the second (actually third) viewing.

There were sixteen debriefings in all. All the sessions were audio taped and subsequently transcribed either by a professional typist or by myself. In all cases I listened to the tapes myself while reading the typescript in order to make notations related to pitch, emphasis, timing and tone of voice and to get a feel for the way the student was approaching the task. I also checked for accuracy of the transcript.

My experience of the debriefing sessions

I found doing the de-briefing sessions with the students immensely rewarding and interesting. First of all, the physical set up of the small interviewing room, the monitor and the very focused task gave a sense of seriousness to the endeavour. The students were aware that I did not have the answers to what I was exploring, that I was genuinely trying to understand the process of affect attunement between therapist and client and wanted their observations and views about the clips that we had just shown. Having the monitor within inches of the student and myself and viewing the excerpt through together provided a sense of intimacy and concentration.

Managing and collating the qualitative material

I subsequently went through the material and collated it in relation to correct and incorrect identification of the two clearly defined excerpts of attuned and non attuned as described in chapter two.

This gave me four categories:

1) those who correctly identified the non-attuned excerpt
2) those who incorrectly identified the non attuned excerpt
3) those who correctly identified the attuned excerpt
4) those who incorrectly identified the attuned excerpt

The three key questions I set out to answer from the transcriptions were:

1 Were the students paying attention to indicators from the therapist that they were tracking and responding to the communication of affect from the client?

2 Were the students paying attention to the affect signals (non verbal) as well as the verbal signals being communicated to the client by the therapist and how the client responded?

3 Were the students paying attention to whether the client explored the situation of concern to them?

I checked through all the transcripts in relation to these three questions, sometimes returning to the original tape of the debriefing session with the student if something was unclear to me to do with tone or emphasis.

For a discussion and an analysis of the methodology, please see appendix 7.
I will now move on to an analysis of the statistical results.

Statistical analysis

Sixteen students rated three excerpts; one excerpt had been clearly identified as attuned in the first experiment described in chapter 2 and the other had been clearly identified as non-attuned, the third excerpt was ambiguous, it had not achieved a clear rating of attuned or non attuned from the experts, but I had included it in the material given to the students in order to avoid giving them a choice between one attuned and one non attuned excerpt. I felt a choice of two would have encouraged the impulse to guess. In addition it would in a sense have given the students only one guess. They would probably assume that if one excerpt was attuned the other would not be. This assumption can not be made with three excerpts. I am treating this third excerpt as irrelevant in terms of the statistical analysis.

Table 4 sets out the numbers of students who correctly identified the excerpts

TABLE 4 CORRECT IDENTIFICATION OF ATTUNED AND NON ATTUNED EXCERPTS BY THE EXPERIMENTAL GROUP AND THE CONTROL GROUP

STUDENT IDENTIFICATION						
		Attuned	Not attuned	Total	No of students who correctly identified both excerpts	% of correct identific-ations
Experimental Group	Attuned	6	2*	8	5 62.5%	75%
	Not attuned	2*	6	8		
Control Group	Attuned	4	4	8	2 25%	44%
	Not attuned	5	3	8		

* one of these was the student who did not read the instructions

The above chart indicates that the Experimental Group did better at correctly identifying both the attuned and non attuned excerpts than the Control Group, scoring twelve 'hits' and four 'misses' as against seven 'hits' and nine 'misses'.

I gave each student a score based on whether they had 2, 1, or O 'hits'. I used the Mann Whitney test to examine the significance of the difference between them. Statistical analysis revealed that:

the two groups were statistically different, on a two tailed test: ($p=.041$, slightly greater if allowance is made for ties), and falling to $p<.01$ if the inattentive student is dropped : $p<.01$

The experiment supported the hypothesis that students who were given instructions to pay attention to the interaction between the therapist and client would be significantly better at identifying empathic attunement and non attunement than those who were judging the interaction using only loose definitions of the concept. This was a good result, confirming that my concept of empathic attunement was goal-corrected i.e. responsive and interactive and could only be judged correctly by focusing on the interaction between therapist and client.

I expected that the qualitative analysis should support this finding and in addition I hoped that the debriefing sessions would provide me with a more in-depth understanding of the students' perception of the interaction between the therapist and client.

I will now present the results of the qualitative analysis.

Qualitative analysis

In this section I set out my analysis of the students comments on the attuned and non-attuned episodes. I was interested to see whether the students who made correct identifications of the episodes associated empathic attunement with a highly interactive and responsive process which facilitated the client's exploration.

To observe this process correctly requires that the student pay attention to the behaviour of the therapist and the client in terms of the verbal and non-verbal signals they are giving each other, how they each respond to these signals and in particular whether the client explores or whether their exploration is stopped or inhibited.

What I found was that while both groups paid attention to verbal and non-verbal interaction, they clearly had quite different views of what they saw and heard and came to different interpretations and conclusions. The question therefore was, 'what distinguished one group from the other?'. What enabled one group to interpret the verbal and non-verbal behaviours correctly and the others to get these behaviours 'wrong'?

While both groups observed the process of interaction taking place between the therapist and client at verbal and non verbal levels the group who got the episode 'wrong' did not seem to pay attention to the goal of the interaction - to the outcome - whether the client succeeded in exploring their concerns or whether they were inhibited from so doing by the behaviour of the therapist. This was true for both episodes - the attuned and non attuned episode. In both cases those who got the episode 'wrong' paid no attention to whether or not the client explored or if they did as in the case of one of the 13 students concerned, overrode this observation based on their view of the therapist behaviour.

The 'attuned' episode that I used for this experiment consisted of a process of interaction between therapist and client which led to the client exploring their concerns. The 'non attuned' episode used for the experiment contained a process of interaction which resulted in the client not exploring their concerns.

The following charts give details of the student's observation which illustrate these points. I will present the comments on the 'Attuned' excerpt first and then move on to the 'Non-attuned' excerpt.

Episode 1 Attunement

This episode takes place between a female therapist and a female client. The episode starts at the point where they have been exploring why the client responds to the therapist as if she (the client) had to conform in some way. The client says there is something that gets in the way between her and the therapist. The therapist suggests that there is particular kind of relationship with herself that probably started in her relationship with somebody else. The therapist then asks if this makes sense. The client responds and takes up the idea. There is a slight pause which is then followed by the therapist putting words on what she thinks the client is experiencing. After another slight pause, the therapist asks another question in a very open ended way and in a tone that suggests she is in touch with something quite tender that is going on inside the client. There is a pause. The therapist is watching the client closely and murmurs something that indicates she is seeing something happening in the client's mind (maybe some thought or something). The therapist says "What?". The client picks this up and goes on to indicate that she is indeed in conflict - doesn't know which way to go:

C "It looks as though.. again..I can't tell if I am being pulled to someplace else..

The therapist intervenes and says "Go for it". The client carries on thus:

"that's big,. Someplace else that's big that denies me. A big part of me that denies me. Or a part of me that denies me in a big way. (pause) It is the part that makes it *inconceivable* to tell the truth (pause) to confront people that matter to me in a meaningful way. To tell them what's really going on with me".

Ten students correctly identified this excerpt as attuned, six students rated this excerpt as not attuned.

As noted above I went through the transcripts to see whether the groups could be distinguished on whether they were each paying attention to both verbal and non verbal behaviours. The chart below shows that both groups paid attention to both aspects of communication. It also shows the strikingly different ways the students interpreted what they saw and heard. Finally the chart illustrates that one group paid attention to the goal of the interaction, i.e. exploration and that the other group did not.

ATTUNED EXTRACT	Correct Identification	Incorrect identification
Non verbal behaviour	It was the body language of being forward and listening. She wasn't frightened of the client. She wasn't frightened of what the client might say - she seemed to be quite actively in the client's space - student J.	She was leaning forwards, so again, quite invasive - student S.
	But again there was that focus, she (the therapist) was constantly watching her eyes (the client's) and their heads were always straightforward together..she was leaning slightly forward which indicated to me that she was concentrating on the client. She allowed a lot of space for her to speak - student A	... the client didn't disagree she was nodding in agreement and..the therapist was nodding as well while the client was talking - student U.

ATTUNED EXTRACT	Correct Identification	Incorrect identification
Verbal behaviour		
	She (the therapist) would interject but it seemed appropriate. it didn't seem to be to divert her from the way things were going ..or anything which would deflect her from exploring what she was feeling - student A	The woman was saying a lot of things and she sounded very confused and lost about being in a big space and the therapist really didn't say anything about it..didn't make it easy I suppose- student D
	...and then there was a really nice pause when there was a period of time when the counsellor said ' Go for it' .. I felt at that stage the counsellor was sort of demonstrating some sort of listening and empathy - student P	There didn't seem to be that much empathy for what was going on from the counsellor - student R
	...she (the therapist) was still trying to clarify a lot - student B	she (the therapist) didn't communicate with the client in a way that showed understanding...she had an interpretation she came up with when the client hadn't said anything - student U.

ATTUNED EXTRACT	Correct Identification	Incorrect identification
Attention to exploration	The woman being interviewed sat back and said what she really felt and how she felt it was difficult to communicate with others. At that point their body language was symmetrical and they were both in the same position and so that was really striking - student L The client expanded but also the therapist was offering an explanation...in quite a simplistic straightforward way..(and) the client nodded in agreement and the way she (the client) opened it up was a brave thing to say, admitting that she wasn't honest (with people)..She (the therapist) was coaxing by saying Go for it' and I thought that was nice and really very encouraging - student X (female) I saw the client actually really look like she was reflecting on something, that there was something that was actually giving her a spot of bother to mull over and then the way the client went on from that...she got into a lot of material, that did seem quite important for her - student C	She (the therapist) had given her an interpretation and the client was trying to fit into it - Student U

As one can see from the chart, the students who make incorrect identifications pay attention to the interaction but form a judgement of the interaction based on their view of the behaviour of the therapist rather than on the outcome of the interaction for the client - whether the interaction facilitated or inhibited the goal of exploration.

The group who incorrectly identified the excerpt saw the therapist as intrusive and unempathic.

> "She was leaning forwards, so again, quite invasive" - student S.

> "There didn't seem to be that much empathy for what was going on from the counsellor" - student R

And they saw the client as compliant:

> "She (the therapist) had given her an interpretation and the client was trying to fit into it" - Student U.

In my view the students' lack of attention to the goal of the interaction meant that they failed to notice the detail of what the client was saying:

> "The woman being interviewed sat back and said what she really felt and how she felt it was difficult to communicate with others." student L

> "it up was a brave thing to say, admitting that she wasn't honest (with people).." student X

and the way that she said it. Apart from the fact that she went on to explore, the way that she explored had the air of being new or novel - a new understanding of her behaviour. In my view in addition to being able to pick up that the client actually did go on to explore there was another element which the students could have commented on but did not in fact do so. I refer to a sense of liveliness, a fluency of speech associated with the exploration. Building on the work of Stern (1985) with infants I

would call the mode of expression, i. e. the rhythm, pace, timing, in adults the vitality affects.

While I think an exploration of vitality affects may be worth returning to in a future project, from the above analysis what is clear is that it is not necessary for identification purposes to take into account the vitality affect of the client and therapist - it is enough to pay attention to whether or not the client actually explores.

I will now turn to the 'Non attuned' excerpt and continue my analysis and exploration. As in the 'Attuned' excerpt, the distinguishing factor between the students rested again on whether they took account of the goal of the interaction and whether they observed what happened in relation to that. In other words whether they observed and commented on whether or not the client pursued their exploration.

Episode 2 Non-Attunement

This episode takes place between a female therapist and a male client. The episode starts with the client referring to a problem he has with his back, but he then immediately moves away from further discussion of it and introduces the fact that he is now doing more of what he wants and spending his time the way he wants to as he has been advised (who has given this advice is not clear but one assumes he was given the advice by the therapist in a previous session). The therapist ignores the problem with his back and asks him questions about what he is doing with his time and whether he is enjoying himself.

He goes on to say that his wife is not too happy with him taking time for himself - but dismisses that as 'her problem'. He doesn't sound very convinced that he believes this. The therapist changes the subject and asks him if his wife has seen X (the implication is a medical consultant). The client answers the question about the appointment. He ends this discussion with the comment that even though he has tried

to get her to chase up the appointment she hasn't done so and 'she won't change'. This is said in a tone which could be interpreted as a mixture of exasperation and despair. The therapist cuts across what he is saying and asks him how all this is for him. When he says he is 'all right' about it - she says:

> T But you are feeling all right? I mean that was the main thing I wanted to check out?"
>
> C "Right. I am. Yea. That feels alright for me now".

Nine students correctly identified the therapist in this excerpt as not attuned. Seven students rated her as attuned.

The chart shows the way each group saw and interpreted the verbal and non-verbal interaction and whether or not they paid attention to exploration.

NON-ATTUNED EXTRACT	Correct Identification	Incorrect identification
Non verbal behaviour		
	..and I think she looked really bored - student B	She showed an interest in him and was listening to him though she did fidget a lot - student K
	She was sitting quite back from him and she seemed to sort of smile at the inappropriate times or looked up at the ceiling. She didn't really look that interested in what he was saying - student D	the client seemed very relaxed...there was a mirroring of the body language between both people - student P
	she didn't have much eye contact or watch actually face to face. She looked down a lot sort of thinking on her feet, not really listening to what he was saying - student A	the tone or the atmosphere was very relaxed and they seemed to be talking in the same tone of voice and she was very much sitting back and letting him have his way - student L

NON-ATTUNED EXTRACT	Correct Identification	Incorrect identification
Verbal behaviour		
	when she asked him how he felt and how it made him feel, she sort of asked it then saying 'that's enough', she was putting her hand up as if to say 'that's enough'. It was inappropriate, if she wanted to explore with him what he was feeling before he got a chance to she was cutting him off - student A	She actually checked with him that the decisions he had made were the ones he felt happy with and that they were the decisions he wanted to make - student R
	..And there were real issues around his wife...but she didn't pick up on them - student B	She gave him time to think and at the end when he said he was feeling better and she made it clear to him that this is what she wanted to hear and re-affirmed to him that that was a good feeling to have and that she was glad. - student S.
	First of all you heard about the pain in his back and she said, 'Oh well, that's a different problem' - student D	She was very much sitting back and letting him have his say but also asking questions and probing more but doing it in a way I really felt she really understood this person.. - student L

NON-ATTUNED EXTRACT	Correct Identification	Incorrect identification
Attention to exploration	when she asked if he was feeling alright about it (his wife's attitude to him), he said he was alright. But then she said 'Right, fine' and cut him off and didn't carry on with the feelings; she just went, 'oh alright' - student D I saw the counsellor actually not responding to some of the things that the client was saying. The client said there was, he actually said 'problem' with his wife, but the counsellor didn't respond. I saw her not responding a way that got him to explore his problem.	

As one can see from the chart both groups observe and interpret non-verbal behaviour.

> ..and I think she looked really bored - student B
> (Correct identification)

and

> She showed an interest in him and was listening to him - student K
> (Incorrect identification)

Clearly both groups of students are interpreting what they see - one is putting a negative gloss on what they are seeing and the other is putting a positive gloss on it.

When it gets to noticing the verbal behaviour however differences begin to show up between the two groups. This time it is not to do with having a different *interpretation* of what they hear it is more to do with the fact that one group apparently do not see the therapist cut the client off in mid flow.

> when she asked him how he felt and how it made him feel,
> she sort of asked it then saying 'that's enough', she was
> putting her hand up as if to say 'that's enough' - student A

The group who rated the excerpt correctly are highly tuned into whether or not the client explores and the behaviours of the therapist that inhibit him doing this. The other group make no comment on this either way other than to imply that the therapist was supportive, non intrusive and that this was a good thing to be or do.

> She actually checked with him that the decisions he had made
> were the ones he felt happy with and that they were
> the decisions he wanted to make - student R

Discussion

From my examination of the transcripts of both groups of students I conclude the following:

1 Both groups pay attention to verbal and non verbal interaction and in general seem to see and comment on the same behaviour.

2 Their interpretation of what they see differs radically from each other.

3 Group A seems to judge the interaction between therapist and client as empathically attuned based on the outcome for the client .

4 No member of Group B comments on the outcome for the client in terms of whether they explore or are inhibited from exploring. They seem to come to a premature conclusion about the episode based on their interpretation of the therapist's behaviour.

The results of the qualitative analysis therefore point to the importance of judging the interaction in terms of the exploratory outcome. One cannot judge the extract based on attention to verbal and non-verbal behaviours alone, however much attention one is paying to the process of feedback at these two levels. The feedback that is important in this exercise is whether the client explores or is stopped or inhibited from exploring.

It is interesting to speculate about why some students seemed able to 'see' this - see the importance of the exploratory process, and why others did not. When I examined the comments of the group who failed to identify the excerpts correctly, what stood out was that they had formed a view about the therapist. There were two therapists involved, nevertheless the attitude formed seemed to centre on two dimensions of therapist behaviour; whether the therapist was seen as intrusive or respectful of privacy and whether the therapist responded or failed to respond to expressions of distress.

Respect for privacy:

> She actually checked with him that the decisions he had made
> were the ones he felt happy with and that they were
> the decisions he wanted to make - student R

Intrusiveness:

> she (the therapist) didn't communicate with the client in a way that
> showed understanding...she had an interpretation she came up with
> when the client hadn't said anything - student U.

On the other hand the students who got the excerpts 'right' had quite a different understanding of intrusiveness and distress. For them, the therapist failed to pick up distress in the male client when he spoke about his physical pain and his emotional pain in relation to his wife. They did not see the therapist's behaviour as conveying respect, for them it would have been more appropriate for her to show that she had heard what the client had said and was willing to engage with it.

> She was sitting quite back from him and she seemed to sort of smile at
> the inappropriate times or looked up at the ceiling. She didn't really
> look that interested in what he was saying - student D
> and
> when she asked him how he felt and how it made him feel, she sort
> of asked it then saying 'that's enough', she was putting her hand up
> as if to say 'that's enough'. It was inappropriate, if she wanted to
> explore with him what he was feeling before he got a chance to she
> was cutting him off - student A

Again with the 'Attuned' excerpt, the group who failed to rate it correctly seemed to think that the therapist left the woman floundering when she should have moved in to help her.

> The woman was saying a lot of things and she sounded
> very confused and lost about being in a big space and the
> therapist really didn't say anything about it..didn't make it easy
> I suppose- student D

The student seems to focus on whether the therapist responds to distress or not.

The group who miss what is going on fail to understand the meaning of the emotion being signalled by the client. They seem to think that the client should be protected from whatever it is they are experiencing - whether that be, distress about oneself (own health), someone close - or distress arising from some thought or memory triggered by the work with the therapist.

From an attachment perspective one could see this as a failure to distinguish between two types of careseeking. On the one hand there is careseeking which is a signal for care and protection, and on the other there is careseeking which is a signal for support for exploration having been temporarily thrown off balance as it were. It is easy to see that if as a caregiver one muddled these two signals up and responded to careseeking as if a call for protection when in fact it was a call for support to carry on exploring, one might well contribute to shutting down the exploratory process. This in turn could give rise to frustration, irritation or despair in the careseeker.

Adult caregivers who intrude in unwanted ways on infants' and young childrens' exploratory process create defensiveness and upset in the infants and children as we saw in earlier chapters. It seems possible that the students who misjudged what they saw taking place between the therapists and the clients may well have been sensitised to these kinds of intrusions based on their past experience. They may well have unconsciously responded to perceived intrusiveness in the caregiver and not waited to judge the sequence as a whole from the point of view of the client that they were

observing. This is highly speculative and would need to be tested. In the meantime it provides a possible reason for why one group failed to grasp what was taking place.

Summing up

I designed this experiment in order to test the hypothesis that affect attunement was connected with interaction and could only be judged by paying attention to the responsiveness of both parties to each other; but particularly the responsiveness of the therapist to the client.

The statistical analysis provided evidence that students who were given instructions to pay attention to interaction did significantly better at judging the episodes that those who were not given such instructions. In addition the qualitative analysis suggested that in addition to paying attention to the interaction one needed to look at whether the goals of the interaction had been met as far as the client was concerned. In other words one had to pay attention to whether the client explored or was prevented from so doing by the therapist . The therapist could do this in various ways, by failing to pick up hesitation in the client, by cutting across them with something else or deliberately stopping them in their tracks.

Finally I speculated as to why some students miss the exploratory process in action as it takes pace in front of them. I suggested that for some students, the behaviour of the therapist may resonate with early experience of caregiving which may well have interfered with their own exploratory process. My suggestion is that when they saw what they considered to be intrusive and non supportive behaviour in the therapists they were observing, they came to a premature judgement of what the therapist was doing and lost sight of the exploratory process for the client.

In conclusion I would suggest that correct identification of empathic attunement requires attention to the process of interaction taking place between therapist and

client at verbal and non-verbal levels and in particular whether the goal of the interaction has been achieved - whether the client explores or not.

The concept of goal-corrected empathic attunement is located within an understanding of the dynamics of attachment which suggests that when caregiving is effective exploration will be activated and that when caregiving is ineffective exploration will be inhibited.

In the next chapter I set out to see whether:

i) empathic attunement could be reliably rated;

ii) whether training would improve students' performance;

iii) whether attachment style was associated with empathic attunement.

Chapter eight sets out the design of this experiment.

CHAPTER EIGHT

THIRD EXPERIMENT:

DESIGNED TO TEST WHETHER SECURE ATTACHMENT STYLE CORRELATES WITH EMPATHIC ATTUNEMENT AND WHETHER EMPATHIC ATTUNEMENT CAN BE IMPROVED WITH TRAINING

Introduction

In the last chapter I presented the results of an experiment designed to see whether students could improve their capacity to rate empathic attunement if given instructions to pay attention to interaction and responsiveness. I found that this was the case but that in addition the students who made correct judgements of the clinical excerpts had a different idea about how therapists should respond to client affect and also about the exploratory process itself. Associated with these distinctive attitudes was the fact that the group who misjudged the excerpts perceived the therapist as intrusive. Given that the Grossmanns (1988, 1991 and discussed fully in chapter 4) amongst others identified that secure caregivers responded more appropriately and actively in free play situations with their toddlers than did their insecure counterparts (the insecure group intruded on their offspring in a way that stopped or inhibited play), I decided to see whether empathic attunement correlated with secure attachment style of the therapist.

I also wanted to see whether empathic attunement was something which could be taught or whether it was simply something that was instinctive and innate. My sense was that given that the process I was interested in was *empathic attunement* not just affect attunement, that it was likely to be more permeable to training than if it were an instinctive process that happened completely out of consciousness. In order to test whether this was so I had first to develop a measure of empathic attunement.

Overall I therefore I wanted to achieve:

a) a reliable way of testing empathic attunement in situations arousing the dynamics of attachment;

b) a measure of attachment style;

c) a training programme designed to improve empathic attunement.

In this chapter I will address the design of the study and rationale for the design; the training programme and the adult attachment style questionnaires that the students completed.

Overview

This experiment involved:

(i) creating two groups, one group who received training, the other who did not.

(ii) measuring individuals from both groups for attachment style

(iii) measuring empathic attunement for each individual at two points in time

(v) giving training input between time one and time two

This enabled:

a) an account of the relationship between attachment style and empathic attunement;

b) a testing of the objective measure of Empathic Attunement against the two subjective measures;

c) a test of the effect of training.

The design and rationale for the study

The experiments were conducted in June 1996.

TIME 1	TRAINING		TIME 2
Interaction experiment	Training in interaction	Theoretical training	Interaction experiment & attachment scales
12 June	19 June	24 June	26 June

For reasons of time, ethics and experimental control, I decided to design the study with the participation of students and actors rather than clients and therapists. A method had to be devised which would produce comparable material which could provide ratings from a variety of perceptions and experiences and be economical to operate. There is no doubt in my mind that this work needs to be tested in the real world of practice and I will return to this at the end of the thesis.

I had a small budget generated from my own consultancy work. I had access to trainee students on a postgraduate social work course. I had access to the audio visual department in the university and had a close and long standing relationship with the technicians and cameramen who were used to either filming students on the skills training course that I was responsible for designing and operating , or filming my own

work with couples and families in clinics in the city. I had access to my colleagues offices - they were willing to let me use them for two days in the middle of the marking period in the summer term. I had many years experience and skill in designing and working with role plays, and understood the power of role play, the effect of role play on the participants, the requirements to debrief and both the strengths and limitations of the medium.

Reasons for employing professional actors.

I decided to engage professional actors for two days work.

I wished to carry out a tightly controlled experiment in which as far as possible all the participants were exposed to similar experiences and in which experimental variables were introduced in a controlled way. This would allow me to compare results.

Hiring actors would have the following advantages:

i it would allow me to provide consistent experiences for the students so that they could be rated against each other;

ii actors would have the training to survive re-enacting the same role play all day and have the training to get out of role at end of the day;

iii actors would take the task seriously as a job to be done and accord it the gravity it required - this would allow me to get as near the real thing of live practice as possible;

iv using actors meant I could control for gender by asking for two male and two female actors;

v The actors had no involvement in the overall professional assessment process that the students were going through to qualify as social workers. I needed objective ratings of the students' performance but it was important in terms of

their participation in this experiment that they could feel absolutely clear that their professional qualification was not put in jeopardy by the results.

Hiring The Actors.

This turned out to be surprisingly easy. It simply required a phone call to an agency that dealt with such things; I explained what I wanted and why, and the manager struck an agreement with me over rates of pay, dates and times.

Reasons for deciding the number of actors and students to be involved.

I had £2000, 3 cameramen, four video cameras and recorders, two days, four rooms, and I wanted to work with the classic responses to threat of loss, or actual loss which are; fear, anger sadness and despair. Given the time, space, and money available and the particular emotions that I wanted to work with, I decided to employ 4 actors and advertise for 14 students. This would allow me to construct four scenarios around the theme of fear; anger; sadness and despair and allocate one theme each to the four actors for day 1 and the same again for day 2. Working out a time schedule which started with a briefing meeting with the actors and cameramen at 9 a.m.; a briefing meeting with the students at 9. 30 and a start time of 10. a. m; I worked out a schedule of interviews lasting 10 minutes each with a ten minute break in between to give the students time to be briefed for the next interview and the actors time to adjust, prepare for the next interview and to rate the interview just happened; this gave enough time to fit 8 interviews into the morning and six interviews into the afternoon. As a result of these calculations it was clear that I could cope with four actors, each being interviewed by 14 students; each interview being videoed live (in three cases by a cameraman present in the room), with sufficient time for the actors to rate the students and the students to rate themselves and also for the students to prepare themselves for each interview in turn.

Constructing the scenarios

I constructed the scenarios around the theme of loss. The theory I am using for understanding careseeking caregiving relationships is attachment theory. Loss is therefore an appropriate theme. It also raises strong emotions. It should therefore allow me to test the students' ability to attune to affect, test the effect of training and test the effect of individual attachment status.

I constructed four scenarios around the following themes:

a) threatened loss of relationship through organic brain dysfunction

b) loss of relationship through desertion

c) loss of relationship through medical negligence

d) loss of life through terminal illness

The briefs are attached as appendix 8.

I also decided in the interest of creating of sense of authenticity and depth of involvement of the participants to keep the scenarios the same over the two weeks but to move them on in time - so that on day one, actor one, would convey feelings of sadness in response to hearing her mother had just been diagnosed as having Alzheimer's; on day two, she would be discussing her feelings of anger with the services her mother was receiving from the local authority. Organising the role plays in this fashion meant that the actors and students had a) actually met in real life before (on day 1) and b) had actually met to discuss this same issue once before at a previous point in time.

Creating a control group and an experimental group for the purposes of training

Fourteen students elected to take part in this experiment. I needed to split this group into two so that I could have a trained and untrained group. As already mentioned this group had a complex composition consisting as it did of students who had taken part the previous year in the identification exercise, and students who had either received or not received instructions in relation to identifying attuned and non attuned audio-visual clips from psychotherapy sessions. I organised the total set of students into two matched pairs so that one set could be given real training and the other dummy training.

The process of creating matched pairs

I created two matched pairs by taking account of the following four factors: number of correct identifications of clinical material during experiment two; whether or not they had been given indicators in that experiment: whether they had been involved in rating the material the previous year and whether they were in their first or final year of training.

Student	Number of correct identifications	Given indicators 1= yes	Took part the previous year 1= yes	year of course
Y	0	1	0	2
R	0	0	0	2
U	0	0	0	1
K	1	0	0	2
M	0	0	0	1
L	1	1	0	1
P	1	0	0	1
D	1	1	0	1
I	2	0	0	1
G	2	1	0	2
X	2	0	1	2
H	2	1	1	2
B	2	1	0	1
F	2	1	0	1
C*	2	0	0	1
A	2	1	0	1

*changed his mind when he heard the tape through again thus giving him a score of two correct.

For the third experiment, I only had 14 students.

Y and P had only volunteered for the identification experiment.

I drew up two lists of students and matched the composition of the two groups as follows:

MATCHED PAIRS

EXPERIMENTAL GROUP Group to be given training in interaction		CONTROL GROUP Group to be given a seminar on attachment theory	
K	1	U	1
R	2	M	2
H	3	X	3
G	4	F	4
A	5	B	5
L	6	D	6
I	7	C	7

Allocation to control group and experimental group

The allocation was done by tossing a coin. If it came down 'Heads' the first member of the pair went into group one and her partner went into group two. If it came down 'Tails' the opposite occurred.

Creating a measure of caregiving: the caregiver's and the careseeker's perspective

Having devised the experiment I wished to get a subjective evaluation of the interviews from the perspective of both the actor and the student - the careseeker and the caregiver.

The measure for both the actor (careseeker) and the student (caregiver) each consisted of 6 six point scales (see appendices 9 and 10). The careseekers measure asked for a rating from one to six on such aspects as feeling understood, being able to say what one wanted, feeling the caregiver was interested and attentive, whether they offered a new perspective or said anything helpful? The caregivers' measures asked for ratings of similar factors: did they think they conveyed that they understood what the client was feeling or meaning; did they think they were attentive and interested, enabled the client to say what they wanted, offered anything new or said anything helpful? The scale was from 'very much' to 'not at all'.

Materials and organisation

I referred to the organisation of the interviewing days in an earlier section in the chapter. What remains to be explained is the actual briefing I gave the actors, the students and the cameramen, before they set about the interviews.

Briefing for students

The following is the brief used with the students :

> We have commissioned four actors to role play four different situations which all of you will encounter during the course of the day. You will see from your time sheet the times that you are interviewing and the room you will be using. We will give you a background brief of the situation before each interview.

Your brief is to set the interview for 10 minutes; find out what the client is feeling about things at the moment, responding as appropriate in ways that might be helpful.

1 There will be 5 minutes 'travel time' between role plays. During this time we will give you the brief the actors are working to. Read it to orient yourself to the context, e.g. Relate Counselling Service, Social Services, whatever.

2 The role plays will take place in the offices along the staff corridor......

3 After each role play, my colleague or I will give you the actor's notes for the next interview - please find us, we will be on the corridor.

4 At the **end** of the sequence of four role plays, please pick up 4 forms from my colleague or myself. These forms relate to your own appraisal of the role play sessions. We want you to fill in these for each role play you have done and return them to us before leaving the building today.

Again please do not discuss with each other or with other students what you are doing, whether they are taking part in the research or not.

If you do not understand anything, seek out my colleague or myself.

Briefing for the Actors

I met with the actors and cameramen together, 15 minutes before the students were timed to arrive and explained the structure and purpose of the day. I gave a brief account of empathic attunement and its role in exploration. I explained the link as I saw it between empathic attunement and attachment and explained the scenarios chosen for the day and the fact that each one depicted a particular emotional response to abandonment or threat of abandonment. I gave out the measurement scales and asked if they would fill them in after each interview. I also explained that the

experiment was separate from the students training and that the actors' evaluation would not be used in any way that would affect the students qualification.

Briefing for cameramen.

The cameramen were present during the briefing of the actors so that they would know as much as possible about the design and purpose of the day. In addition they were asked to set up the cameras so that I would get a view of both the student and actor as I wanted to be able to study the verbal and non verbal interaction between them. I also asked them to label the video cassettes with the name of student, date and time of interview. Due to demands on technical staff I was only able to have three cameramen on day one. This meant that one of the actors controlled the camera in his room. I will discuss the implication of this later in the thesis. The reasons behind having the cameramen present were that the actor and student could be free to concentrate on what they were doing and not have to think about time or output in terms of video and sound quality. There are of course drawbacks to having the cameramen actually in the room, but these are not serious problems for the students involved in this project in that they had a lot of exposure to both having their interviewing filmed and having it filmed by these same cameramen on other parts of their training. Having the cameraman keep time was an enormous advantage to the project; the interviews were short, and very intense; the fact that the actors and students could become wholly engrossed in what they were doing came through in the quality of the tapes and was distinctly different for the last few minutes of each session for the actor who was keeping time and doubling as cameraman.

Observations of the day

I have been describing the thinking behind the organisation and structure of the day. Equally important and to some extent unanticipated was what *actually happened* on the day itself.

I had asked the same colleague who had helped me with the administration of the identification experiment to help with the organisation and administration of both interviewing days.

In addition to the four rooms commandeered for the interviews, we also had a large room available to us as our headquarters as it were. In this room, I briefed the actors, students and cameramen. In addition this room became base for all the students throughout the day and for my colleague and myself.

At 9.30 a.m. the actors and cameramen had left to prepare themselves and the rooms. At the same time the first four students appeared who were scheduled to begin interviewing at 10 a.m. I gave them written material to help orient them to their work (see appendix 11)

At 10. a.m. they left the room to do the interviews and the project was underway. My colleague and I waited. I had never used professional actors before and at this point had simply to wait and see what was going to happen. At 10.10 the four students reappeared. They were absolutely quiet, one looked ashen, they all had the appearance of having gone through a powerful experience. Naturally, I could not say anything to them at this point and certainly not for at least a month until the whole experiment was over. I was very worried about what on earth I had exposed the students to. As important as my emotional and intellectual responses to the students presentation was the *behaviour* of my colleague and me in relation to them. We had a job to do which was to give them the brief for the next interview and remind them that they had their next interview at 10.20. This we did. But we also had the impulse which we acted on to offer to get coffee, biscuits, chocolate, milk, water, whatever and one of us dashed downstairs to the canteen to get supplies.

The four students duly went off for their next interview at 10.20; hardly a word had been spoken between them or between them and us other than us offering food and drink during the 10 minute interval. At 10.30 they emerged again. Again they were solemn, silent, white faced, this time one or two talked briefly and the effect on my

colleague and me was as before. We offered drink, food, anything. We gave them their brief for their next interview and they went off at 10.40; reappearing at 10.50. By this stage I was actually seriously worried about what was going on behind the interviewing doors. I have worked with students for nearly 25 years in one form or another and I had never seen them so subdued and serious.

At this point we were three quarters of the way through. The new cohort of four student who would begin their set of interviews at 11.20 had arrived and needed briefing. By 11.10 our first group had finished their fourth interview and I was relieved to hear one say and the others agree, 'My god, that was good". That was all that was said, they had been told not to discuss the process while it was still underway. My colleague and I took turns between briefing the new group of four and distributing rating forms to the four just finished so they could rate their performance over the four interviews. We proceeded like this for the remainder of the day. By lunch time my colleague and I were conceptualising our briefing room as a secure base. The students came there to be briefed, they left from there to do their interviews, they returned to food and drinks from us, got their next brief and set forth to do their next interview. It took on a rhythm of its own; we were in no doubt that having the same room available and the fact that we were there throughout the day was enormously important to the smooth running of the enterprise and to the students' morale and sense that what they were doing was important.

With hindsight, I would certainly structure such an experiment along the very same lines and insist as this time that they did not discuss with each other what was going on. An unexpected outcome of this instruction was that it meant that they did not discharge their energy, they kept focused on the task and they contained the experience. It also created the conditions for my concern. I was not used to seeing students contain their experience - hence the source of some of my panic as described just now. It was also true as I saw later on when I watched the video recordings of the interviews that the actors had gone straight into role and created very convincing scenarios.

At the end of that first day, I had a video record of 56 interviews, each lasting ten minutes; ratings on all fourteen students from four actors; and the students ratings of their own performance[1].

Training

I will now discuss the training that each group received prior to the next session with the actors which was scheduled for two weeks hence. As mentioned earlier I had split them into two groups with a view to giving one group training in relation to interaction which I hoped would improve their performance at time two and the other group a training at the level of theory, which I thought unlikely to impact significantly on their performance. I will discuss further down the difficulties involved in this type of project of finding something that is sufficiently convincing as a training but which is likely not to influence the work.

Training: the experimental group

I had seven students that I needed to provide training for. It is worth reminding myself and the reader that I was doing this project in the context of the last four weeks of the summer term when the students were still involved in a tightly packed teaching schedule. I had a three hour slot with both groups which I could use for training purposes. I therefore had to devise the best training I could think of within those time limits.

Principles and procedure

The goal I set myself was to devise an individual training programme for each student within the context of training for the group as a whole. I therefore established a programme of training which first of all involved me in seeing the video record of their work on my own and rating it according to a form that I devised for the purpose (see appendix 12). I organised the training day so that each student had time on their own

[1] The students completed their evaluations of their own performance at the completion of all four interviews.

in private to view all four of their video tapes. I devised an evaluation form and gave it to the students to use while they watched each of their four videos (see appendix 13). I presented each student with the task of identifying one aspect of their practice that they wished to improve on and to do a force field of driving and restraining forces towards the goal of achieving improvement in that one area. I worked with the group as a whole before they looked at their tapes and afterwards.

There were four reasons for this strategy:

1 I wanted to locate and work with each individual's strengths and weaknesses as I saw them.

2 By personalising the work I wanted to acknowledge the individual character and particular contribution of each person and that it was their person which was the basic instrument of helping.

3 I have a fundamental belief, based on years of teaching experience that people are their own best experts at identifying weaknesses in their own practice when they have the information available to them from audio visual feedback; what they may need help with is conceptualising them in a meaningful way, not exaggerating them and figuring out ways of changing what they need to change.

4 I also hold the view that losing sight of the context one is working in can put too much emphasis on personal faults and failings and is counterproductive to learning. I therefore wanted to keep the students located in the fact that they were part of a research project, all working to the same task, all facing the same stresses, strains, and anxieties, albeit each in their own way, and that I was actively working with them as individuals and as a group to enable them to improve their practice.

Working on the students' tapes prior to the training input

The goal of looking at the students' video tapes was to get an idea of how the six students that I had selected for training were already doing in relation to empathic attunement and how in my view they could improve on what they were doing. I set about this task as follows.

I devised a form (appendix 12) to use as I set about this task which would direct my attention to such factors as: whether the student seemed present, whether they brought their imagination to the problem, how responsive they were, whether there was a creative exchange going on between client and student; whether they enable the client to explore and whether the interchange was fluent or staccato like.

Having looked at four tapes for each student (48 in all) I made a list of what they did and how they responded that in my view either inhibited exploration on the part of the actor or facilitated exploration. I made notes on each of the students work such as:

student N "More robust start..brings energy, remembers client's mother lives in Kent"

student H "Not putting in enough..dry atmosphere ..sticky..client is having to put in too much work. Worker remains fixed in one position. Says some things that seem to work".

student L "Good opening. Light, energy, personal. Keeps good eye contact..keeps seeking out client's eyes. Affirms what client says..'so half of you..?' Imaginative exploring.. so what would you have to do..?"

student M "Keeps eye contact. Client has to do too much. Smiles benignly too much. Asks a question..gets response but response is kind of bland. Jumps around from one thing to another"

student X "Dragging. A bit flat. Not putting in enough. Gives information - received well (by client) Imaginatively getting in there - going a bit fast for the client. Shares personal information"

student R "Opens positively and with energy. Looks and sounds present, very calm. Asks a complicated question which gets at an emotional experience which the client build on. Puts his imagination into it. Client feels able to talk to him. Pacing is very good. Introduces an idea - one can see where he is going with it but he leaves enough room for client to get there first. Client not having to think of things to say - quicker speech. Caps the client's feeling with an interpretation. Talks too much at the end and undoes some of the good work"

student F "Good energy. Positive approach. Leans forwards, keeps eye contact Keeps present. Client seems very emotional very fast."

From such observations I developed the following list:

i) the student looks present;

ii) the student brings their imagination to the problem;

iii) the student responds in an appropriate and relevant way;

iv) there is a creative exchange between student and "client";

v) the student enables the "client" to explore;

vi) the atmosphere is strained or sticky.

vii) the student changes the subject when the "client" says something painful

viii) the student fails to match the pacing or intensity of the "client"

ix) the student looks frightened or anxious

x) the student waits too long before responding

I grouped the above into categories and came up with the following positive and negative poles

	Positive	Negative
1	Looks and sounds present	Does not hear
2	Brings imagination to it	Client has to do too much work
3	Enables exploration	Stops exploration
4	Creative exchange	Dry and sticky

On this basis I constructed a measuring instrument that I used to rate the students' performance. It consisted of 6 six point scales where a score of 1= 'very much' and a score of 6 = 'not at all'.

The six scales were:

1 Does the student look and sound present?
2 Does the student bring their imagination to the problem?
3 Does the student respond in an appropriate and relevant way?
4 Is there a creative exchange of ideas or feelings going on between student and client?
5 Does the student enable the client to explore?
6 Is the atmosphere strained or sticky?

I am aware that the above measures tap subjective judgements. It is worth remembering that I devised them for my own use in order to have a form that I could use with all seven[2] students across 24 interviews.

[2] Seven students took part in the training programme. One of these was unable to complete the research project as they were called for a job interview on the day in question.

Structure for the training input

Organisation and structure provide the context for caregiving by the students. In line with the principles set out in the introduction and affirmed through the theory of attuned interaction in chapter three and attachment in chapter four, my goal was to create as safe a context for learning as possible by making each step of the learning programme explicit from the start, being clear about the overall goals, setting out clearly and explicitly how I intended to work with each one of the students, the type of work they would do in private and what they would do in the context of the group as a whole.

Using these principles I devised a three hour training which involved:

(i) first meeting with them as a group to remind them of the goals of the training input and explain the structure of the afternoon.

(ii) I then sent them off to view their tapes and complete their force fields and met up with them for coffee in the college bar.

(iii) Working with them individually in the context of the training group

1 Introductory Session

Having explained the structure of the three hours, I spent some time introducing the main concept being explored in the research - empathic attunement. I explained that at this stage I considered this to be

facilitated by:

attending to what is being said and the feelings associated;

thinking about it imaginatively;

putting oneself in the other person's shoes and asking questions that indicate you are thinking about the problem from their point of view or the point of view of the person they are concerned about;

responding in a way that adds something.

inhibited by:

fidgeting and looking distracted;

looking anxious or frightened;

not responding or having too long a delay in responding;

simply repeating what the other has said;

asking questions that show one is not really attending;

not adding anything that the client has not come up with themselves;

asking a question that takes the client away in time or place;

asking a question after a client has expressed a powerful feeling;

recapping in an energetic voice tone when the client has just said their life is in tatters;

keeping too much of an emotional distance;

resting one's face on one's elbow and stretching one's feet out in front of one.

I then gave them the forms I had devised for them to use while watching their own work (appendices 13, 14 and 15) and said that I wanted them to identify two things they wished to improve on next time and to identify the driving and restraining forces in relation to achieving change in these two areas. The plan was that they write down their two goals - construct a force field, come back to the group, discuss with the others and do some practice in changing their behaviour.

2 Work On Their Own With The Videos

As mentioned earlier, I devised a form for them to use while watching their own tapes (see appendix 13). The reader will see that this form directs the students to pay attention to whether they think they are attuned to the client's feelings, whether they change the subject when the client says something painful, whether they are out of rhythm with the client (i.e. talk too much), whether they are responsive enough (i.e. talk too little), whether they look and sound present (i.e. whether they are emotionally and intellectually available) and finally whether they think they enable the client to deepen their exploration of their feelings or thoughts. The form was accompanied by a handout which was designed to help locate their experience in context, clarify the goal of what they were doing in order to reduce their anxiety so that they could take in information and learn. (The handout is attached as appendix 14.)

Rationale for viewing own work and using the forms.
It seemed to me that if the students were going to improve on what they had done first time round they needed to have some idea what it was they were supposed to be doing in the first place. I was absolutely clear that they needed time on their own, in private to examine their performance against the expectations set out in the form. Video feedback is a powerful form of learning and was already in use in the interviewing skills programme designed by me on their course (Facts Feelings and Feedback 1999). Some psychotherapy trainings are also now using it to help people monitor and improve their practice (see Anstadt et al 1997). The new element which I introduced for this exercise was that the students watched the videos of their interviews on their own and used a form to guide what they paid attention to (see appendix 15). My reasons for doing it like this were two fold:

(i) I wished to lower their anxiety as much as possible so that they could take in new information. Putting them in charge of judging how they were doing put them in control of the process as much as possible:

(ii) time restrictions - I had seven students to train in three hours, and wanted to provide a highly individualised training programme for each of them.

For both these reasons it made sense to get them to help with the training. There is no way that one can completely eliminate anxiety from situations which focus on judging one's performance, but sticking with the facts - the sheer verbal and non verbal behaviour that one can see on the screen of what is actually happening - does help (see Agazarian, 1997).

Meeting up afterwards in the coffee bar.

As before this was an unanticipated moment of information gathering and collection. By arrangement I said I would meet with them in the coffee bar after they had viewed their own work. We would have coffee together and then return to the lecture room from which we had started off. Again, to my amazement, the students returned from their various booths subdued and thoughtful and instead of the usual racket I have come to expect from students, *sat down on their own at different tables* and clearly were setting to on constructing their force fields. There was no chat to speak of. Given that they were under instruction not to discuss their work until the whole programme was over they clearly were in no mood to use the time for small talk. It was impressive. I had not anticipated it would be quite like this.

Looking at the students work afterwards I found that they had all used the form (appendix 13) to rate themselves - using all six scales in addition to writing notes on the back.

3 Work In The Group As A Whole

Back in the lecture room, I had five objectives:

1 to settle their anxieties so that they were in a position to take in information, use their cognitive faculties to the full, and learn;

2 to attune to where they were at in terms of their emotional and responses to viewing their own work;

3 to convey to each of them my view on what I thought they needed to improve;

4 to finish the session with each student clear about what precisely they were going to work on improving for the next session with the actors within the overall context of attuning and empathically responding to emotional state;

5 to leave all seven students feeling important, valued, supported and confident that they had identified one thing that they felt they could do something about improving in relation to their practice for next time.

To achieve these purposes I started by saying that I had also viewed their work and had identified some changes that they could make to improve their practice. I told them that before I heard from them on what they thought they needed to change I would give them my feedback. This was a deliberate strategy on my part. I did not wish to induce in them a feeling that somehow I had figured it all out and that once they had finished giving me their view I would put them right as it were. In addition I reminded them that this was a learning context - that the project was exploratory and that the aim was to try and discover more about empathic attunement, how it worked and how if at all one could get better at it. I then proceeded to give each student feedback (verbally) and receive their views on their work. We also worked with their goals for next time and the driving and restraining forces they had identified in relation to achieving these goals. To my great surprise, all the students without exception were

in agreement with my view on what needed changing. The sceptical reader may think - of course - you gave them your view first. But this is not borne out by the written comments on the forms - I collected these up afterwards - students did not change what they brought up in relation to my feedback (in fact they read it off the forms at the time). This whole training session was a profoundly moving experience - I was very struck by the level of intimacy and seriousness that accompanied the work. The following information is taken from one student to give a flavour of both how they used the forms and the force fields.

STUDENTS RATING OF OWN WORK

	SCALES	RATING					
		1	2	3	4	5	6
1	Do you look and sound present?			√			
2	Do you help the client discuss and develop the thoughts that hey have about their problem					√	
3	Do you come in after the client has spoken with something that is slightly out of touch with their feelings?			√			
4	Do you ask a question referring to another time and place when the client has said something painful?						√
6	Do you talk too much						√
7	Do you say too little		√				

The scales were rated 1-6 where 1 = very much and 6 = not at all

In addition to the above rating the student had written on the back of the form

I look anxious a lot of the time

I sit back in my chair

I let him keep talking

I don't ask any useful helpful questions

I seem quite defensive and a bit impatient

I stick to factual matters

I try to clarify what he means

I try to empathise but do it crudely

Needless to say his comments on the other three interviews he watched were slightly different - not all as self critical!

This student identified two changes he wished to make:

1 Not to put thoughts into people's heads

2 Body language - sitting

The following is the force field he constructed in relation to his first goal:

GOAL

Not to put thoughts into people's heads

Driving (what gets you closer to the goal?)	**Restraining** (what prevents you getting to the goal?)
listening carefully to what people say	racing ahead of client
picking up on key phrases that are repeated	feeling the need to clarify all the time
not trying to summarise so often	
not putting my own interpretation on what they are saying	

My feedback to the above student was that I thought he was not properly present - did not have enough energy in his voice.

At the end of the training session all the students rated the training using a form that I had devised for this purpose (see appendix 16)

The form had six scales and the students were asked to rate from 1 to 6 where 1 = very much and 6 = not at all

Results of rating the training programme

	SCALES	RATING					
		1	2	3	4	5	6
1	Was looking at your own tapes useful?	7	0	0	0	0	0
2	Was having a form to do this useful?	4	2	1	0	0	0
3	Was the group discussion useful?	7	0	0	0	0	0
4	was getting feedback from me useful?	6	1	0	0	0	0
6	Any other comments						

One can see from the feedback that the students clearly found looking at their own tapes, the group discussion and feedback from me very useful. The one who gave a 2 for feedback from me wrote on the form she would have liked more. My reading of the results is that I did achieve my aim of lowering their anxiety within reasonable levels so that they were able to take in and process information, and have a good experience of learning. The 'other comments' elicited - 'more time for discussion and feedback'.

Training: the control group

Principles and procedures

My main goal was paradoxical; it was to provide a convincing training programme that would not train - that would not improve their interactive performance with clients. The students knew the project was on attunement in adult psychotherapy. They knew it was about interaction. They had already been asked to rate interaction between clinicians and their clients. They were taking part in a two day project which was at its very essence interactive. I had to construct a training in an area that they would associate with the project - attunement, attachment theory, counselling/psychotherapy but which avoided doing anything that might make a difference to how they conducted themselves on day two. What I did was to shift the focus of training from the level of interaction to the level of theory. A lot of trainings are at the level of theory, institutes of analytic psychotherapy all over the country spend hours covering theoretical perspectives, holding seminars, elucidating theoretical perspectives, having their students write up their case notes illustrating theoretical perspectives, so I hoped this angle to training would be acceptable as a convincing training strategy. Like the first group I had this group rate the training on a scale of 1-6 at the end of the training session.

I also intended to make this group feel valued and important but did not give them their own work to view or help them identify what they wished to improve next time round. In order to manage the possibility of leakage from one group to the other, through slips of tongue or whatever I wanted to have as many elements the same for this group as I had for the experimental group. Videos were involved in the real training; I had this group watch a video; small group discussion was involved in the real training, I organised small group discussion in this training; each group rated their training programme. There the similarities ended.

Structure and design

The elements that I wished to incorporate into the 'dummy' training in order to camouflage it as the real thing were:

a) a focus for discussion they would know was highly relevant

b) video material

c) group discussion

At the level of theory my objectives were to

a) keep the focus on early childhood experience and the development of patterns of relationship.

b) present attachment theory but focus on the formation of relationships during infancy and childhood - not make the links with adults

c) present a video on the thinking of Alice Miller which would direct their focus to childhood experiences of abuse and the impact of abuse on interactions

I therefore decided to start the session with a brief overview of attachment theory concentrating not on the attachment dynamic linking careseeking/caregiving and exploration, but on aspects of attachment theory that focus on internal working models of relationship and how they persist into adulthood.

I reminded them that the research was in the general area of psychotherapy - that which is generally known as 'the talking cure' and its associated uses by other professions; social work, psychology nursing, occupational therapy and others.

I told them that the focus of the day was on links between childhood experience and later disturbance in adult life - but with particular attention to the process of forgetting, splitting, repression - the distortion of what actually happens to us in childhood and how this process comes about and is maintained during childhood long into adulthood.

The scenes which tend to get shut out are:

(a) those which parents wish their children not to know about;

(b) those in which caregivers have treated children in ways the children find too frightening to think about;

(c) those in which children have done or perhaps thought about doing something about which they feel unbearably guilty and ashamed.

I gave them Bowlby's (1988) article 'On knowing what you are not supposed to know and feeling what you are not supposed to feel' (from which the above points are taken) and directed them to certain sections of it to read while we were working together.

We then watched a video about the work of Alice Miller which had several reconstructions of childhood experiences of emotional abuse depicted on the film.

This was followed by a small group discussion on whether or not the students thought child rearing practices affect emotional development and if so how - and the pros and cons of psychodynamic and feminist analysis.

The students rated the training in relation to whether it had improved their ability to understand the connections between childhood experience and adult behaviour - 5 gave it a 1 rating and 2 gave it 2.

In general therefore both the control and the experimental group valued the training and took it seriously.

Discussion

I was satisfied with both programmes of training from the point of view of design and execution and relationship with the students. I was not convinced that I had achieved a wholly neutral training effect on the seven students being given dummy training. However in terms of the goals of this project, what was important was that I see whether training directed explicitly rather than implicitly at interaction made a difference

I think it is probably more accurate to conceptualise what I did as providing two types of training; one at the level of theory and one at the level of interaction. I expected that those given training in interaction and responsiveness would do better on day two but I would expect both trainings to have a positive impact.

In addition I would expect all the students to do better on day two than they did on day one simply because they would feel more at ease with the structure and be familiar with the people they were about to interview. They would have less novelty to cope with on day two therefore I would expect them all to be more available emotionally to be attuned to the clients simply based on the impact of familiarity. I will now turn briefly to a description of day two.

Experiment: time two

There were two main issues to be dealt with on day two. The scene had to be set for the interviews with the actors, students and cameramen and I had to introduce to the students the idea of completing attachment questionnaires, and ensure to my best

ability that this happened. I will deal with the design first and then address the attachment questionnaires.

Structure and administration

a) One of our interview rooms was different: this we had no control over, I was being given the rooms freely on the goodwill of my colleagues and their ability to make them available on the day required.

b) We had four cameramen. I was very pleased about this as it meant that all the actors could concentrate on the job in hand and not have to concern themselves with time boundaries. It is difficult to keep track of time when absorbed in emotional work as the images and memories evoked often take one to the past and away from the reality of the present.

Briefing

The briefing procedure was similar to day one. The cameramen simply needed a word about room changes. The actors were given their new role plays (see appendix 17) and I explained the reasons for keeping the scenarios the same but moving them on in time. The brief for the students was the same as on day one. In addition those who had received training in interaction were reminded to be conscious of the goal they had set for themselves.

Attachment questionnaires

As mentioned at the beginning of this chapter, I wanted to test whether the adult attachment style of the caregiver correlated significantly with their attunement to affect signals from the careseeker in situations arousing the dynamics of attachment. This was a primary purpose for this experiment. Mary Ainsworth's work in relation to her Ganda project (1967) and subsequently her Baltimore study (1978) had shown that mothers who were more tuned in to the nuances of their infants behaviour, could describe their behaviour spontaneously with great detail and who responded and interacted with them (as seen from the home observations) were much more likely to

have children who were classified as securely attached (using the Ainsworth Strange Situation) at one year of age than those who seemed unaware of their children's responses and interactions. This association between attunement and responsiveness to affect and attachment status, I thought important to pursue. What Ainsworth was noticing was that the caregiver's responsiveness to the infant was a key factor in determining her infant's sense of security. In my study I am examining the capacity of would be professional caregivers to attune to the affect of their clients and respond and interact in ways that shut down careseeking and promote exploration. Haft and Slade (1989) had also found a correlation between maternal security and capacity to attune to a range of affect in infants. I was therefore testing the following hypothesis that:

(i) secure individuals will be effective caregivers;

(ii) effective caregivers will attune to a range of emotional complexity in careseekers and seek out its meaning in situations arousing the dynamics of attachment

(iii) insecure caregivers will fail to respond to a range of affect signalling from the careseeker indicating that they are distressed

I therefore needed some measure of the students' adult attachment style against which I could test this hypothesis.

There were two choices in relation to this - only one of which was realistic - I either got an assessment of the attachment status of the students using the Adult Attachment Interview designed by George and Main (1985) or I got a measure of their attachment style using self report measures in the public domain. The first solution which is by far the more rigorous and actually gets at the defensive structures of individuals in relation to attachment issues was not available to me. In order to administer and code such an interview one has to undergo a two week training; in addition even if one had such skills the time required to do the coding afterwards is

enormous. For this reason there has been interest in the field in developing self report measures of attachment style. It was these I turned to and I chose three[3] which were based on the theoretical ideas underpinning attachment. In addition to the problems regarding administering the AAI I needed a numerical score for attachment which I could use to measure against the attunement score. It therefore made sense to turn to the pen and paper measures already in the current domain. For a fuller account of the thinking involved in the choice of measures see appendix 18.

Resources and materials on the day of the second experiment

The students were told that at the end of their set of four interviews they would be required to fill in three attachment style questionnaires. I explained that I wanted to use the results of these questionnaires to compare with their performance in the interviews. They all agreed to do this. One person raised a query about the principle of it, they felt that personality questionnaires were an inadequate way of assessing human beings. I explained to this student that there was some evidence that attunement to affect was linked with attachment status and that I wanted to test for this. Another student came and said that filling in such intimate details about a romantic relationship was very painful as they had just split up from their partner - so there were questions about whether to answer the questions in the past or present tense. We agreed that they should try and make them as representative as possible of the nature of the recent relationship. Two other students raised the issue of absence of romantic partner; this was addressed by asking them to fill the questionnaire in as best they could drawing on information they had from their experience of the person they would go to if in trouble.

Summary

This chapter has described the data collected in order to establish:

[3] The three I chose were: Feeney Noller and Hanrahan (1991) Assessing Adult Attachment: West. M. Sheldon, A., & Reiffer,(1987) The Reciprocal Attachment Questionnaire. University of Calgary. Faculty of Medicine; and Brennan , K. & Shaver, P. R. (1995) Dimensions of Adult Attachment; Affect Regulation, and Romantic Relationship Functioning.

(i) an independent measure of empathic attunement

(ii) the correlation between attachment style of the caregiver and empathic attunement

(iii) the correlation between caregiver and careseeker measures of empathic attunement

(iv) the impact of training on empathic attunement

At the end of this experiment I had three measures:

(i) caregivers' measure of empathic attunement;

(ii) careseekers' measure of empathic attunement;

(iii) a measure of attachment style of each of the 14 caregivers.

I did not have an independent measure of empathic attunement. This proved quite difficult to establish. In my next two chapters I describe the process leading to a successful method of measurement. This process was essential in helping to discover that empathic attunement could not be judged on the basis of behaviours alone. My next chapter describes the shift from an examination of behaviour to an examination of interaction rather like the intellectual journey of my predecessors described in chapter two but building on what they discovered and getting a deeper understanding of the complex processes involved in careseeking and caregiving.

CHAPTER NINE

THE PROCESS OF OBTAINING A RELIABLE MEASURE FOR GOAL-CORRECTED EMPATHIC ATTUNEMENT

Introduction

In the last chapter I described an experiment constructed to elicit the dynamics of attachment. I wished to test the hypothesis based on the work of Haft and Slade (1989) that caregivers who were securely attached would be better able to attune to a range of emotion. I had suggested that attunement was necessary for effective caregiving, therefore I was hoping to achieve a positive correlation between a score for attunement and a secure attachment style. I also wished to see whether students could be trained to attune to their clients' affect and respond with empathy.

Before I could do any of these tests I needed to achieve an independent reliable score of empathic attunement for each of the twelve students. This chapter sets out the work involved in obtaining such a measure. After almost a year's work and two failed attempts we eventually achieved a correlation of .8 between two independent raters based on the average score of seven 1.5 minute segments of interaction from each of 12 videoed interviews.

The work of obtaining a reliable score involved developing a much more complex understanding of attunement, one which involved empathy, goal-correction and attachment theory. I will present the process of obtaining reliable ratings as it happened over three phases.

Phase one: method

I asked a colleague in the social policy department to act as an assessor for the student-actor video tapes. The person I approached had an interest in the work and was willing to commit the time involved. It was hoped that we would write up the process of our work for publication which would be some recompense for her time[1].

Creating a measuring instrument.

There were three stages to the process of creating a measuring instrument. The first stage was devising a form that I could use to get a measure of the performance of those students whom I had selected for training. The second stage involved incorporating more detail about the process of empathic attunement gleaned from the training exercise as a whole and the third stage involved incorporating observations from clinical material. I will describe each of these in turn.

Devising a form for rating purposes

As described in the last chapter I devised a measuring instrument that I could use to rate those students who were selected for training. This work produced a six-scale measure. Each of the scales were scored from one to six ranging from 1= 'very much' to 6 = 'not at all'.

The six scales were:

1 Does the student look and sound present?

2 Does the student bring their imagination to the problem?

3 Does the student respond in an appropriate and relevant way?

4 Is there a creative exchange of ideas or feelings going on between student and client?

5 Does the student enable the client to explore?

[1] This did happen, see McCluskey, U., Hooper, C. and Bingley Miller, L. (1999) *Psychotherapy, Theory, Research, Training and Practice,*, 80-90.

6 Is the atmosphere strained or sticky?

Incorporating other material from the experience of rating the tapes.

I had made a number of notes in the margin of each form that I had used to rate the seven students who took part in the training programme. I had used these on the training day as specific markers and indicators of each student's style that either needed modifying or sustaining and improving. They were therefore integral to my new understanding of what would facilitate or inhibit the exploratory process. I therefore made a list of the type of behaviours, responses and interactions that I had noted.

These were:

wooden
unresponsive
energy focused
positive approach
brings imagination to it
not putting in enough
sticky
dry atmosphere
dragging
client having to do too much
searching out the client's eyes
asks a question
jumps around
gives information
going a bit too fast for client
shares personal information
looks, sounds present

explores the fact there is a feeling there

client feels able to talk

client quickens their response

interprets

talks too much

affirms feeling

fixed physical posture

not saying enough

delayed response

railroading over client's emotion

getting own points across

not noticing client's response to input

elicits feeling but does not know what to do with it

I asked two colleagues to join me in grouping the above items. This gave me groupings of the material: (i) items relating to the verbal input of the worker. (ii) items relating to the non verbal input of the worker and (iii) items relating to the understanding of the worker and (iv) the flow of interaction.

This led me to modify the original rating form. I increased the scales from 6 to 13 in order to capture different aspects of the verbal and non verbal interaction.

These were:

1 Does the therapist look and sound present?

2 Does the therapist look frightened, nervous, anxious, defended or distracted?

3 Does the therapist help the client discuss and develop the thoughts they have about their problem?

4 Does the therapist help the client discuss and develop the feelings they have about their problem?

5 Does the therapist misunderstand what has just been said?

6 Does the therapist ask a question focusing on an irrelevant detail or change direction when the client has said something very painful?

7 Does the therapist inhibit further exploration by either timing, tone or content (jumps in too quickly...; body language..moves away/back into the seat...develops a fixed posture, etc.?

8 Does the therapist talk too much?

9 Does the therapist say too little?

10 Does the therapist help the client explore?

11 Is the flow of input from the therapist appropriately pace for the client?

12 Does the therapist match the emotional intensity of the client?

13 Does the therapist intrude into the space around the client in a way that makes the client look uncomfortable?

The scales were marked out on a range of 1-4. 1= 'very much' and 4= 'not at all'.

Incorporating observations from clinical material.

Obtaining the clinical material.

I wrote to colleagues from the field of family therapy for help with access to pre-existing videos of interviews. However I came up against procedures, policies and contracts with clients that were not conducive to lending out this material for research purposes. I decided to advertise for assistance and placed an advertisement in *Psychotherapist* (the newsletter of the United Kingdom Council for Psychotherapy) asking for help with a project I was running on Attunement in Psychotherapy.

I got a range of responses; one from an eminent psychoanalyst practising in London and others more local and from different sections of the psychotherapy fraternity. This public appeal for help combined with personal contacts produced enough material for me to move forward. In all I got fifteen samples of clinical work from

humanist therapists, gestalt therapists, NHS medical psychotherapy consultants, psychoanalysts in private practice, psychodynamic social workers working in departments of child and family psychiatry, family therapists. This provided me literally with a view of the settings as well as different therapeutic modalities. Some therapists worked in very informal surroundings sitting on cushions on the floor with their clients. Others were sitting face to face on hard chairs; others sat in armchairs at a slight right angle from each other and so on. Nobody used a couch for this exercise. One of the people who took part was an analyst. They had got permission from a patient who was in five times a week therapy to let us video a full week's worth of sessions.

Getting the video material involved sending a technician from our audio visual department to set up cameras in the therapists' consulting rooms. I wanted the material to be such that I could have a view of both parties. The technician was not present during filming. The therapists operated the equipment themselves. In all cases care was taken to get the full and informed consent of the clients/patients involved. See sample of consent form in appendix 19.

Working on the clinical material

This work provided me with material that I could use to sharpen and refine the measuring instrument.

My colleague and I used it as follows:

- We started by looking at the videos and discussed the behaviours and interactions between therapist and client that we were agreed facilitated exploration. We then checked our observations against the scales that I had put together to see whether we thought that using the scales would have picked up what we wanted.

- To ensure that our scales were relevant to the student population that we needed to assess, we then used these scales to rate two interviews undertaken by the students who had not completed the project for reasons referred to earlier. We then discussed our procedure and identified areas of agreement and disagreement between us, modifying slightly the phrasing of the different scales in the process

The following list gives an indication of the kinds of behaviours we identified at this time (prior to the development of the concept of goal-corrected empathic attunement) as being associated with facilitating or inhibiting exploration.

Facilitating Exploration

- leaning forward into the client's space
- comes in relatively quickly after the client has spoken
- actively explores feeling with the client
- naming the feeling
- getting the client to explore their thoughts
- brings energy to the encounter
- searches out the client's eyes
- mentions the feelings present in the client and brings them into the relationship between the two of them so that they are present and available for discussion.
- modulates tone of voice to display a range of affective response to the client
- sits in a way that comes across as in balance or balanced, in other words a posture that conveys one is not going to be literally thrown off balance.
- picks up on complex or contradictory feelings and names them
- opens up the conflict
- fluid atmosphere
- putting stress on own body - reaching out to the client.

- keeping ones eyes on the client - almost like a predator - when providing input - ideas reflections etc.
- talking in a way which allows the client to see where you are going before you get there and then stopping.. to let them take over and finish it in their own way
- coming in on the tail of the other person tracking what they are saying and adding a little, not too much, difference
- taking charge appropriately to contain the feelings being expressed so that they can be managed between the therapist and the client
- matching the client's emotion with one's own tone of voice or body movements.

Inhibiting Exploration

- being silent too long
- energy in voice does not match client - either too strong or too weak
- feet stretched forward, leaning back in chair and resting head on hand
- doesn't get sufficiently emotionally involved
- looking too detached
- not responding enough
- eating or drinking in the presence of the client
- recapping at the expense of adding anything new
- rounding it off and closing down the conversation by a clever remark, a synopsis, tone of voice, etc.
- reassurance as the main mode of response
- doesn't get in there and line up with the client's emotion.
- too laid back and apparently unaffected.
- coming in too quickly to name the feeling
- asking questions that take the client away from where he is in his thoughts or feelings

- getting the client to think about future scenarios when he is not ready
- attaching meaning to what the client is saying that the client disagrees with
- hypothetical questions
- looking frightened
- physically agitated
- switches to talking about services and practical details when the client has been pursuing more personal matters.
- coming across as out of one's depth
- too many questions
- not coming in quickly enough to name the feeling.
- not focused
- doesn't get hold of what the problem is
- keeping the conversation cerebral and way from emotions

Of course all the above is context specific and can only be judged in the context of the interaction between client and therapist. One can see that there is a bewildering array of behaviour to take into account and that the task that I had set myself was complex.

Even though it should have been clear to me that working out specific indicators of empathic attunement from such material was bound to fail (given the subjective nature of many of the judgements and the interactive nature of the concept) I was still at the stage of thinking that the behaviours which facilitated exploration could be sufficiently clarified to get a significant correlation between independent raters.

Modifying the rating instrument

A close examination of the 13 scales that my colleague and I were using revealed that three scales referred to focused attention (scales 1, 2, 5); 3 scales referred to moderated responses (7, 8, 9), one scale to input (11), four scales to exploration (3, 4, 6, 10), and 2 scales referred to attunement (12, 13). I decided to increase the number of scales to

fifteen in order both to increase the dimensions that we could rate based on our observations and to have an even number of scales for each category [2] (see appendix 20) . At this point it seemed better to err on the side of including too much rather than narrowing the focus of what we were looking at.

Creating a second measuring instrument

In addition to these 15 scales I created a second measuring instrument which had five scales corresponding to the five categories that I was measuring: *Focused Attention, Modulates Response, Input, Exploration and Attunement*

I started by working out definitions for each of the categories. The following is an example of initial work on the concept of attunement (before the concept of goal-corrected empathic attunement was developed):

> "Definition of attunement:
> Attunement is more than mere mimicry of another's state; it has as its reference the inner state of the other, their somatic experience of that state, and their cognitive and affective processes. The process of attending to the inner state of the other in this way demands intense concentration on verbal and non verbal signals, including breathing, colour, tiny muscle movements in the face or hands, and other signs that indicate where the other person might be in themselves.
>
> What happens between the two is like a dance or some creative moving together, with one person adding words, ideas, sense, meaning, and the other is building, joining, adding, creating, so that between them there is a sense of play, of something new being formed, some new understanding, something that could not

[2] scales 1,2 and 3 represent focused attention; scales 6, 7, and 11 represent modulates response; scales 9,14 and 15 represent input; scales 8, 9, and 12 represent exploration; scales 4,5 and 13 represent attunement.

have happened without this sense of sympathy between them, as if they could search out what the other was thinking even before the other had formed the thought, so that sometimes there could be an overlap of speech which did not interrupt, distract or take away from the ideas being followed through. While there may be an occasional mis-timing, there is no overall impingement.

Indicators.

A quickness of speech between the two, like a spilling over each other with words. An increase in energy level in the voice, a sense of liveliness."

Having mapped out a similar range of material for the other categories, I then reduced my definitions to two lines each for the five categories.

The brief definitions were:

(1) Focused attention:
Does the student look as if they are attending to the client with their full concentration.

(2) Modulates Response:
Does the student moderate their tone of voice timing, pacing etc. in relation to what the client is saying.

(3) Provides input:
Does the student provide something extra for the client other than simply repeating what they say themselves.

(4) Facilitates exploration:

Does the student respond to the client in such a way that the client carries on exploring and developing what is of concern to them.

(5) Attunement:

Refers to rhythm and harmony between student and client so that each is responding to the other in such a way that the experience for the client intellectually and emotionally is deepened.

Overall the second measuring instrument comprised:

a) brief definitions of each of the five categories (as given above)
b) a 6 point scale to rate each category
c) space for the rater to note indicators and counter indicators for the category in question

See appendix 21

I now had two measuring instruments to use to rate the videos. The first instrument had 15 scales and the second instrument had five scales - one for each category.

Rating procedure.

I chose 12 tapes from day one - one for each student. The independent rater and self rated these tapes using the two measuring instruments described. We ended with two scores for each student - one for each of the instruments.

The following is an example of the scoring sheet:

Measuring Instrument 1 — Measuring Instrument 2

		FA	FA	FA	M	M	M	1	1	1	EX	EX	EX	A	A	A			*FA*	*M*	*I*	*EX*	*A*
U	R1	4	4	6	3	3	2	3	4	4	3	5	6	5	5	5			4	5	4	5	5
U	R2	4	4	5	3	5	2	3	5	5	4	5	6	4	5	4			3	4	5	4	5

In relation to the scoring sheet above :

U	refers to the code allocated to a particular student
R1	refers to the independent rater
R2	refers to self

FA	refers to focused attention (3 scales) -	[cumulative score for R1 = 14]
M	refers to moderated response (3 scales)	- [cumulative score for R1 = 8]
I	refers to input (3 scales)	- [cumulative score for R1 = 11]
EX	refers to explore (3 scales)	- [cumulative score for R1 = 14]
A	refers to attunement (3 scales)	- [cumulative score for R1 = 15]

===

FA	*refers to the overall category of focused attention using definitions alone -*	- [score for R1 = 4]
M	*similar for modulates response*	- [score for R1 = 5]
I	*similar for input*	- [score for R1 = 4]
EX	*similar for exploration*	- [score for R1 = 5]
A	*same for attunement*	- [score for R1 = 5]

We used two instruments for the following reasons:

(i) we thought that by using the individual scales relating to the five dimensions we would be less likely to miss material which we had identified as important.

(ii) we thought that being alert to the detail of the interaction would help us make a more informed judgement when we came to using the second instrument which relied on definitions of the behaviour and not discrete aspects of it.

However we hoped that there would be a correspondence between the two instruments. i.e. that the score we gave on instrument 1 for focused attention (the sum of the three scales relating to focused attention, reverse scoring where necessary) would be similar to the score we gave to focused attention on instrument 2.

Examinations of the ratings made by my colleague suggested that there was little value in using the scores based on the more specific scales. The correlation between these scores and the relevant overall rating varied form 1 to .82. This suggested that whatever they were measuring it amounted to much the same thing in each case.

A rather more worrying feature of the overall ratings was that there was a very high degree of correlation between them. The correlations varied from .95 ($p<.001$) to .55 ($p=.07$). This suggested that in the raters mind at least the different ratings were tapping the same (or at least highly related) rather than different aspects of performance.

I examined the correlation between my ratings and those made by my colleague. All were positive but none were significant. They varied in size from .27 to .50. I then calculated a score based on adding up the overall ratings. The correlation between the sum of my ratings and the sum of hers was .54 ($p=.07$) - encouraging but not conclusive evidence of reliability. These findings suggested that we were seeking to rate an aspect of interaction that did not divide easily into separate parts. The

correlation between the "parts" into which we had tried to cut it was exceedingly high. The correlation between the two of us was higher on a global measure than on our more specific ones. As we shall see we later decided to use just one score rather than the five outlined above.

Issues arising from the first attempt at getting a reliable rating

When we discussed our reasons for scoring the way that we did it seemed that we were understanding the concepts differently. This was possible because one of us has a clinical background and the other does not. For example my colleague gave the students high marks for input if the student brought in something new or gave the client something to think about. She did not adjust her score in relation to how the client responded to the input. She was therefore not working within an interactive frame.

I decided to invite a colleague who had therapeutic experience to work in the project. I still wished to retain my colleague from social policy for two reasons: (i) I was too intimately involved with the research design to be involved in the final rating process myself and (ii) it seemed to me that if I were going to establish a reliable measurement of empathic attunement then it should be possible for non-clinicians as well as clinicians to use it .

Involving a second independent rater

The second independent rater was also trained on two tapes. I introduced her to the 15 scales, the aggregate scales, the definitions and went through the training video tapes identifying the behaviours and the sequences that we were after. She and I then rated two tapes using the 15 scales (as warm up) and the 5 aggregate scales. To get a score for empathic attunement we used the sum of the scores for each of the five

dimensions. We then compared our results. We followed this with a detailed and intensive debriefing. The second rater then rated the original 12 tapes[3].

I present the result in table 5.

TABLE 5: EMPATHIC ATTUNEMENT SCORE:
CORRELATION BETWEEN TWO INDEPENDENT RATERS AND SELF

	Independent rater 1	Independent rater 2	self
Independent rater 1	1.000 n=12 P=.	r=.1938 n=11 p= .568	r=.39 n= 11 p= .209
Independent rater 2			r=.6294 n=11 p=.038

* the empathic attunement score was established by adding the scores achieved by each student using instrument 2.

As predicted (based on the assumption that having a clinical background was helpful in rating the tapes) there was a much better correlation between myself and the second independent rater. The correlation between the two independent raters while positive was poor and so further work needed to be done to see why this was the case

[3] Though she rated 12 tapes one of these was the wrong tape; it took a while to figure out the mistake.

Phase two: method

Over the next months myself and the two independent raters met at regular intervals with the following agenda:

1. to look in detail at the tapes where there was the biggest discrepancy between us;

2. to get markers for the five aspects (categories) that we were rating - focused attention, modulate response, input, attunement and exploration;

3. to get an example of 'good practice' and 'bad practice' for each category of behaviour.

Over a period of six months we met every three weeks for three hours and went through the interviews where there was the highest level of disagreement between us. We observed and tracked sequences of interaction. We stopped the video at points of interest and replayed sequences until we were clear we each understood what we were looking for and how we would rate it. We taped our discussions. I transcribed them, we used the transcripts to keep track of our discussions and read them before the start of the next session so that we were not going over the same ground.

Our debriefing and ongoing training took the following form:

1 We checked our understanding of the five categories by going through tapes in detail and identifying examples of 'focused attention'; modulates response'; input' and 'attunement' and therapist behaviours which facilitated and inhibited exploration.

2 Having discussed in detail the behaviours that we had seen and how we thought they fitted the different categories, we would then assign a rating to the student for each of the categories and compare our scores.

We therefore had 11 tapes that all three of us had scored.

3 We made minute observations of the process of interaction between the actor and the student, noting eye contact, tone of voice, gestures, mirroring behaviour. We noted when there was a flow of head movements from the actor which seemed to have the purpose of scanning the face of the student as they brought in emotionally laden material (this behaviour I considered to be akin to social referencing).

4 We noticed the response of the actor to the way in which the student responded to his material and replayed these sequences over and over again stopping sometimes frame by frame to examine the way they were tracking and responding to each other.

When we were satisfied that we were clearer about what we were rating, we rated another set of 12 unseen video tapes and correlated our results: to our astonishment our correlation had gone down.

I present the results in table 6.

TABLE 6: EMPATHIC ATTUNEMENT:
CORRELATION BETWEEN INDEPENDENT RATER AND SELF

	Rater 1	Rater 2	Self
Rater 1		r=.5201	-.3001
		12	12
		p=.101	p=1370
Rater 2			.2474
			12
			p=.463

* the empathic attunement score was established by adding the scores achieved by each student on instrument 2.

The correlation between rater 1 and rater 2 is .52, p=.101, the correlation between myself and rater 1 is negative, -.30 and the correlation between myself and rater 2 was .25, p= .463.

I was now negatively correlated with the first independent rater. The correlation between myself and the second rater had gone down. What had improved was the correlation between the two independent raters.

In order to try and make sense of what was going on, I looked at the raw scores:

Table 7 provides the raw data on the scores.

TABLE 7: SCORES OF ALL THREE RATERS FOR EACH OF THE 12 STUDENTS

Student	Independent Rater 1	Independent Rater 2	Self
L	20	22	17
U	23	21	21
M	17	12	18
F	24	23	16
D	10	20	18
C	5	13	22
I	16	24	22
X	21	13	10
H	24	26	25
N	7	14	24
G	15	22	17
A	23	22	23

What is clear from the raw data is that the correlation between myself and rater 1 is influenced by our ratings of student C and student N. These are the students where there are major differences. For similar reasons the correlation between myself and Rater 2 is influenced in addition by the scores of students F and M.

Rater one thought C and N were very good, I rated both students as poor. Rater two marked them in the middle. If one looks at all the scores for rater 2 one sees these two students were amongst the most highly rated by her. There was only one student who scored better, that was student M. Therefore even though the discrepancy between myself and rater 2 was not numerically as big as that between rater 1 and self, raters 1 and 2 were obviously in agreement that these students were doing comparatively well.

In relation to students M and F, the independent raters were in very close agreement about F, I was the odd one out, and with M it was rater 2 who had a different view.

Learning from our mistakes or repeating our mistakes.

We returned to undertaking a detailed look at those tapes on which we were furthest out. We selected students N, C, D and X to go through in detail to see why we scored them so differently. Again this entailed detailed analysis of tone of voice of student or actor, whether we heard the tone, how we thought the one party responded to it, whether we thought this was input or modulated response or attunement and so on. Finally we realised that we were becoming obsessed by the categories and not really addressing a problem that we actually knew was lurking in the background. *This was the way in which our own personality structure and defences were influencing our response to the interaction that we were observing.*

It was becoming clear to us as a possibility that because of these differences we may have been assessing different levels of attunement:

1 attunement to the defence

2 attunement to the feeling against which a defence is constructed.

An example of number 1 above, 'attunement to the defence' , would be when someone presents as if everything is fine when it clearly is not - in this case the therapist relates to the surface feeling and ignores what is underneath. The therapist might do this for any number of reasons such as a sense of timing, and also because they themselves find it difficult to access or attune to the particular feeling being defended against. In this case the response is likely to be out of consciousness.
An example of number 2, 'attunement to the feeling against which a defence is constructed', would be when one picks up the despair behind the witty remark.

This and other factors made us think that we needed to review our rating procedure and make radical changes to it. Another five months went by with extensive viewing of the contentious tapes, rating them, discussing our judgements and transcriptions before we took the third and final step in the rating process.

Analysis of our attempts so far

There were many factors that might account for the continuing discrepancy between us. We concentrated on four.

1 Training
2 Time
3 Interaction
4 Concept

1 Training

We had trained on students C , F, M and N (albeit in relation to different actors) because we had been 'out' on these students in our previous rating. We therefore had memories of these students associated with examples of what we had classified as either good or bad examples of practice. We were therefore open to having a prejudiced view of them. This could have influenced our present judgement.

Also, we felt that we had got very vivid images from our training sessions of what we were looking for that fitted the categories we were using, for example, we had used the image of an alert animal when defining 'focused attention'. These and other images may have influenced how we went about viewing the tapes. It may have introduced a certain rigidity of expectation that could have got in the way of seeing what was there to be seen.

2 Time

We were scoring on the basis of watching a ten minute video. We were all aware from our previous training and de-briefing sessions that one's view of the student and the interaction between the student and client changed from moment to moment during the session and that one's score depended on which sequence of the interaction one had in mind when rating. One's final score was based on a composite impression. We knew this was a very crude and imprecise measure.

3 Interaction - the pattern of global and specific measures

Rater 2 said she was aware of having a lot more information to look at this time, having become much more tuned in to the interactive process between the student and actor during the debriefing sessions following the last bout of rating. This left her feeling she had twice as many judgements to make.

I felt that I was much more focused on a pattern of interaction between student and actor based on the client's communication of distress. *I felt I was rating a process* and not giving my full attention to the individual categories and thinking out what score I should give them based on definitions alone.

Before each rating session all three of us had read through the transcripts of our training sessions which had detailed descriptions of the various categories. We all found this a lot of information to hold in our heads (comparable to the difficulty of rating a ten minute tape) and wondered if we remembered particular bits from the transcripts more than other bits. In addition it was clear that we were all doing different things with this information. I was scoring a process and then backtracking and filling in the indicators; rater 2 was spending a great deal of time very carefully attending to the indicators and rater 1 was doing similarly to rater 2, if less intensely. (I and rater 1 took 30-40 minutes to rate each tape while rater 2 took over an hour.)

4 Concept

What had become almost completely lost in the process of rating was the concept under consideration. At this point I took a much more active part in the team and reasserted my view of the concept of goal corrected empathic attunement as described in chapter 5. This concept is based on an understanding that careseeking and caregiving form an instinctively based goal-corrected complementary partnership. The complex pattern of careseeking engaged in by insecure careseekers is likely to be difficult to track.

Concentrating on behaviours alone (as we had been doing) either of the therapist or the client was unlikely to get at the nature of the process set in motion when the dynamics of careseeking and caregiving are aroused. The theory suggested that ineffective caregiving gave rise to defense and self care. It was the process of goal-corrected empathic attunement that we needed to track within the theoretical framework of the dynamics of attachment.

At this point in the process of refocusing us on the task of achieving a reliable rating I constructed the model which I referred to as the spiral of goal corrected empathic attunement and which I presented in chapter 5, p 108. This would help us track the process under observation.

The spiral of goal-corrected empathic attunement depicts the following process:

- expression of distress in the careseeker (actor)

- met by attunement to affect from the caregiver in such a way that the vitality affects of the actor is regulated so that it comes within manageable and optimal limits for exploration(student)
- expression of relief from the careseeker (may be momentary - maybe so brief as not to be visible)
- followed by expression of concerns from the careseeker
- met by attunement to affect and empathic response from the caregiver
- expression of relief from the careseeker (again may be momentary - may not be visible)
- Exploration of concerns from the careseeker
- resonance with and attunement to underlying affect by the caregiver followed by empathic comment from caregiver
- followed by input from caregiver
- visible expression of relief from careseeker

(See chapter 5 for more variations on this pattern)

The following analysis of interaction between a careseeker and a caregiver taken o the videos of student actor interaction is an example of the processes that we were attempting to rate. I give two examples - one where there is goal-corrected empathic attunement and the other where there is not.

The brief for the interview being observed was as follows:

Sadness

You are 36, living in the north of England where you have a job that is very important to you. Your family are in Kent where you were brought up. You don't have a partner and despite the geographical distance had a very close relationship with your parents. You thought for years that you would move back down south at some stage, but kept putting it off. Your father died five years ago, leaving your mother alone. She encouraged you to pursue your career rather than to move down to live with her.
You know your mother has been having some memory problems, but you have put this down to recent stresses she has had with her house. However, her GP has contacted you to say that he thinks your mother has Alzheimer's disease.

You are very upset and have contacted social services.

Example 1: Goal-corrected empathic attunement:

Careseeker	" ....that is what is terrifying me really, one that she is not going to be there for me in a physical sense and two, that she will not know me when I walk through the door". As she says this she looks to the caregiver and opens her hand wide placing the edge of her hand along the wooden arm of the chair facing the direction of the caregiver.	expression of affect
Caregiver	Nods head and raises hand to chest... "almost like,..... sounds like... (opens his hand flat and brings it down across his chest and facing towards his chest between him and the careseeker) on the one hand she's dead, she's not there any more, but also, you'd.... be in contact with someone who doesn't know who you are.."	cross modal attunement followed by empathic input
Careseeker	"That's right, someone new.. (careseeker intakes breath and exhales; giving an impression of relief)	expression of relief and momentary rest
Caregiver	" That's really sad for you.."	affective comment

Careseeker	"yea" (nods her head and looks straight at him and seems to stop for a while even though in real time it is only about a second) "That's it..... that's it" (nods head vigorously, looks at floor, bangs hand to same rhythm lightly, on the arm of the chair; looks across at caregiver and says "what do you do? (she shakes head right to left as she looks at caregiver, he responds by nodding his head up and down)...this is what I don't know what to do about it to make it better" (all the time she is saying this she is glancing at and away from caregiver)	expression of relief and momentary rest followed by exploration of area of concern
	Caregiver is nodding head in short tight movements, looking at the careseeker.	cross modal attunement
Caregiver	"In what way do you think..how would things be if they were better?"	exploratory comment
Careseeker	"I would feel less stranded...less like someone flapping about waving their hands about and creating a lot of air...	exploration of concern

Example 2: Poor goal-corrected empathic attunement

Same brief as above.

Careseeker	"My mum is a strong capable awesome woman, so this is...I know it must be shocking for everyone...but it feels, it just feels wrong, and I feel he must have got the files muddled up or something (looks at ceiling), because this can't be happening to my mum (runs her hands through her hair)".	expression of affect
Caregiver	(Very calm still posture elbows on arms of chair, hands on thighs, voice has a clear questioning tone). "Have you actually seen your mum recently to see for yourself?" Careseeker: "	avoidance of affect
Careseeker	No. I do speak to my mother very often on the phone (hand on neck looking very stressed) and I have...	momentarily disorganised, reasserts careseeking non-verbally
Caregiver	"How do you find her? (clips the end of careseeker's sentence)	avoidance of client's here and now affect
Careseeker	"yea" (clearly not understanding)	momentarily disorganised

Caregiver	"How do you find her, do you find her any different?"	avoidance of client's here and now affect
Careseeker	"I do find her". Pause. (Nods head up and down as she says this. She looks very preoccupied, brings hand up to face and starts to twirl a piece of hair on her temple) "Although it wasn't until the Dr. told me that I put all the pieces together and thought she is distracted, yes, she is sounding much older all of a sudden and she is talking about things that don't have an immediate relevance to what we are talking about. But I don't want to leave her there all by herself. My instinct is to love her.." (puts a lot of emphasis on the word instinct, puts energy on voice as she says it and locks both hands together points to her chest with her thumb and opens hands forward as she says 'love her').	momentarily disorganised, reasserts careseeking
Caregiver	(Cuts in again) "That is understandable. have you discussed this with your mother at all?"	avoidance of attachment behaviour

Careseeker	Careseeker at this point is looking at caregiver, her mouth is slightly open as she is in fact in the middle of talking, but her mouth stays open as if in freeze in response to caregiver's question.)	momentarily disorganised
Careseeker	"No" (purses mouth, looks down) "No, I ..."	possibly the reassertion of careseeking
Caregiver	"Does she know that your Dr. has told you?"	avoidance of affect
Careseeker	"oh! yes, she does, but she isn't really willing...she may be to him, but to me she isn't.. " (Careseeker is clearly looking distressed - sad tone of voice- bit preoccupied)	careseeking
Caregiver	(Again cuts in before careseeker has clearly indicated she has finished speaking) "Have you discussed it at all? (upbeat tone, coming across as slightly inquisitorial)	avoidance

Phase three: method

Having arrived at the above conceptualisation of the process under consideration we made the following changes to our rating method:

(i) we changed the unit of time on the video that we chose to rate from the full unit of 10 minutes to 1.5 minute segments. This was to deal with the issues

outlined just now, namely, length of concentration and difficulty in knowing whether we were more influenced by one section of the interaction than another;

(ii) we stopped using the 2 measuring instruments as we felt:

a) they distracted us from observing the interaction by focusing us more on behaviour;

b) they vectored our energy and attention to our cognitive processes of thinking and conceptualising and away from our apprehensive sense of what was taking place between the two people that we were observing.

iii) to be congruent with the above change in direction we decided to reintroduce the definitions that I had originally used with the senior clinicians and with the students in the experiment described in chapters 4 and 5;

iv) before each rating session we read through the definitions of affect attunement and reminded ourselves of the sequence of goal-corrected empathic attunement as described on page 230;

v) it was agreed that the rating by the two assessors would be done in the same room on the same segment of tape at the same time so that there would be no ambiguity about which section of the tape or what length of tape was being rated;

vi) the rating was to be done on a scale of 25 divided into three segments - 1-8 represented attuned; 9-17; represented tuning in and 18-25 represented non attuned;

vii) finally, as mentioned at the conclusion of the last section it seemed highly probably that our own defensive structures were influencing the way that we

were rating the interaction between student and actor, and we developed a way of dealing with that problem.

Techniques for managing defensive processes

Given that it was impossible to really know for certain how and in what way our defensive structures were interfering with the rating process, I decided as a first step to introduce a method from systems centred theory (SCT) and practice, devised by Yvonne Agazarian (Agazarian, 1997, Agazarian and Gantt, 2000) and in which I am a licensed practitioner, to deal with the most obvious problem of moving out of a social or academic role and into the role of a rater of psychodynamic process. The technique used to move from one role to another in SCT is known as the 'Distraction Exercise' Agazarian and Gantt, (2000) pp. 199-200 and 244-246.

The goal of the *Distraction Exercise* is to cross whatever role boundary it is so that one has one's full energy available for the task. I have included a short example of the technique in the appendices - appendix 22.

Our experience of operating this system was that the feelings we worked on that were causing distraction (for example - meeting a colleague in the photocopying room just before meeting with the research team and being reminded of essays still awaiting marking) were similar to the feelings being stirred up by the task . The distraction exercise proved a powerful method for recognising these feelings and checking them out with members of the research team (for example feelings about not being competent for the task, or letting the research team down in some way). Not being distracted by these thoughts and feelings and seeing them as shared by other members of the team made it possible to have one's full energy available to concentrate more fully on the information on the videos.

So in summary the new method consisted of

1 dividing the tape to be rated into 1.5 minute segments

2 reading the definition of affect attunement used in the first phase of the research[4]

3 reminding ourselves of the processes involved in goal-corrected empathic attunement

4 performing the distraction exercise

5 rating the segments using a 25 point scale divided into three parts (see appendix 23)

We tested the method on the set of tapes belonging to the two students who had not completed the project. Each tape was divided into 1.5 minute segments. Each of these segments was scored independently by the two raters. The four interviews provided between them 21 segments of tape.

The test achieved the following correlations. See table 8

TABLE 8: CORRELATION BETWEEN THE TWO INDEPENDENT RATERS ON 21 SEGMENTS OF TAPE TAKEN FROM FOUR INTERVIEWS

	Rater 1	Rater 2
Rater 1	1.000	.7439
	21	21
	p=.	p=.000

The correlation between the raters was highly significant r=.74. Much encouraged by this result we carried on discussing the observations being taken into account for the ratings made and proceeded to rate another 12 tapes using the same procedure. This

[4] The definitions were: Attunement is a way of communicating to the other that one has recognised the affect that they are experiencing. Attunement conveys to the other that one has a feeling sense inside of what it feels like to be them right now.

time we arranged the score for the segments giving each tape a single score. Table 9 sets out the result

TABLE 9: CORRELATION BETWEEN THE TWO INDEPENDENT RATERS ON THE AVERAGE OF 1.5 SEGMENTS OF TAPE FROM TWELVE INTERVIEWS

	Rater 1	Rater 2
Rater 1	1.000	.8901
	12	12
	p=.	p=.000

Again we achieved a highly significant result based on the average score of the segmented interview.

As a final test we chose 12 tapes that we were absolutely sure had not been involved in previous rating attempts and divided them into 1.5 minute segments. We used the method as described above and correlated the results. A correlation of .798 was achieved between the two independent raters at which point we were satisfied with the result. See table 10

TABLE 10: CORRELATION BETWEEN THE TWO INDEPENDENT RATERS ON 12 TAPES*

	Rater 1	Rater 2
Rater 1	1.000	.7981
	12	12
	p=.	p=.002

* These 12 tapes were divided into roughly 7 segments each of 1.5 minutes in length. Each of these segments was given a score. An average was computed for the seven segments. The average score for each of the 12 tapes was the subject of the correlation.

It then remained to get a score for all the 96 interviews. This work went on in the summer of 1998. It was decided that one of the independent raters would take on the job of rating all 96 videos and that the second rater would rate one video in every batch of ten in order to compare the results and discuss any differences in order to ensure that the first rater was rating in line with the standard developed rather than creating a standard of her own.

The work was done over a period of six weeks and went on in batches of 6 videos a session. I met with the rater on each occasion and we went through the definition of attunement, reminded ourselves of the process of goal-corrected empathic attunement and what she was looking for in terms of sequence of interaction and the signals that the goal of careseeking had been met. I then did the distraction exercise and left.

By the end of this procedure I had an empathic attunement score for all 96 interviews.

Summary

This chapter has described the process involved in getting a reliable measure of goal-corrected empathic attunement. It was eventually achieved by clarifying the nature of what was being observed. The concept referred to *a process that was triggered under certain conditions and came to an end under other conditions* at which point other behaviours would then come into play. What was required was the *observation of both the activation and deactivation of a process.*

In addition we recognised the impossibility of trying to rate all 10 minutes of an interview - so we divided the interview into segments, thus ensuring that the raters were at least not rating an unmanageable number of interactions. We abandoned all previous rating measures, returned to using definitions of key elements of the process under observation (the subjective experience of goal-correction - successful empathic attunement) and instigated a single 25 scale marked off in three segments - attuned, tuning in, not attuned.

This new method was tested on several tapes, ending with a final rating of 12 completely new tapes on which a correlation of .8 was achieved between two independent raters.

At the conclusion of this work I had an empathic attunement score for each of the 96 interviews.

In my next chapter I present the results of all the experiments.

CHAPTER TEN

RESULTS

Introduction

I set out in the third experiment to explain:

i) whether careseekers (actors) and caregivers (students) shared a similar evaluation of their experience of caregiving and whether these experiences were related to the independent measure;

(ii) whether the attachment status of the students was related to (a) their ability to attune to client affect and be empathic and (b) to the way actor and students evaluated their experience;

(iii) whether students who were given training directed at encouraging them to attune to client affect and be empathic would subsequently do better at empathic attunement than those students who were not given this training.

The reasons for this exploration should be apparent from earlier chapters. Basically I expected that the measures I used would prove valid in the sense that they would relate to each other and distinguish between students. I also expected that students who had a secure attachment style would "do better" on all these measures. Finally I expected (or to be more accurate hoped) that the performance of the students could be improved by training.

I now present what I actually found starting with a presentation and analysis of the results of the subjective and independent measures. I will then present the results of the attachment questionnaire and conclude with the results of the training programme.

Measures

Subjective measures of empathic attunement: caregivers' (students) score

The following is a description of the measure.

The measure consisted of six questions each presented on a scale marked 1-6 in decreasing order of agreement. So, point one on the scale indicated high levels of agreement with the question (very much) and point 6 indicated low levels of agreement with the question (not at all).

The questions used were:

1 Do you think you conveyed to the client that you could see what they were feeling?

2 Do you think you conveyed to the client that you understood what they were saying?

3 Were you attentive and interested in the client?

4 Did you think you enabled them to say what they wanted?

5 Did you feel you enabled them to see things in a new way?

6 Do you think you said anything helpful?

These questions were chosen based on the research carried out in the pilot study (experiment one) and described in chapter 6. In that study I discovered that the experts associated empathic attunement with: focused attention; modulating response; input and facilitating exploration. My analysis of the experts answers suggested that

the therapist had to attend to the feelings that the client was expressing and conveying and to the content of what they were saying. They had to respond in such a way that they facilitated rather than inhibited the client's natural capacity to explore the meaning of their predicament and their feelings about it.

The reader will see that in the light of this way of thinking, my first question relates to whether the student is attending to the actor's emotional experience; the second question relates to whether the student understands what the actor is saying; the third question concerns the level of attentiveness and interest on the part of the student; the fourth question addresses exploration; the fifth question asks the student whether they think their contribution was used and responded to (in other words asking them to pay attention to feedback) and the final question asks them to evaluate their input.

At the end of the experiment I received completed forms from all the students giving me answers on all six scales for each of the eight interviews. I wanted to see whether the questions I had put together for this measure were in fact measuring aspects of the same thing. For example, if a student scored well on attention to feeling, did they also score well on enabling the client to say what they wanted? This would provide support for my analysis of the data from the first experiment and suggest that the elements of the therapists' response that were important, i. e. affect attunement and empathy, went together in a meaningful way. A measure of their 'internal consistency' is provided by Cronbach's alpha. As can be seen from table 11 this was very high.

Table 11 INTERNAL CONSISTENCY OF THE SCALES INVOLVED IN CAREGIVERS' MEASURE OF CAREGIVING

N of cases	96.0
N of items	6
Alpha =	.8723

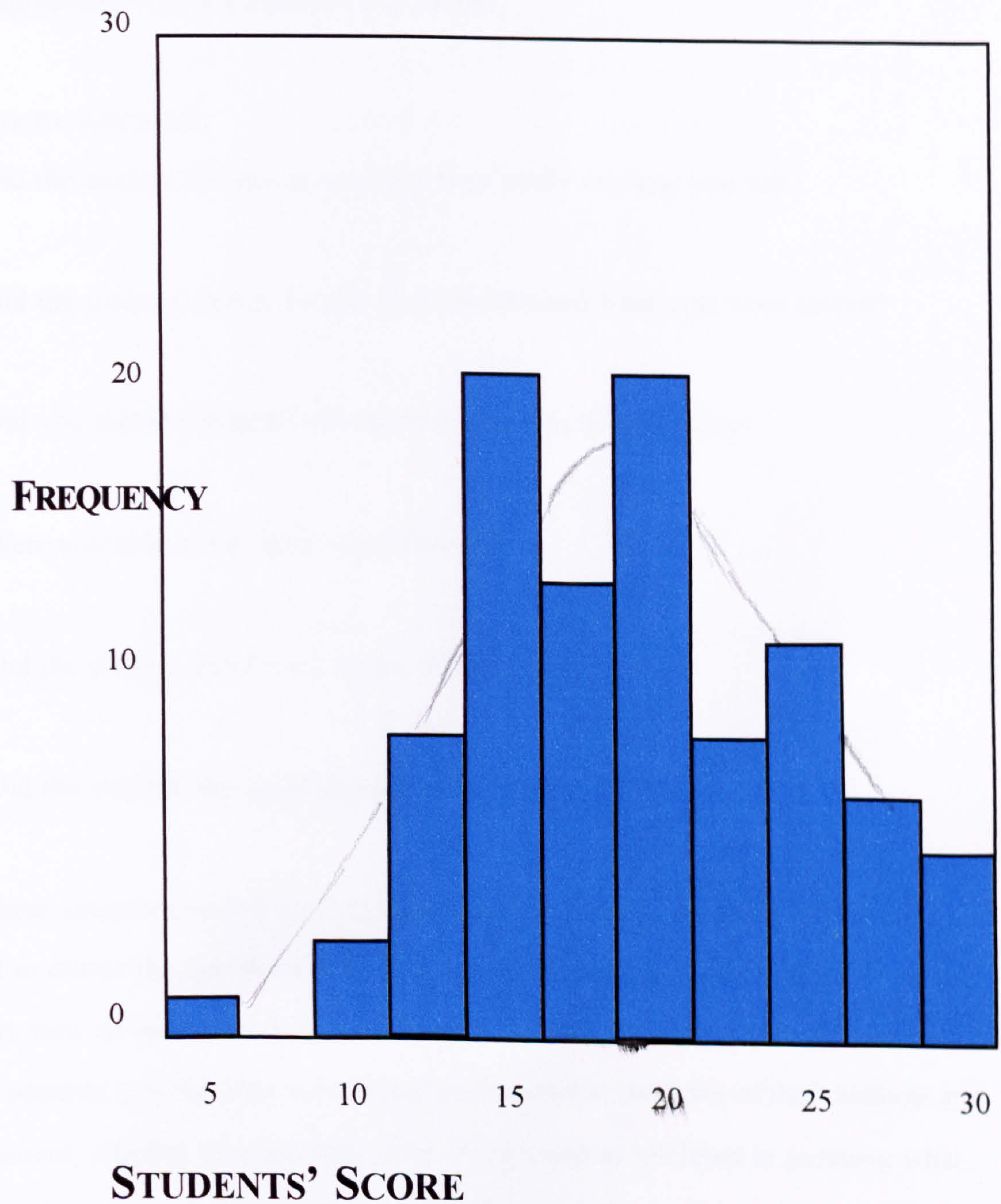
Table 12 gives a distribution of the scores.

Table 12 FREQUENCY OF DISTRIBUTION: CAREGIVERS' (STUDENTS) SCORE

Score	Number	%
6-10	4	5
11-15	23	23
16-20	34	35.4
21-25	19	20
26-30	16	17
Total	96	100%

The range goes from a score of six to a score of 30. Clearly there is a considerable variation in the way the students rate their performance.

STUDENTS' SCORE
FREQUENCY OF DISTRIBUTION



Std. Dev = 5.27
Mean = 19.3
N = 96

Subjective measures of empathic attunement: careseekers' (actors) score

This measure also consisted of six questions presented on a scale marked 1- 6 in decreasing order of agreement as described above with a mark of 1 indicating high levels of agreement with the question (very much) and a mark of 6 indicating low levels of agreement with the question (not at all).

The questions used were:

1 Did the student convey to you that they could see how you felt?

2 Did the student convey to you they understood what you were saying?

3 Did you feel the student was interested in you and attentive?

4 Were you able to say what you wanted?

5 Did the student enable you to see things in a new way?

6 Did the student say anything helpful?

Again, these questions were based on the results of the pilot study but were also designed to mirror the questions being put to the students. They were designed to get the actors view of the interaction, the response they felt they were getting from the student, whether they felt they were being understood at the level of their feelings and their concerns; whether they felt they were encouraged or inhibited in pursuing what they wanted to explore; whether they were able to use the student's input and finally how they evaluated that input. The questions were designed to get at the nature of the contact between actor and student and to assess whether the student was interactive, responsive, and tuned into the actors' emotions and concerns.

These questions were then subjected to a test measuring internal consistency and the results obtained are shown in table 13. I got an extremely high level of internal consistency : .86

Table 13 INTERNAL CONSISTENCY OF THE SCALES INVOLVED IN CARESEEKERS' MEASURE OF CAREGIVING

N of cases	96.0
N of items	6
Alpha =	.8573

The next question I addressed was whether the actors rated the students as similar or different from each other.

Table 14 depicts the spread of scores given by the actors.

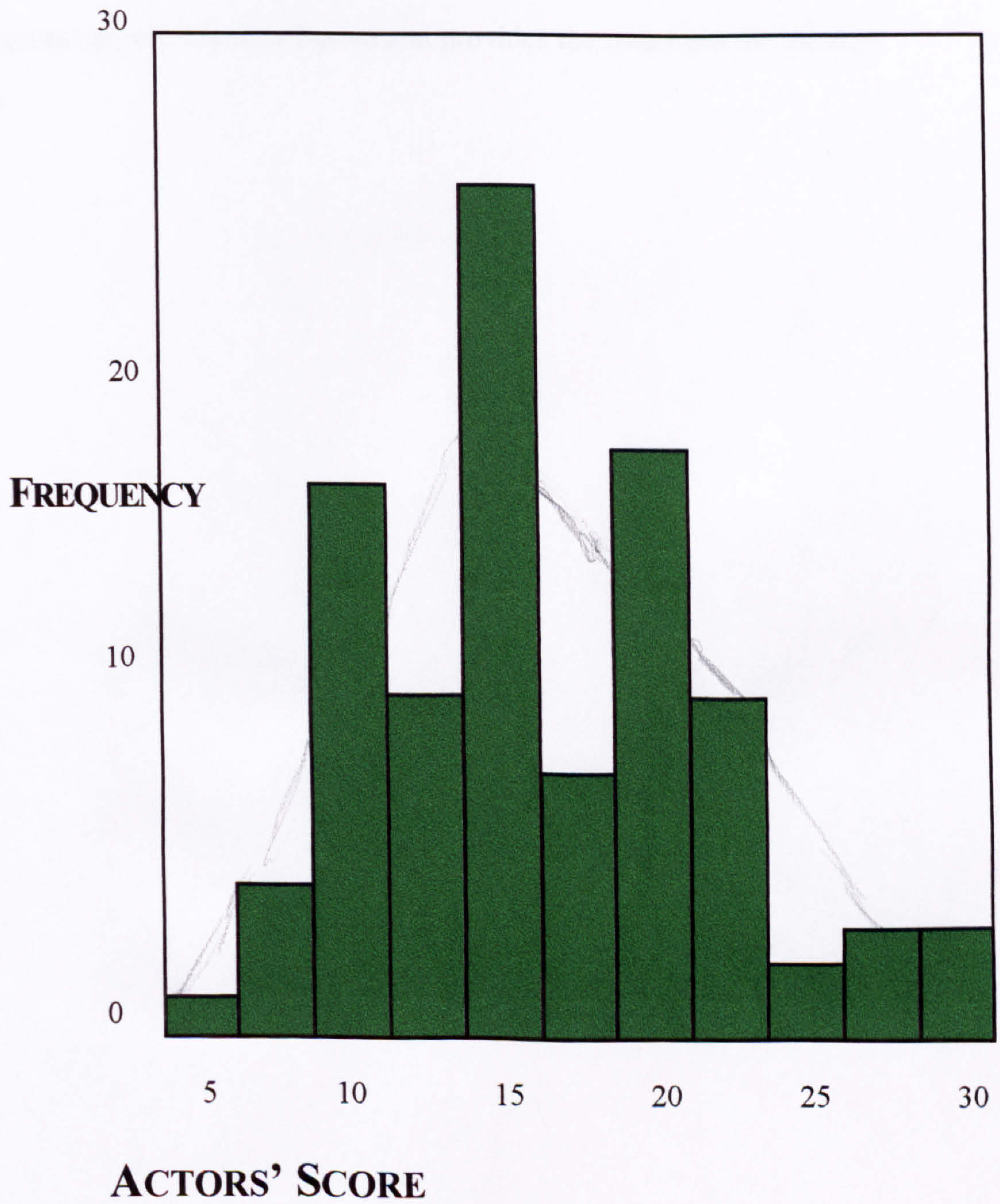
Table 14 FREQUENCY OF DISTRIBUTION: CARESEEKERS' (ACTORS) SCORE

Score	Number	%
6-10	19	19.79
11-15	28	29.1
16-20	25	26.04
21-25	17	17.70
26-30	7	7.29
Total	96	100%

The scores range from 6 to 30. Six was the best score that any student could get, 36 was the worst. The actors were clearly using the full range of the scales to score the sessions.

The following graph shows that the actors discriminate between the students in quite substantial ways along a fairly normal distribution curve.

ACTORS' SCORE
FREQUENCY OF DISTRIBUTION



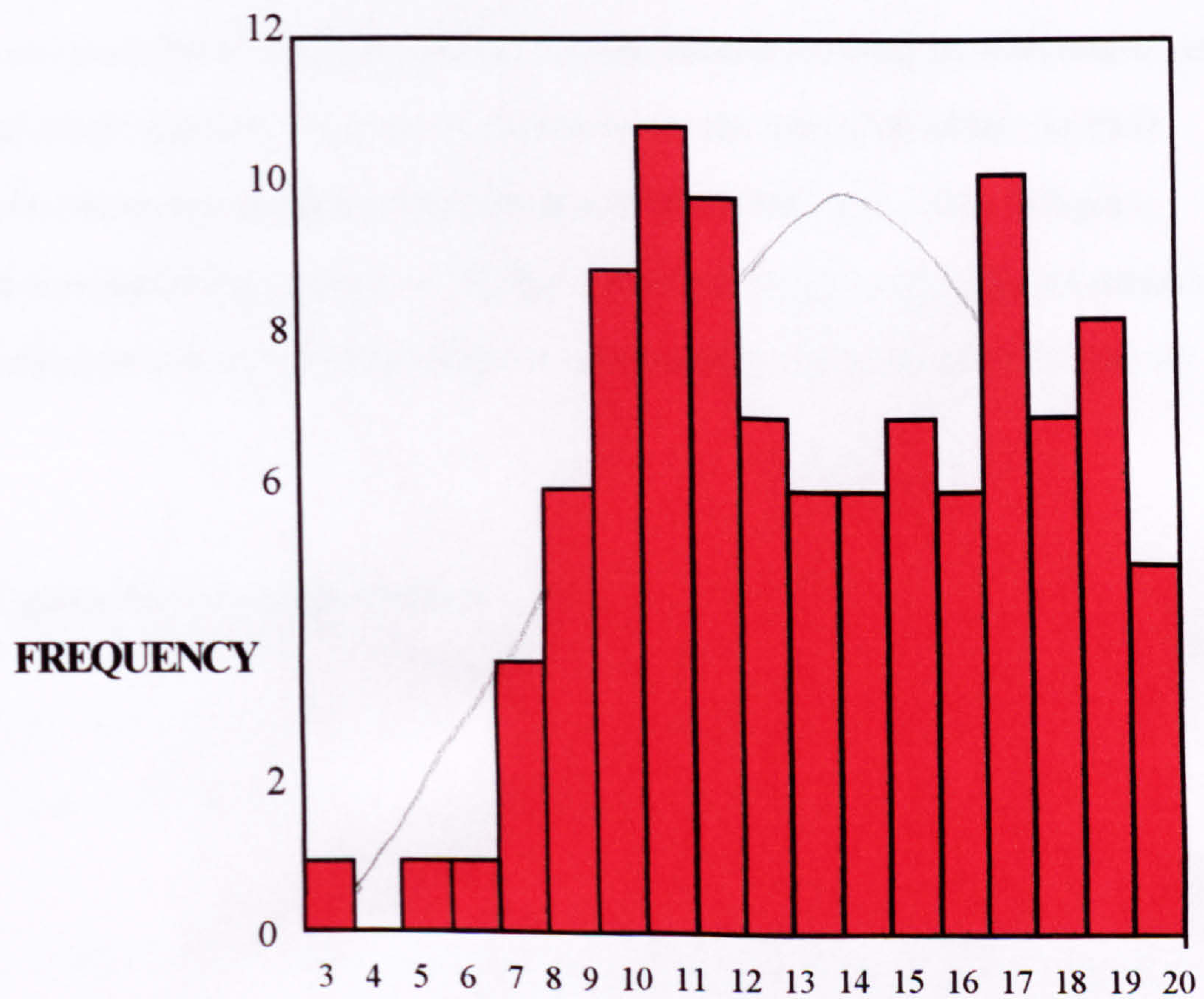
Std. Dev = 5.62
Mean = 16.3
N = 96

Independent measure of goal-corrected empathic attunement:

I now looked at the scores given to the students by the independent rater in order to see whether there was a normal distribution.

The histogram sets out the distribution and provides the mean and the standard deviation:

INDEPENDENT MEASURE OF GCEA
FREQUENCY OF DISTRIBUTION



Std. Dev = 4.03
mean = 13.2
N = 96

One can see from the chart that there appear to be two distributions: one group of interviews gets ratings in the lower end of the scores, i.e. between 6-12 and the other group bunches at the higher end, 16-19.

Correlations between the measures

A test for goal-corrected empathic attunement has not yet been devised. It was therefore not possible to test the validity of these measures using an independent and already validated criterion. I therefore needed to see the extent to which the three measures of careseeker-caregiver interaction correlated with each other. If I got a significant correlation the chances were that I was measuring something real something which all three parties to the observation (actor, student and observer) could agree about.

Table 15 gives the correlation achieved.

Table 15 CORRELATION BETWEEN MEASURES OF CARESEEKER-CAREGIVER INTERACTION

		INDEPENDENT Rater	STUDENT (Caregiver)	ACTOR (Careseeker)
INDEPENDENT (Rater)	Pearson Correlation	1.000	.295**	.246*
	Sig. (2-tailed)	.	.004	.016
	N	96	96	96
STUDENT (Stutot)	Pearson Correlation		1.000	.510**
	Sig. (2-tailed)		.	.000
	N		96	96

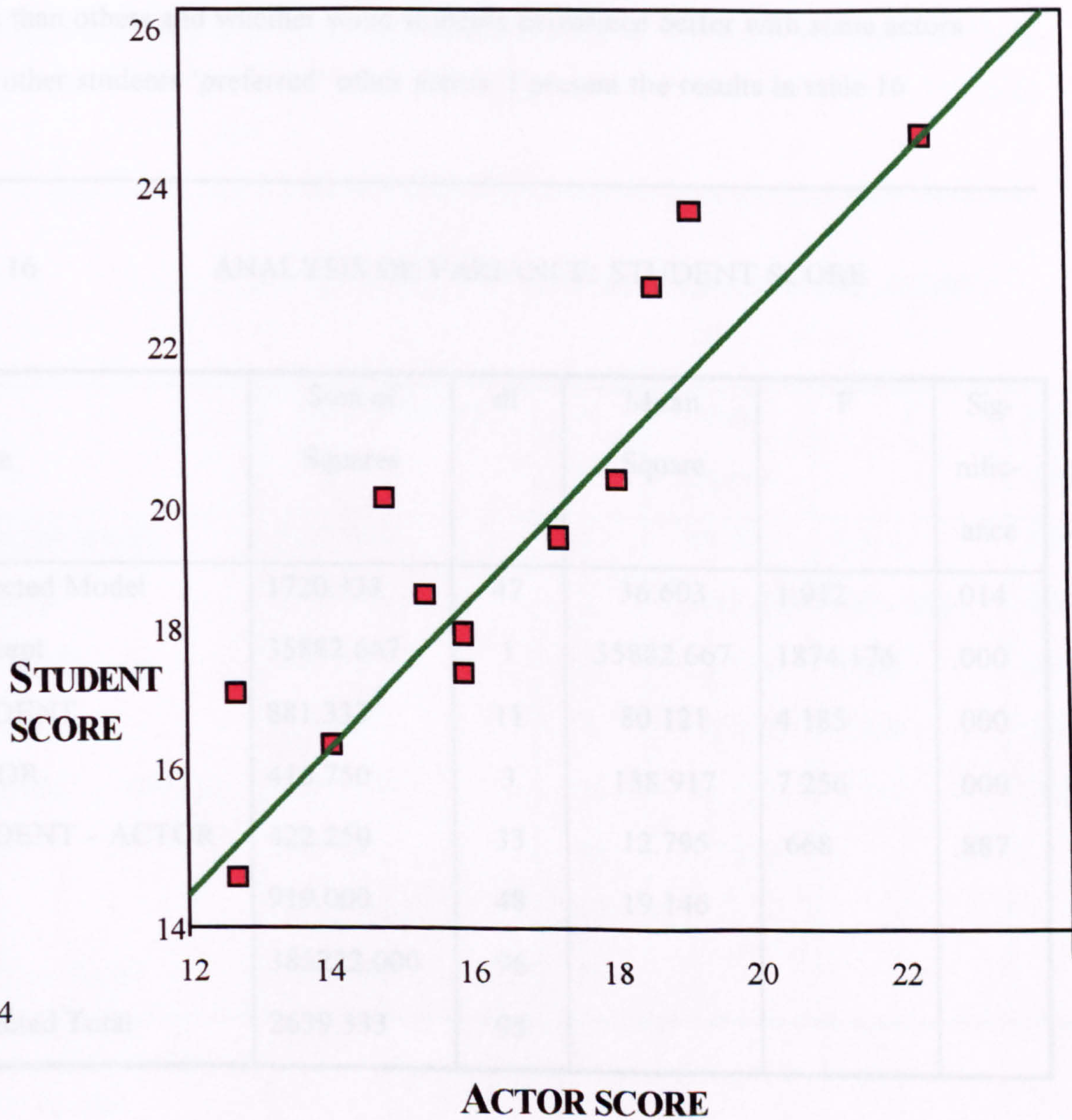
*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed)

***. Correlation is significant at the 0.001 level (2-tailed)

As can be seen there is a highly significant correlation between the actor (careseeker) and the student (caregiver) in terms of their experience of the interaction between them. The correlation of .295 between the independent rater and the student is also significant at the .01 level (2-tailed). The correlation between the independent rater and the actor is not as high at .246 but is significant at the 0.05 level (2-tailed) which means that it is unlikely to happen by chance more than 5 in a hundred times.

STUDENT SCORE BY ACTOR SCORE



Analysis of variance

I next set out to examine whether some students were better than others as measured by themselves, the actors and the independent rater. I took the students' score and subjected it to an analysis of variance to see whether the students differed significantly from each other, whether all students on average did better with some actors than others and whether some students performed better with some actors while other students 'preferred' other actors. I present the results in table 16

Table 16 ANALYSIS OF VARIANCE: STUDENT SCORE

Source	Sum of Squares	df	Mean Square	F	Significance
Corrected Model	1720.333	47	36.603	1.912	.014
Intercept	35882.667	1	35882.667	1874.176	.000
STUDENT	881.333	11	80.121	4.185	.000
ACTOR	416.750	3	138.917	7.256	.000
STUDENT - ACTOR	422.250	33	12.795	.668	.887
Error	919.000	48	19.146		
Total	385222.000	96			
Corrected Total	2639.333	95			

As can be seen from table 16 there were three main results.

1. There was a highly significant difference in how the students rated themselves (student effect - $p<.00$) - i. e some rated themselves consistently higher than others.

2. Students on average did as they saw it better with some actors than with others (actor effect, p<.00)

3. The 'interaction' was not significant - particular students did not, as they saw it do better with particular actors (p<.8).

I then looked at the actors' score with similar questions. I present the results in Table 17.

Table 17 ANALYSIS OF VARIANCE: ACTOR SCORE (TOTAL SCORE)

Source	Sum of Squares	df	Mean Square	F	Significance
Corrected Model	2147.906	47	45.700	2.564	.001
Intercept	25447.591	1	25447.594	1427.802	.000
STUDENT	698.531	11	63.503	3.563	.001
ACTOR	421.865	3	140.622	7.890	.000
STUDENT - ACTOR	1027.510	33	31.137	1.747	.038
Error	855.500	48	17.823		
Total	28451.000	96			
Corrected Total	3003.406	95			

As can be seen.

i) there was a highly significant difference by student (.001) in how the actors saw the different students, i. e. some students were consistently seen as doing better than others (p<.001)

ii) some actors were consistently more generous with their ratings than others ($p<.001$), individual actors rated some students significantly better than others

iii) there is some evidence that some actors "favour" some students while other actors "favour" different students ($p<.038$).

I then looked at the independent measure of the students performance. The results for that are presented in table 18

Table 18 ANALYSIS OF VARIANCE: INDEPENDENT MEASURE

Source	Sum of Squares	df	Mean Square	F	Significance
Corrected Model	1046.36	47	22.263	2.142	.005
Intercept	16637.163	1	16637.163	1600.722	.000
STUDENT	438.904	11	39.900	3.839	.001
ACTOR	50.000	3	16.667	1.604	.201
STUDENT - ACTOR	557.452	33	16.892	1.625	.061
Error	498.890	48	10.394		
Total	18182.409	96			
Corrected Total	1545.246	95			

On this measure

1. Some students do consistently better than others ($p<.001$)
2. On average students do not do better with some actors ($p<.2$)

3. There is some evidence that some students do better with some actors and others with other actors (interaction) - p=.061

Summary of findings

i) There is a high level of internal consistency between the individual scales which comprise the subjective measures;

ii) there is a highly significant correlation between the subjective measures;

iii) there is a significant correlation between the independent measure and the subjective measures;

iv) all three measures distinguish between students in the sense that some students do consistently better than others.

I will discuss these results more fully later in this chapter.

Goal-corrected empathic attunement and attachment style

I had predicted that the attachment style of the caregiver was associated with a capacity to attune empathically to the presentation of distress in another person. In order to test this it is necessary to have measures of a) attunement and b) attachment status. The measures of attunement were those already described. This left the problem of assessing attachment.

The most common method of assessing adult attachment status is probably the Adult Attachment Interview. However this was not used for three reasons, a) it would yield a more detailed knowledge of the individual's history than was appropriate for a tutor, b) I was not qualified to carry out the test, and even if I could find someone who was (which is very difficult to do as so few people are trained) it is time consuming and expensive, and c) it does not yield a quantitative measure.

Instead of the adult attachment interview it was decided to use three 'paper and pencil' self-completion questionnaires. These were: Feeney, Noller and Hanrahan's 'Assessing Adult Attachment: Developments in the conceptualisation of security and insecurity', (Feeney et al., 1994); West and Sheldon's, 'The Assessment of Dimensions Relevant to Adult Reciprocal attachment', (West and Sheldon-Keller, 1992) and Brennan and Shaver's, 'Dimensions of Adult Attachment, Affect Regulation, and Romantic Relationship Functioning'(Brennan and Shaver, 1995). For a full discussion about the reasoning behind this choice see Appendix 18.

These three questionnaires (see appendices 24, 25 and 26 for the actual scales used, coding etc.) yielded 20 sub-scales. To simplify the analysis and reduce the chance of spurious correlations it was decided to combine them into a smaller number. Ideally this would have been done by administering the questionnaires to a large sample of adults and then carrying out some form of factor analysis. Again this was not possible. The best that could be done was to reduce the number of scales by analysing the data from the 12 students in the study.

The procedure used to reduce the scales was rough and ready. A correlation matrix showed that most of the sub-scales were correlated with each other. The scale with the highest average correlation with the others was "angry withdrawal". Six of these correlations were significant with values ranging from .79 to .57, nine were not significant, although sizeable (.5 to .29), and five were low (.1 to 0). It was decided to form a general measure of 'disturbed attachment' by simply adding the fifteen scales (reversing the score where necessary) which showed significant or sizeable correlations with "angry withdrawal". I termed this "Insecure Attachment".

Further examination of the correlation matrix showed that three of the scales were not correlated with "angry withdrawal" but were highly correlated with each other. These were "Need for Approval", "Compulsive Caregiving" and "Self Reliance".

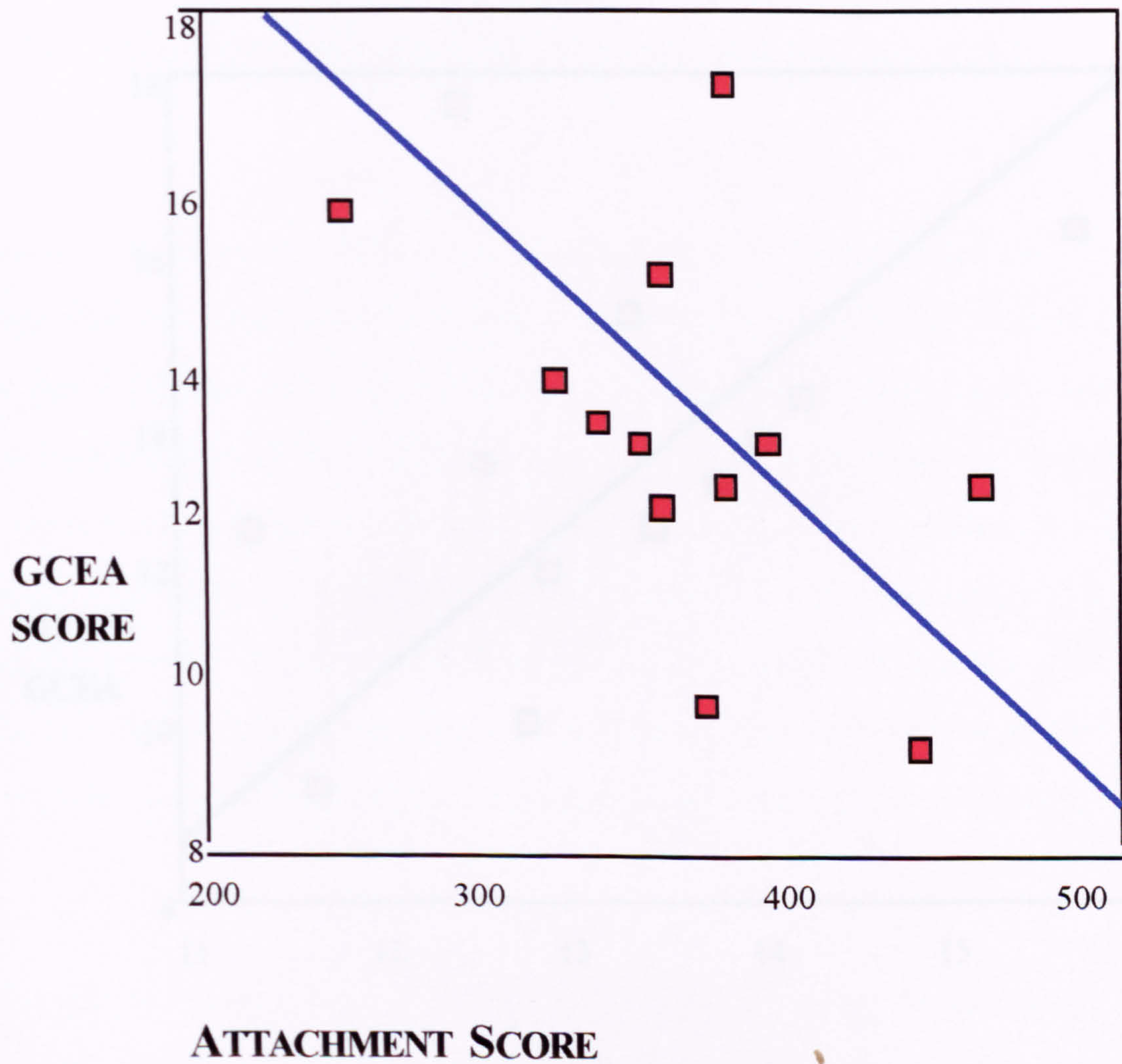
Compulsive Caregiving had a correlation of .79 with Need for Approval and a -.71 with Self Reliance. The correlation between Need for approval and Self Reliance was -.71. These three scores were therefore combined after reversing the score for "Self Reliance" to yield a kind of 'Other Directedness score'. I termed this "Compulsive Caregiving". Individuals who scored high on this measure would perhaps deal with their reluctance to look after themselves and need for approval by looking after others.

We correlated these two scores, Insecure Attachment and Compulsive Caregiving with the three measures of attunement. Table 19 gives the result.

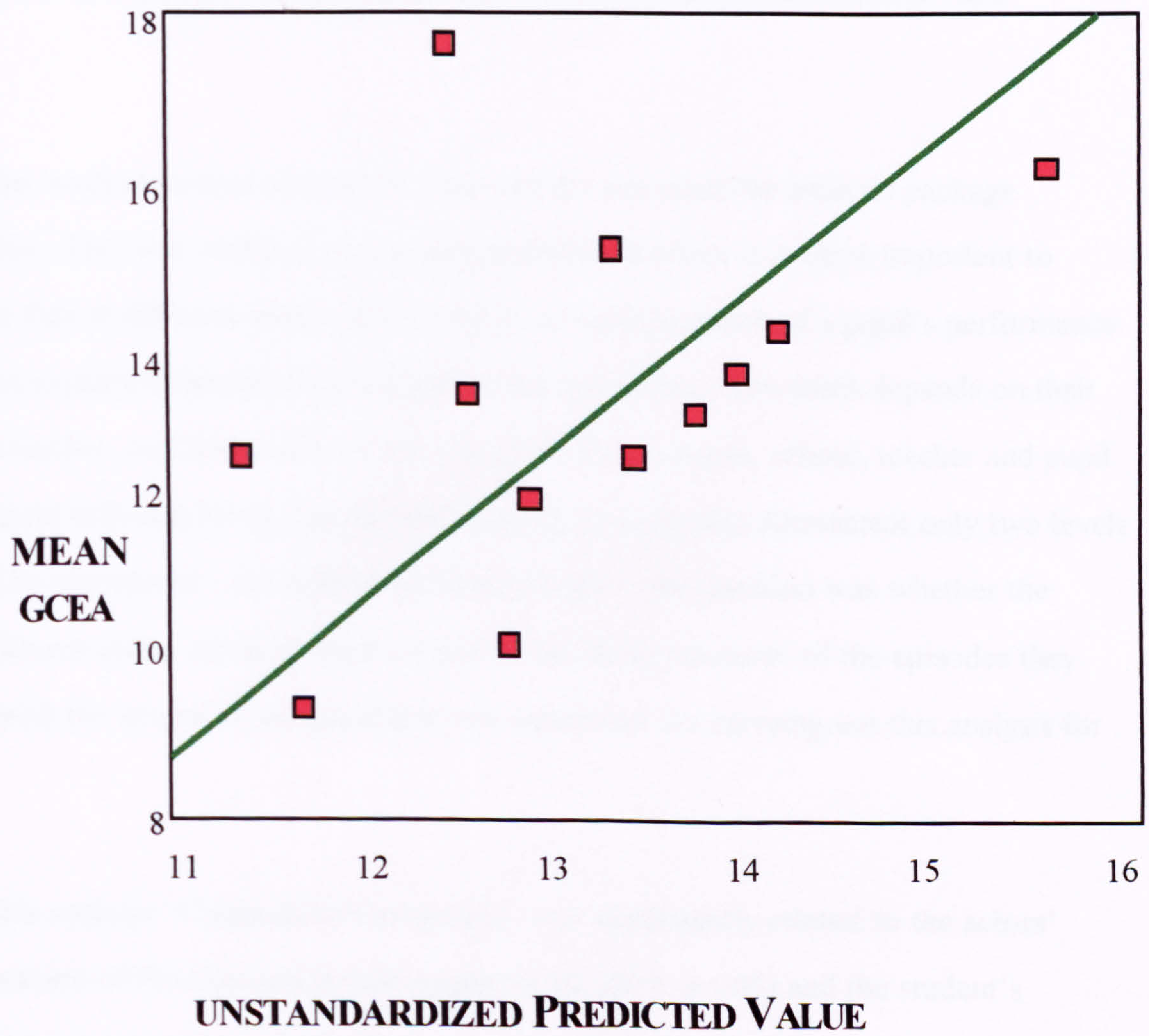
TABLE 19 CORRELATION BETWEEN MEASURES OF COMPULSIVE CAREGIVING AND INSECURE ATTACHMENT WITH THE CARESEEKERS', CAREGIVERS' AND THE INDEPENDENT SCORE FOR EMPATHIC ATTUNEMENT

		INSECURE ATTACHMENT	COMPULSIVE CAREGIVING
Careseeker score	Pearson Correlation	-.001	-.521
	Sig. (2-tailed)	.997	.081
	N	12	12
Caregiver score	Pearson Correlation	-.041	-.603*
	Sig. (2-tailed)	.899	.038
	N	12	12
Independent score	Pearson Correlation	.552	-.265
	Sig. (2-tailed)	.063	.406
	N	12	12

GOAL CORRECTED ATTUNEMENT SCORE BY ATTACHMENT SCORE (MEAN)



MEAN GOAL-CORRECTED ATTUNEMENT SCORE BY PREDICTED GCEA SCORE



UNSTANDARDIZED PREDICTED VALUE

Examination of the correlations and graphs suggested that there was a significant negative correlation between the 'Insecure attachment score and the Independent measure of empathic attunement. p=.063. In other words those students who got a rating of insecure attachment style did worse on the score for goal-corrected empathic attunement. As the theory predicted this we can half the correlation achieved, thus bringing the correlation to around .03. There was a significant correlation between the score for 'Compulsive Caregiving and the Actors' (careseekers) score, p=.038.

Further analysis tended to confirm these results and used the analysis package MIWin. This was written for educational research where it is often important to relate data at different levels - for example, to see how much of a pupil's performance can be explained through their individual characteristics, how much depends on their class teacher, and how much on the school. In this example, school, teacher and pupil represent different levels, but for the research on empathic attunement only two levels need be considered - the student and the episode. The question was whether the attachment status of the student related to the three measures of the episodes they had with the actors. I am grateful to my supervisor for carrying out this analysis for me.

On this analysis "Compulsive Caregiving" was significantly related to the actors' assessment of the interaction (chi-square=4.16, df=1, p<.05) and the student's assessment (chi-square=7.02, df=1, p=<.01). In both cases the direction was the same - the more 'other directed' the student the better the interaction was assessed as being.

The 'Insecure Attachment' score was not related to either of these two scores. It was however related to the independent score (chi-square= 4.23 df=1, p<.05). The higher the disturbed attachment score the worse the interaction was assessed as being.

This analysis is encouraging in the sense that it produces the results expected. From a statistical point of view the results are more dubious. Essentially they comprise an analysis based on 12 individuals. This is a small number on which to carry out the kind of analysis done here. the correlations assume a normal distribution - non parametric correlations on the same data are not significant. Multi-level analysis of the kind done here also usually involve a much greater number of individuals. The results must therefore be seen as interesting and encouraging rather than definitive.

Results of training: experimental group

I will now turn to see whether the training programme that I devised for the experimental group students made a difference to how they performed on day two.

Table 20 below gives the averages for day one and day two for those students who received training

TABLE 20 THE AVERAGE SCORE ACHIEVED BY THE TRAINED STUDENTS ON BOTH DAYS AS GIVEN BY THEMSELVES, THE ACTORS AND THE INDEPENDENT RATER

		Actors' Score	Students' Score	Independent Score
Day 1	Mean	18.7917	20.6667	14.2790
	N	24	24	24
	Std. Deviation	4.5010	4.2902	3.5378
Day 2	Mean	15.2917	18.9583	12.1181
	N	24	24	24
	Std. Deviation	5.7971	6.0755	3.9896
Total	Mean	17.0417	19.8125	13.1986
	N	48	48	48
	Std. Deviation	5.4302	5.2740	3.8867

N= number of interviews each day. Total refers to the number of interviews over both days.

As one can see from table 20, the actors the students and the objective rater agreed that there was an improvement in the students performance on day two: the average score from all three sources dropped (i.e. it "improved").

I then set out to examine each of the three scores in detail - the students' score, the actors' score and the independent score. Table 21 sets out the results of an analysis of variance based on the students' score for those students who had been trained.

TABLE 21 STUDENT, TIME AND STUDENT SCORE
AN ANALYSIS OF VARIANCE

Source	Sum of Squares	df	Mean Square	F	Signif
Corrected Model	760.062	11	69.097	4.545	.000
Intercept	18841.687	1	18841.687	1239.471	.000
STUDENT	437.428	5	87.488	5.755	.001
TIME	35.021	1	35.021	2.304	.138
STUDENT-TIME	287.604	5	57.521	3.784	.007
Error	547.250	36	15.201		
Total	20149.000	48			
Corrected Total	1307.312	47			

Table 21 shows that there was a significant difference between students in how they scored themselves (.001); that time along with training did not make a significant difference to how they scored themselves (.138). However there was a significant 'interaction effect' between time and student: some students improved significantly more (according to themselves) than others (.007).

I then looked at the actors score and did a similar analysis. Table 22 sets out the results.

TABLE 22 STUDENT, TIME AND ACTOR SCORE:
AN ANALYSIS OF VARIANCE

Source	Sum of Squares	df	Mean Square	F	Signif
Corrected Model	668.417	11	60.765	3.049	.006
Intercept	13941.083	1	13940.083	699.433	.000
STUDENT	388.167	5	77.633	3.895	.006
TIME	147.000	1	147.000	7.376	.010
STUDENT-TIME	133.250	5	26.650	1.337	.271
Error	717.500	36	19.931		
Total	15326.000	48			
Corrected Total	1385.917	47			

One can see that the actors saw a significant difference between the students (.006). They also saw them doing better after training on day two (.010). However their ratings did not suggest that some students had improved significantly more than others.

I will present the results of the Independent score - see table 23

TABLE 23 STUDENT, TIME AND INDEPENDENT SCORE: AN ANALYSIS OF VARIANCE

Source	Sum of Squares	df	Mean Square	F	Signif
Corrected Model	154.573	11	14.052	.911	.540
Intercept	8361.725	1	8361.725	541.968	.000
STUDENT	82.035	5	16.407	1.063	.397
TIME	56.035	1	56.035	3.632	.065
STUDENT-TIME	16.503	5	3.301	.214	.954
Error	555.424	36	15.428		
Total	9071.722	48			
Corrected Total	709.997	47			

As one can see, the model used for this analysis did not provide a robust base from which to draw conclusions (.540).

To test whether the differences being seen for the trained group are not just the effect of getting used to the scenarios and the actors I did the same analysis for the untrained group.

Results of training: control group

Table 24 presents the average score

TABLE 24 THE AVERAGE SCORE ACHIEVED BY THE UNTRAINED STUDENTS ON BOTH DAYS AS GIVEN BY THEMSELVES, THE ACTORS AND THE INDEPENDENT RATER

		ACTOR Score	STUDENT Score	INDEPENDENT Score
Day 1	Mean	17.1250	19.5000	13.1133
	N	24	24	24
	Std. Deviation	5.1017	4.7913	5.0181
Day 2	Mean	13.9167	18.2083	13.1475
	N	24	24	24
	Std. Deviation	6.0427	5.7557	3.3359
Total	Mean	15.5208	18.8542	13.1304
	N	48	48	48
	Std. Deviation	5.7649	5.2794	4.2153

N= number of interviews each day. Total refers to the number of interviews over both days.

One can see that from the students and the actors point of view the students got better by day two. The averages went down from 17.13 to 14 and from 19.5 to 18.2 respectively. Not so with the independent score. With that score the students did slightly worse on day two; the average went up just a fraction, from 13.11 to 13.15.

Table 25 sets out the analysis of variance based on the students' score

TABLE 25 STUDENT, TIME AND STUDENT SCORE: AN ANALYSIS OF VARIANCE

Source	Sum of Squares	df	Mean Square	F	Signif
Corrected Model	508.729	11	46.248	2.078	.049
Intercept	17063.021	1	17063.021	766.638	.000
STUDENT	421.854	5	84.371	3.791	.007
TIME	20.021	1	20.021	.900	.349
STUDENT-TIME	66.854	5	13.371	.601	.700
Error	801.250	36	22.257		
Total	18373.000	48			
Corrected Total	1309.979	47			

One can see that there is a significant difference between the students in how they rate themselves (007), on average they do not see themselves as doing significantly better on day two, nor, in contrast to the situation in the trained group do some students see themselves as improving significantly more than others.

Table 26 sets out the analysis of variance based on the actors' score

TABLE 26 STUDENT, TIME AND ACTOR SCORE: AN ANALYSIS OF VARIANCE

Source	Type 111 Sum of Squares	df	Mean Square	F	Signif
Corrected Model	457.729a	11	41.612	1.357	.235
Intercept	11563.021	1	11563.021	376.970	.000
STUDENT	254.854	5	50.971	1.662	.169
TIME	123.521	1	123.521	4.027	.052
STUDENT-TIME	79.354	5	15.871	.517	.761
Error	1104.250	36	30.674		
Total	13125.000	48			
Corrected Total	1561.979	47			

The model used provided a significance level of .235 indicating that it was not robust enough to provide a sound basis for conclusions.

Improvement score

I next turned to the group as a whole

Tables 27 and 28 sets out the average scores given by the independent rater at time 1 and time 2 to each of the twelve students.

TABLE 27 STUDENTS' AVERAGE SCORE AT TIME 1
INDEPENDENT RATER

Student	Mean	N	Std. deviation
1	14.395	4	2.65
2	13.85	4	3.40
3	13.45	4	2.41
4	13.43	4	6.34
5	16.22	4	4.26
6	14.31	4	2.43
7	8.41	4	4.02
8	15.70	4	5.07
9	12.93	4	5.04
10	9.78	4	3.42
11	16.92	4	4.01
12	14.92	4	4.55
Total	13.6	48	4.33

Independent score at time 2

TABLE 28 CAREGIVERS' (STUDENTS') AVERAGE SCORE AT TIME 2
INDEPENDENT RATER

Student	Mean	N	Std. deviation
1	10.22	4	.97
2	12.22	4	4.32
3	11.51	4	2.03
4	11.38	4	4,54
5	15.90	4	4.92
6	11.46	4	5,26
7	10.29	4	2.44
8	14.35	4	2.07
9	13.70	4	2,78
10	10.26	4	1.18
11	17.45	4	.92
12	12.81	4	3.98
Total	12.63	48	3.67

To see the improvement at time two I subtracted the scores for time 2 from time one and subjected the results to the Mann Whitney Test. Table 29 sets out the improvement score. The first six students are the ones who received training.

TABLE 29 IMPROVEMENT SCORE
FOR EXPERIMENTAL AND CONTROL GROUPS
BASED ON THE INDEPENDENT SCORE

	STUDENT	IMPROVEMENT
Trained Group	1	4.18
	2	1.63
	3	1.94
	4	2.06
	5	.32
	6	2.84
Untrained Group	7	-1.87
	8	1.35
	9	-.77
	10	-.49
	11	-.53
	12	2.11
	TOTAL	12

From this table one can see that the students who had been trained all improved on average more than the students who had not. The different was subjected to a Mann-Whitney U test giving the following result:

Mann-Whitney U = 5, p=.037 (two tailed).

Table 30 sets out the improvement score by actor and student

TABLE 30 IMPROVEMENT SCORE

CARESEEKER (ACTOR) AND CAREGIVER (STUDENT)

STUDENT (CAREGIVER)	CAREGIVER IMPROVEMENT SCORE	CARESEEKER IMPROVEMENT SCORE
1	-4.00	1.25
2	6.75	6.00
3	6.50	6.75
4	1.5	7.00
5	-5.50	2.00
6	5.00	-2.00
7	.00	4.00
8	4.00	5.00
9	2.50	2.75
10	2.75	4.50
11	-3.25	-2.25
12	1.75	5.25
TOTAL	12	12

I subjected the results of the actors' score and the students' score to the same procedure and got no significant result.

TABLE 31 STUDENT, TIME AND INDEPENDENT SCORE: AN ANALYSIS OF VARIANCE

Source	Sum of Squares	df	Mean Square	F	Significance
Corrected Model	378.571	11	34.416	2.714	.012
Intercept	8275.550	1	8275.550	652.523	.000
STUDENT	356.758	5	71.352	5.626	.001
TIME	1.404E-02	1	1.404E-02	.001	.974
STUDENT-TIME	21.799	5	4.360	.344	.883
Error	456.566	36	12.682		
Total	9110.687	48			
Corrected Total	835.137	47			

One can see that the independent measure differentiated significantly between students (.001); did not see an effect for time (.974) and did not see some students doing significantly better on day two than others (.883)

Discussion of results

I have three sets of results.

1. Measures of interaction between careseekers and caregivers.
2. Relationship between measures and attachment score.
3. Evidence that training can improve goal-corrected empathic attunement.

In short I have developed three measures of careseeker-caregiver interaction that are internally consistent and reliable. I have also set out the basis of a training programme

for improving caregiver performance. I have developed a unique way of testing student performance based on short role-play scenarios using video and professional actors. Finally I have used the experiment to develop a theory of effective caregiving within the conceptual framework of attachment theory. I will discuss these results in order.

Measures

I have three measures of interaction: two subjective and one objective.

A Subjective measures

The subjective measures have an internal consistency of .87 (caregivers) and .86 (careseekers). This is an impressive result, one that I hoped for, but much better than I expected. I had constructed a model of effective caregiving that I thought consisted of particular behaviours attributes and responses. I devised these measures with these attributes in mind. This result suggests that the caregiving properties that I suggested should go together - do go together.

In addition, the two measures correlate in a highly significant way ($p= <.001$) with each other suggesting that both parties to the interaction evaluate it or experience it in similar ways. It also looks from this study as if I have found a way, through the use of these measures, of differentiating between caregivers (students). There was a highly significant difference between students based on their own score (.000) and on the actors score (.001). This means that these measures actually get at which students are "better" than others in their own and others terms.

These measures therefore yield two sets of information both of which could be useful in selection, training and ongoing development of practitioner performance. Given these results, I consider that it would be worth the time and effort to replicate these

measures in other contexts using a larger sample of subjects and locating the study in the real world of practice.

B Independent Measure

In addition to the very high correlation between the careseekers and the caregivers, there was a significant correlation between the careseekers' score and the independent score of .246, (p=.016) and a significant correlation between the caregivers' score and the independent score of .295, (p=.004). This suggests that the independent rater was measuring something akin to that of the caregiver and the careseeker. Like the latter measures it distinguished significantly between students.

The process that the independent rater was assessing was in fact a more complex process than was being assessed by the actors and the students. While the careseekers and the caregivers were each rating their experience of the interaction between them, the independent rater was rating the process of interaction as it went on between them. The process of interaction or the pattern of interaction is quite different to interaction as experienced. Patterns of interaction develop in relation to careseeking and caregiving and go back to the earliest experiences of relationship for all of us as described in chapter 3 - they go back to our pre-verbal selves. The behavioural pattern of responses triggered by defensive caregiving or defensive careseeking will not necessarily be available to consciousness and accessible for the purposes of evaluating the session as required by the measuring instruments used by the careseekers and the caregivers (which are self report measures).

The fact that there is a significant correlation between these three measures suggests to me that the experience of interaction and the process of interaction may be related. It suggests to me that I should continue investigating the dynamics of careseeking and caregiving along the lines suggested in this thesis and that I should continue refining the measures that I have developed.

Attachment style and independent measure of goal-corrected empathic attunement

There was a significant correlation between secure attachment *style and the* independent measure.

I had hoped to find such an association. Caregivers with a secure attachment style got a significantly better independent score for effective caregiving than those who had a less secure attachment style. They did so in relation to working with four different emotions - anger, sadness, fear and despair. The reader will remember that a study by Haft and Slade (1989) in the parent- infant domain suggested that parents with a more secure attachment style attuned effectively to a range of emotions, while those who were less secure did less well with some emotions.

Despite the statistical caveat the fact that I have found one provides support for the theoretical concept of goal-corrected empathic attunement. The theory of goal-corrected empathic attunement (GCEA) suggested that the instinctively based careseeking system will shut down (goal-corrected) when careseeking has been assuaged by the caregiver. I suggested that affect attunement and empathy were necessary components of effective caregiving and that without them careseeking will remain active in whatever form. When careseeking is assuaged, the natural and ever present exploratory system goes into action and remains active until it is once again over-ridden by the careseeking system. I suggested that effective caregiving in the adult to adult context was associated with secure attachment.

The failure of the actors' and students' score to correlate with the measure of secure attachment is disappointing. The fact that they did correlate with my measure of 'compulsive caregiving' is puzzling. Possible reasons are that these students can be

experienced as other directed and effective in the short term but may need help to sustain empathy over the long haul.

Training

I have some evidence to suggest that even a short training programme designed to modify and improve responses to emotional reactions to loss made a difference to students' performance. The difference related to the objective rating of performance not those made by the student and actor. It was not accounted by the raters knowledge of who was trained and who was not since the ratings were 'blind".

The training programme was based on self reflection and audio-visual feedback of own work, a force field analysis of driving and restraining forces in relation to self-selected behaviour targeted for change with very specific input from a facilitator who has also watched at length the video feedback of the previous session. It is very encouraging to find evidence that this makes a difference in the way the student subsequently responded to the presentation of acute emotional distress. In terms of the future, if I were to build on this research I would focus even more strongly on the concept of goal-corrected empathic attunement and the affective process of goal-correction. This had not clarified in my mind as I put this training programme in place, I would welcome the opportunity and the challenge of exploring how to build this into the design of such a training programme in future.

Given that the intervention was short and part of a controlled experiment it is worth building on these results, developing the training programme and testing it in the real world of practice.

A first step in improving the training programme apart from making it longer and more intensive would be to include, as part of the video feedback work, sessions where I worked with the students or trainees to identify the interaction which suggested that

there was distress in the careseeking-caregiving partnership. I would envisage being able to get clearer (from further analysis of the videos I have already got from this research) about the behaviours in each that signalled such distress. Finally I would hope to be able to work out with the trainee what was going on in the interaction which disabled them and got them 'locked in' to a dissatisfying careseeking-caregiving pattern and develop some strategy with them for noticing when this happens and devising ways to get round it in order to open up the flow of communication again or to seek help in regaining their empathic capacity from a competent supervisor.

Conclusion

As far as I know no one has previously developed any measure or measures of social work student performance in a test situation which

(a) distinguishes between students
(b) correlates with a personality measure in a sensible way
(c) can be improved by training.

For all the limitations and caveats I feel I have done this. The next challenge is to see whether these measures can be applied in the 'real" world of practice.

In my final chapter I summarise the work of the thesis and draw conclusions for future work.

CHAPTER ELEVEN

CONCLUSION

Introduction

In this final chapter I will summarise the points made in the thesis and make suggestions for future work. In doing this I will distinguish between the actual development of the concept of goal-corrected empathic attunement and the empirical research I carried out. In practice each influenced the other so that separation is form a historical point of view misleading., Nevertheless it is easier to explain my current position in this way.

Theoretical development

I started off in the introduction with an account of failed careseeking leading to despair and inaction. It had serious consequences. It drew attention to the implications of indirect or complicated patterns of careseeking. The suggestion was that if people cannot express directly what is of utmost concern to them to someone they perceive as being able to help them, then the person who is in role of 'helper' needs to be alert to the indicators that accompany failed careseeking if they are to provide an effective response. It is this idea which is at the centre of my thesis.

A related idea was that people bring with them their feelings in relation to their experience of previous careseeking and the behaviours they have developed to cope with these feelings, into the relationship with potential caregivers. This idea also struck me as having implications for *all* who work in the 'caring professions', whether they be social workers, care staff, medical staff, physiotherapists, psychotherapists, whoever. It seemed to me to be important to examine the processes involved in

effective caregiving and to trace the development of careseeking-caregiving patterns from their roots in infancy.

I proceeded in chapter one to introduce the importance of affect attunement between careseekers and caregivers by suggesting that what I had observed as a trainer over many years was that careseekers monitored the reaction of caregivers when they introduced into the conversation an area of some importance to them and that caregivers often deflected caregivers from the emotion accompanying their concern by distracting them with unrelated questions. In so doing they both bypassed information available to them from the careseeker and deflected the careseeker from information that was potentially available to them.

In addition I noticed that what the careseeker seemed to do when they got this response from the caregiver was to inhibit their own exploration, change the direction of their flow and follow the lead given by the caregiver.

On reflection, this behaviour suggested to me that attachment processes were at work here. By following the lead of the caregiver, the careseeker was not increasing the distance between them and the caregiver, they therefore kept the caregiver within reach as it were. However I suggested that by experience of following the caregivers lead and giving up on their own agenda could induce the affective experience of anger depression and or despair.   A withdrawal by the caregiver from the careseekers affect could elicit (a) a pattern of behavioural response in the careseeker that had the characteristics of attachment behaviour and (b) an affective experience that was embedded within the behavioural response.

In this way I drew attention to the fact that failures in caregiving could induce in the careseeker a desire to retain the inadequate caregiver in proximity or to abandon them altogether. I saw a link between these observations and the attachment concepts of 'set-goal', 'retrieval' and 'proximity'. The concept of 'set-goal' is based on an

understanding of instinctive systems which are activated under certain circumstances and cease to be active when certain other conditions are met, at which point that particular system within the organism as a whole remains in a state of quiescence until activated again. Within attachment theory, it is postulated that once the instinctively based careseeking system has been activated it will remain so until it reaches its set-goal, i.e. effective caregiving.

In seeking to understand these processes I drew first on the understanding of Ainsworth, Bowlby and Heard. These authors suggest an interdependent relationship between the three instinctive goal-corrected systems of careseeking, caregiving and exploration. To the extent that careseeking remains unassuaged, the exploratory system of the careseeker is inhibited. Further work by Heard and Lake based on their observations of adults in the clinical context of adult psychotherapy suggested to them that there were other instinctive systems involved in attachment dynamics - those of sexuality (intra-individual and interpersonal) , interest-sharing with peers and self defence. In their view, human beings drew on all these systems to retain a homeostatic equilibrium and maintain as good an experience of well being, engagement with the world and sense of competence as possible.

The implications of this theory is that the consequences of inadequate caregiving are enormous and that careseekers who have a history of inadequate caregiving will present their careseeking needs in ways that are difficult to identify and respond to. Careseekers who continually fail to reach the goal of careseeking experience feelings associated with this phenomenon, anger, depression and despair and develop adaptive strategies to cope with these feelings; avoidance of careseeking; ambivalence towards careseeking and disorganisation in relation to careseeking. The consequences for interpersonal relationships have been well described (see for example the study by Mattinson and Sinclair (1979), as are the consequences for work and relationships in the workplace. It is obvious, and therefore hardly needs to be said, that the effect of inadequate caregiving on a person's life is mitigated by social, cultural and

environmental factors, such as education, money, health, other people, support networks and cultural norms and expectations. But while for some the effect of ineffective caregiving might well be mitigated, for many others no such mitigating factors are available.

In working out these ideas I thought it right to look at other psychotherapy research over the past fifty years. This research has highlighted:

a) the importance of process (Chicago School);
b) the relationship between process and perceptions of and attitude to self (Chicago School);
c) the importance of quality of interaction between therapist and client - affect matching, intensity, depth of empathic input (Carkhuff and Berenson);
d) the need to relate the work of psychotherapy to

    i) measures of process (McLeod)

    ii) early patterns of relating to people (Modern School - e. g. Anstadt, Bucci. Oster, Luborsky)

What the this research did not take account of was recent research into interactions between infants and parents.

In seeking the sources of an appropriate developmental theory I was particularly struck by the work of Fairbairn with his emphasis on the way infants are programmed to respond to persons. This was reinforced for me by observational studies such as those of Murray and Trevarthen, and also by brain research. The latter highlights the importance of affect regulation for emotional and cognitive development in infants and shows that this is dependent on interaction. Infants cannot do this for themselves. The management of vitality affects is dependent on an attuned and sensitive caregiver.

More specifically I linked the ideas to the work of Daniel Stern on the stages of development that infants progress from non-verbal to verbal - he locates the affective core in the preverbal infant as the emergent self - the self that is interacting with caregivers. Other research from the developmental psychologists confirmed the way that infants were communicating non-verbally - their understanding of the meaning of affect and their communication of their own affective states.

Attunement to affect is not empathy. Attunement precedes empathy developmentally. Infants are born capable of attuning to the affect of their caregivers, expressed in many ways including the rhythm of their voice ((Trevarthen et al., 1998). It is my understanding that attunement to affect transmits information that is necessary for immediate survival. The studies by Meltzhoff, Trevarthen and others suggest that babies are tuned in to the very breath of their caregivers so that babies literally anticipate the next beat of their mother's voice (see Trevarthen 1999). In contrast empathy is a metacognitive capacity. It requires the ability to see things from another's point of view, understand their emotions, resonate with these emotions and convey in words one's appreciation of the others person's state in a way that is recognisable to them that you have understood them.

The transpositions I made from the world of infancy to the adult world were: (i) to think in terms of the therapist as the caregiver in the adult to adult context; (ii) to think of the client as careseeker especially when attachment issues are aroused (as they are when careseeking is active); (iii) to think of exploration within the therapeutic context being overridden while careseeking is active; (iv) to think of both careseeker and caregiver resorting to self defensive strategies when careseeking and caregiving are unsuccessful; (v) to think that insecure caregivers will interact with careseekers in similar ways to the behaviour of the caregiver in the insecure dyads described by the Grossmanns (1991) and will thereby instigate defensive behaviours in the client, which will be accompanied by levels of emotional distress.

I then looked at the way these states were attuned to or not by caregivers and the infants' sense of enjoyment or distress that ensued from different types of caregiving. It became clear from the studies such as those of the Grossmanns that attunement to affect alone is not enough - the play sequences that they describe between secure and insecure interacting dyads show that non empathic responses from the caregiver triggers distress as does misattunement to the affective state.

I then linked this work on attunement to affect with research by Ainsworth et al (1978) on attachment and noted that sensitive attunement to infants' signals was associated with a secure attachment pattern between infant and caregiver.

I then put together the following ideas: (i) attachment status correlates with sensitive attuned caregiving (Ainsworth 1978); (ii) the exploratory system can be overridden by careseeking (Ainsworth 1978, Heard 1978); (iii) in insecure careseeker-caregiver dyads, caregivers interfere with the child's play in such a way as to inhibit exploration (Tronick, 1989; Grossmanns 1991). . We know from attachment theory that the goal-corrected instinctive system for careseeking remains active until assuaged. It seemed a small step to create the idea that empathy was the crucial ingredient in assuaging careseeking. It seemed to me that attunement and empathy were preconditions for effective caregiving.

Finally the last extrapolation I made was based on the fact that when instinctive goal-corrected systems reach their goal the instinctual system for careseeking becomes quiescent and the person experiences relief.

Empirical research and next steps

As I mentioned in the introduction to this thesis all the elements of this theory were not in place when I set out to do my research. The experiments I conducted were not set up to test the theory of goal-corrected empathic attunement. However I was aware of the research by Ainsworth et al (1978) and Haft and Slade (1989) that linked

attunement to affect with attachment status in the infant and adult domain. My first experiment therefore was to see whether attunement to affect could be identified in the context of one to one psychotherapy with adults.

My first experiment suggested this was possible to some extent. A panel of 9 experts were almost unanimous in identifying one video excerpt of therapy as "attuned" and another extract as "non attuned". They were not agreed on the status of four others, possibly because what was being shown in these extracts was a process of "tuning in". I selected the two excerpts on which there was a very high degree of agreement and presented them to students to see whether they could also identify which was which.

To my surprise students were unable to discriminate attunement from non attunement. This finding really surprised me. Because the experts were so clear as to what constituted attunement and non attunement I almost stopped my experiments at this point, I thought the whole thing was obvious. It was the students inability to discriminate attunement from non attunement that woke me up as it were to what was going on in the interaction that they were failing to see. What I found when I examined the experts response was that when making their judgements they paid attention to the interaction between therapist and client and took the responses (the feedback client and therapist were giving each other) into account. In particular they took account of what each said to the other implying that cognitive appreciation of the other's situation was an essential element in their account of attunement. What this signified to me was that they were not just looking at attunement to affect but were also tracking empathic response.

Another aspect that the experts seemed to pay attention to was whether or not the client was enabled to explore their concerns. They were also looking at the client to see whether the response of the therapist had stopped them in some way that was causing them distress. Enabling exploration therefore seemed to be a key element in

their concept of attunement. The experiment seemed to confirm that paying attention to interaction was a key ingredient in identifying affect attunement and also that affect attunement on its own was insufficient to promote exploration: empathy was also essential.

I then conducted my second experiment. This was constructed to see whether students capacity to correctly identify empathic attunement would improve if they were given instructions to pay attention to the interaction between therapist and client. I divided the student group into two groups; a control group and an experimental group. The experimental group were given instructions to pay attention to the interaction between therapist and client. The results indicated that the group who were given instructions to pay attention to the interaction did better at identifying empathic attunement that those who were not given instructions. The experiment supported the hypothesis that empathic attunement referred to an interactive process based on feedback.

However, qualitative analysis based on debriefing sessions with the students to discuss what they had taken into account when making their rating, revealed that it was not as simple as that. All the students were paying attention to the interaction but were clearly evaluating it differently from each other. The statistical analysis suggested that the students who were given guidance on how to judge the interaction made more accurate ratings. However in the light of qualitative material other processes, were also at work. Students were affected by what they were observing and were evaluating the same behaviour in very different ways - where one person saw respect for privacy, the other saw abandonment; where one saw intrusion, the other saw support for exploration.

The nature of the students' responses centring as they did on views about appropriate responses to distress indicated to me that the observers own attachment dynamics might have been getting involved and influencing their judgement of the interaction. I

wondered whether students who had a more avoidant style themselves in relation to attachment figures were more tuned in to perceiving a therapist as intrusive, irrespective of the information available in the context as a whole (i.e. the feedback that was there for them to observe from the clients' response). In terms of my project, the experiment confirmed for me that paying attention to interaction and feedback were crucial in judging empathic attunement.

This raised for me the question of whether careseekers and caregivers shared a similar evaluation of their experience of caregiving and whether attunement to feeling and empathy were associated with feeling understood. I constructed self report measures for caregivers and careseekers. I also set out to see whether students who were given training directed at encouraging them to attune to client affect and respond empathically would subsequently do better than those students who were not given this training. Finally I set out to see whether the attachment status of the students affected their ability to attune to client affect and to explore the impact of training on this ability.

In order to test for the impact of training I needed independent reliable ratings of the interaction. Through the process of obtaining a reliable rating I realised that the process could not be judged by observing interactive sequences alone - it had to be judged by monitoring a process that went into action when certain responses were triggered in either the careseeker or the caregiver - the interaction then took on a character of either assuagement and exploration or continued and deepening distress - the affective expression of which was more or less dramatic. This led to the construction of the concept of goal-corrected empathic attunement as set out in chapter 5.

The main experiment conducted in the research therefore centered on three issues; (i) whether empathic attunement between adults in a careseeking caregiving context could

be reliably rated; (ii) whether effective caregivers had a secure attachment style and (iii) whether caregiving could be influenced by training.

The results were related to these questions, they showed:

1 that it was possible to produce three measures of goal-corrected empathic attunement which were significantly correlated with each other and consistently distinguished between students in a test situation;

2 that one of these measures was significantly correlated with the attachment status of the student as predicted;

3 That the same measure could be improved by training.

One puzzling result was that two of the measures correlated with a measure of "compulsive caregiving". This had not been predicted and further research is needed to see if it is a "statistical blip'. In general however the results were as predicted and highly encouraging.

In my view it is now vital to try and apply the system of rating goal-corrected empathic attunement within the real life setting of social work and adult psychotherapy. The aims would be to find out whether (a) these measures can be validly applied in real settings, and (b) whether those who score "well" on these measures do "better" in other respects, e. g. whether their clients improve more. If this proves to be so the results would be very important. They should lead on to:

(i) the development of training programmes based on an understanding of the role of the affective communication between careseeker and caregiver and the conveyance of an empathic response,

(iii) the exploration of the use and value of selection processes and training based on role-plays with professional actors, for social work, psychotherapy and counselling; and finally

(iv) more experimental work directed towards a deeper exploration of the relationship between affect attunement and empathy and the effect of misattunements, inappropriate tuning and non-attunement on the proper functioning and development of the instinctual goal-corrected systems of careseeking and caregiving.

Conclusion

My hypothesis is that attunement to affect and empathy is a process that regulates arousal levels in the adult careseeker. When it is done effectively it assuages careseeking, in other words it 'settles' the careseeker in some way that they are then able to access their natural exploratory capacities and utilise their intelligence and physical stamina in whatever degree they have these to accomplish what they need and want to do. Achievement of goals is likely to be accompanied by a sense of competence. The study that I have presented here goes just a very small way to establishing that this may be the case, but I am filled with curiosity and interest in exploring this subject further.

I have enjoyed the work for this thesis and look forward to carrying it on in the world of education as well as the world of practice.

> We shall not cease from exploration
> And the end of all our exploring
> Will be to arrive where we started
> And know the place for the first time

T. S. Eliot, 1942, 1963
Little Gidding