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SPECIAL SECTION: Clinical Applications of the Adult Attachment Projective

Use of the Adult Attachment Projective Picture System (AAP) in the Middle of a Long-Term Psychotherapy

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This article relates how the Adult Attachment Projective Picture System (AAP) was used as a midtherapy intervention with a middle-aged man being treated for relationship difficulties. The man, who was identified via the AAP as having a dismissing attachment status, had difficulties committing to psychotherapy, presumably because he was terrified of experiencing the underlying depression and grief revealed on his Rorschach and AAP. Reading an AAP-based description of his attachment status helped the man become aware of his characteristic defenses against painful affect, and gave him the motivation to stay in therapy while experiencing and getting support for his unresolved mourning. This work led to the man's experiencing less ambivalence about intimate relationships. There are several important ways that the AAP augments a traditional personality assessment battery and is useful in conducting a long-term psychotherapy.

Can clinicians use assessment tools in the middle of long-term psychotherapy to help clients deepen their work and progress in their healing? I have long been interested in this question, particularly in reference to the Rorschach and the Minnesota Multiphasic Personality Inventory–2 (MMPI–2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; Finn, 1994, 1996b, 2007b). In this article, I present a case in which I employed a relatively new test, the Adult Attachment Projective Picture System (AAP; George & West, 2001, 2011/this issue), to impact a psychotherapy that was in serious difficulty.

My Background with the AAP

I first became aware of the AAP in 2003 through a presentation given by Carol George, one of the test's developers, at the annual meeting of the Society for Personality Assessment. I had been reading about attachment theory for years, and had considered pursuing training in the administration and interpretation of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984/1985/1996), but I never did because of the time required to administer, transcribe, and code an AAI. I could not see a way that such a time-consuming procedure would ever be viable in my clinical practice. I was immediately struck by the potential clinical utility of the AAP, and I invited Dr. George to Austin to give a presentation to my colleagues at the Center for Therapeutic Assessment. Shortly after that, a group of us decided to pursue formal training in the AAP, and Dr. George began coming monthly to Austin to work with us. This was an extremely rich training experience, and later I write more about its impact on my clinical work.

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Although I eventually decided not to pursue certification as a reliable coder of the AAP (I pay others to code the protocols that I administer), I frequently use the AAP in my practice of Therapeutic Assessment and have also used it with clients in psychotherapy. The case I present here concerns the impact of the AAP on a long-term psychotherapy client, and I chose it because it illustrates the potential therapeutic utility of the AAP. At the end of this article I make more comments about the general utility of the AAP in clinical practice.

Case Presentation

"Mike" was an attractive man in his late 40s who I met 4 years before the events I describe, when he and his wife, Sally, were referred to our clinic by friends for a couples' assessment. I was unable to do the assessment myself, so I referred the couple to two colleagues, while agreeing to consult. Sally complained that Mike was condescending and did not really care about her; he saw her as unreliable, childlike, and incredibly selfish. Shortly after that assessment, Mike and Sally separated, with plans to divorce. Mike then called and asked if I would see him for individual therapy, and I agreed. I had been working with Mike in individual therapy for about 2 years before I had the idea of asking him to do the AAP with me.

Early Therapy Sessions

As you might imagine, the early part of Mike's therapy concerned his separation from Sally and the prospect of their divorce. At the time, they had been married for 12 years and had three small children to whom Mike was devoted. He anguished over the thought of hurting his children, and we spent many hours discussing whether it was better for him to stay with Sally—in a marriage that he found increasingly toxic—until his children were older, or whether he should leave then. I was struck by how intense his guilt feelings were and by how overly responsible he felt for Sally and his children.

I commented on this and learned that Mike had been in a caretaker role in various relationships since he was a child. His father was sickly and his mother quite depressed, needy, and egocentric. Mike had taken care of his younger siblings, done most of the chores around the house, and been a star athlete and pupil to boot. The only things that seemed to get him attention and approval from his parents were his academic and athletic achievements, and Mike soared to the top of his chosen sport, earning national titles and at one point almost making it onto the U.S. Olympic team. Although his many activities kept him busy, Mike also remembered many lonely times as a child. He told of one poignant episode when he was 8, had nothing to do, and felt tremendously alone and sad. He went outside and started raking leaves until he felt better. During this period of psychotherapy, Mike came weekly to our sessions, cried a few times, and seemed to become less anxious and guilty.

As we talked about his history as a caretaker, Mike eventually became clear that he wanted to end his marriage, and he and Sally finalized their divorce about 6 months after I started seeing him, a year into their separation. I think Mike's decision was aided by the fact that he was starting to get a lot of attention from women he met, for he was an exceptionally attractive and financially successful man. He began dating, still saw his kids almost every day, and succeeded in setting better limits with his parents, who continually asked for his help and attention. It was at this point that Mike's therapy took an unusual course that lasted for over a year.

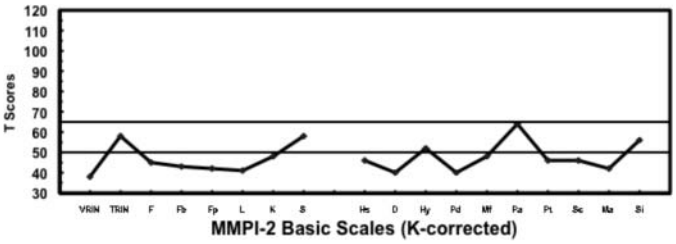

FIGURE 1.—The MMPI–2 profile from Mike's pretherapy assessment. *Note.* VRIN = Variable Response Inconsistency scale; TRIN = True-Response Inconsistency scale; F = Infrequency; Fb = Back F; Fp = Infrequency Psychopathology; L = Lie; K = Defensiveness; S = Superlative Self-Presentation; Hs = Scale 1, Hypochondriasis; D = Scale 2, Depression; Hy = Scale 3, Hysteria; Pd = Scale 4, Psychopathic Deviate; Mf = Scale 5, Masculinity-Femininity; Pa = Scale 6, Paranoia; Pt = Scale 7, Psychasthenia; Sc = Scale 8, Schizophrenia; Ma = Scale 9, Hypomania; Si = Scale 0, Social Introversion. Excerpted from the *MMPI®–2 (Minnesota Multiphasic Personality Inventory®–2) Manual for Administration, Scoring, and Interpretation, Revised Edition.*

Second Phase of Therapy

It took some months for me to recognize the pattern that characterized the second phase of Mike's treatment. He would come weekly for a series of 6 to 10 sessions, then disappear for a month or more. Eventually, Mike would call and ask to come back to discuss some crisis, usually concerning Sally or one of the women he was dating. Sometimes, Mike would tell me that he was taking a break from therapy, and that his life was going extremely well and he had nothing to talk about. Other times, he would call and cancel his scheduled appointment, telling me that he would be out of town for work and would call me when he got back. Sometimes he did, in fact, call; other times he would wait until he felt some urgency.

I was not put off by these comings and goings, but I was curious about them. After the second or third repetition, I began to ask Mike to talk about what he was experiencing when he felt like leaving, something he found quite difficult. The most I could get him to say was that he was used to handling things on his own, preferred that way of doing things, and did not want to waste his or my time if he could manage by himself. Although his pattern of coming and going in therapy continued, he did start to get wise to himself, and would laugh when he would tell me once again that he thought he was "all cured." Also, after several rounds of this cycle—at my suggestion—Mike came a couple weeks longer than he otherwise might have, to see what it was like to be in therapy when he did not have an urgent agenda. I remembered how trapped he had felt as a child by his parents' needs, and I never attempted to constrain him when he wanted to go.

During this period, I also kept in mind various aspects of Mike's test results from when he and Sally did the couples assessment, and this helped me be patient with him. (See Figure 1 for Mike's MMPI–2 and Table 1 for the lower portion of his Structural Summary.) He was one of those clients I have written about elsewhere (Finn, 1996a, 2011b) who had a pretty clean MMPI–2 profile and a much more distressed Rorschach. There was a slight elevation on Scale 6 (Paranoia) of the MMPI–2, which we interpreted at the time of the assessment as due to Mike's feeling persecuted by Sally. Because of the discrepancy between his MMPI–2 and Rorschach, I knew that Mike ran the risk of opening "Pandora's box" and accessing a lot of underlying depression and shame if he really settled into a long-term uncovering psychotherapy. I also remembered that he had an Isolation Index of .25, no cooperative movements (COP), and only 2 Pure H responses in his 32-response Rorschach protocol. Clearly, as he had told me, he was a "solo flier" from way back, who had learned to navigate treacherous territory without others' assistance. It seemed a lot to expect that he would start depending on me.

As this second year of treatment continued, however, Mike began to feel more and more upset with himself. Much of his distress centered on his dating relationships with women. Not unexpectedly, Mike showed the same kinds of conflicts in that arena as he did in his therapy relationship with me. He would meet a new woman, get intensely involved in the relationship, then start to get cold feet after about 4 to 6 weeks. He would notice things about the woman he did not like, worry that he was "settling," then eventually break off the relationship, usually to the woman's great surprise, leaving her angry and hurt. This pattern repeated itself again and again, until Mike realized there was something going on in him that made it impossible for him to commit to anyone. We began talking about what might be happening, and how to learn more about his internal dilemma. I had recently completed the basic AAP training, and I suggested to Mike that we do the AAP to see if it would shed any light on his concerns. He was enthusiastic and also agreed to repeat the MMPI–2 and Rorschach.

TABLE 1.—Lower portion of the Structural Summary for Mike's pretherapy Rorschach.

RATIOS, PERCENTAGES, AND DERIVATIONS									
R	= 32	L	= 1.00			FC:CF+C	= 3:0	COP = 0	AG = 1
						Pure C	= 0	GHR:PHR	= 2:4
EB	= 4:15	EA	= 5.5	EBPer	= N/A	SmC':WSmC	= 0:1.5	a:p	= 5:4
eb	= 5:3	es	= 8	D	= 0	Afr	= 0.75	Food	= 0
		Adj es	= 6	Adj D	= 0	S	= 3	SumT	= 2
						Blends/R	= 4:32	Human Cont	= 6
FM	= 2	SumC'	= 0	SumT	= 2	CP	= 0	PureH	= 2
m	= 3	SumV'	= 1	SumY	= 0			PER	= 0
								Isol Indx	= 0.25
a:p	= 5:4	Sum6	= 7	XA%	= 0.63	Zf	= 14	3r+(2)/R	= .36
Ma:Mp	= 5:1	Lv2	= 0	WDA%	= 0.75	W:D:Da	= 12:14:6	Fr+rF	= 0
2AB+Art+Ay	= 7	WSum6	= 16	X-%	= 0.37	W:M	= 12:4	SumV	= 0
MOR	= 1	M-	= 0	S-	= 0	Zd	= + 7.5	FD	= 0
		Mnone	= 0	P	= 5	PSV	= 0	An+Xy	= 3
				X+%	= 0.52	DQ+	= 5	MOR	= 1
				Xu%	= 0.11	DQv	= 0	H:(H)+Hd+Hd	= 2:4
PTI = 0		DEPI = 5		CDI = 4		S-CON = 3		HVI = No	OBS = No

Midtherapy Assessment

I asked my colleague who had tested Mike 2 years earlier to administer the Rorschach and AAP, and Mike and I came up with the following assessment questions for the testing:

- Why don't I let people get really close to me, and/or myself get really close to them?
- What keeps me from diving into a relationship, or just saying no, instead of dancing around and sending mixed signals?
- Why don't I feel I deserve what I accomplish?

Before turning to the AAP results, let me briefly discuss Mike's MMPI–2 and Rorschach results.

MMPI–2 (See Figure 2). This profile was fairly similar to the one Mike produced in the initial couples assessment. As you can see, there were no indications of significant psychological distress or psychopathology, and I felt the profile accurately depicted the way Mike presented himself to others, as a man who was psychologically healthy and "had it all together." I noted from Mike's scores on Scale 2 and Scale 7 that he rated himself as less depressed and anxious than the average man in the MMPI–2 normative sample.

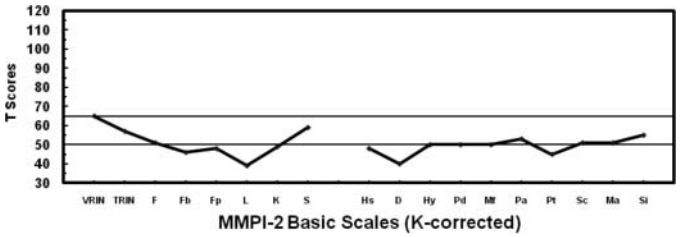

FIGURE 2.—The MMPI–2 profile from Mike's midtherapy assessment. *Note.* VRIN = Variable Response Inconsistency scale; TRIN = True-Response Inconsistency scale; F = Infrequency; Fb = Back F; Fp = Infrequency Psychopathology; L = Lie; K = Defensiveness; S = Superlative Self-Presentation; Hs = Scale 1, Hypochondriasis; D = Scale 2, Depression; Hy = Scale 3, Hysteria; Pd = Scale 4, Psychopathic Deviate; Mf = Scale 5, Masculinity-Femininity; Pa = Scale 6, Paranoia; Pt = Scale 7, Psychasthenia; Sc = Scale 8, Schizophrenia; Ma = Scale 9, Hypomania; Si = Scale 0, Social Introversion. Excerpted from the *MMPI®–2 (Minnesota Multiphasic Personality Inventory®–2) Manual for Administration, Scoring, and Interpretation, Revised Edition.*

Rorschach. Mike's repeat Rorschach Structural Summary was also not that dissimilar from his previous one. As shown in Table 2, the protocol suggested that Mike dampened his emotions (FC:CF+C = 2/0; Lambda = 1.23; SumC'/WSumc = 2/1), and relied on intellectualization (2AB + Art + Ay = 5) and other defenses to protect him from underlying feelings of depression, low self-esteem, and shame (DEPI = 6, Vista = 1, 3r+(2)/R = .32). His Affective Ratio (Afr = .81) suggested that he shut down his feelings because he had a tendency to get caught up in his emotions and to have trouble backing away from them. I was pleased to see that there was somewhat more human content in the protocol [Pure H = 3; H + Hd + (H) + (Hd) = 10]—compared to the previous testing [Pure H = 2; H + Hd + (H) + (Hd) = 6]. Also, the Isolation Index (.03) was now in the normal range—whereas the previous year it had been .28— and Mike had one cooperative movement (COP) score, whereas there had been none in the previous protocol. Last, the GHR to PHR ratio was now in the positive direction, indicating that Mike had a more positive view of human interactions. In fact, the Rorschach suggested that Mike had changed over the 2-year interval I had seen him, was more aware of people now and of their potential to be helpful to him, and was more likely to turn to them for assistance than he had been earlier.

As mentioned earlier, I have written (Finn, 1996a, 2011b) about the pattern of test results reflected in Mike's assessment, where clients show little distress or disturbance on their MMPI–2 profile (without evidence of intentional defensiveness) and significant distress and disturbance on their Rorschach. At our clinic, many of the clients with this pattern are independent, high-functioning people, who are very successful in business; well liked by coworkers, neighbors, and friends; and easy to treat in the initial phases of psychotherapy. But, these individuals are often unsuccessful in intimate relationships, and can become

TABLE 2.—Lower portion of the Structural Summary for Mike's midtherapy Rorschach.

RATIOS, PERCENTAGES, AND DERIVATIONS									
R	= 29	L	= 1.23			FC:CF+C	= 2:0	COP = 1	AG = 2
						Pure C	= 0	GHR:PHR	= 6:5
EB	= 6:1.0	EA	= 7.0	EBPer	= N/A	SmC':WSmC	= 2:1.0	a:p	= 8:2
eb	= 4:4	es	= 8	D	= 0	Afr	= 0.81	Food	= 0
		Adj es	= 8	Adj D	=0	S	= 3	SumT	= 1
						Blends/R	= 2:29	Human Cont	= 10
FM	= 3	SumC'	= 2	SumT	= 1	CP	= 0	PureH	= 3
m	= 1	SumV'	= 1	SumY	= 0			PER	= 0
								Isol Indx	= 0.03
a:p	= 8:2	Sum6	= 4	XA%	= 0.66	Zf	= 10	3r+(2)/R	= .32
Ma:Mp	= 5:1	Lv2	= 0	WDA%	= 0.74	W:D:Da	= 4:19:6	Fr+rF	= 0
2AB+Art+Ay	= 5	WSum6	= 8	X-%	= 0.34	W:M	= 4:6	SumV	= 0
MOR	= 1	M-	= 0	S-	= 0	Zd	= + 7.5	FD	= 0
		Mnone	= 0	P	= 7	PSV	= 0	An+Xy	= 3
				X+%	= 0.52	DQ+	= 7	MOR	= 1
				Xu%	= 0.14	DQv	= 0	H:(H)+Hd+Hd	= 3:7
PTI = 0		DEPI = 6		CDI = 1		S-CON = 2		HVI = No	OBS = No

highly disorganized in the middle of long-term psychotherapy if they start to become emotionally dependent on their therapists. Their good MMPI–2 profiles reflect their good character defenses and coping mechanisms; their disturbed Rorschachs reveal a level of "underlying disturbance" that they keep in check with these defenses. I felt I understood Mike's dilemma of change from his Rorschach and MMPI–2 and could answer his assessment questions. Thus, I was curious about what additional light would be shed by the AAP.

AAP. Dr. George coded and classified Mike's AAP protocol. Figure 3 shows the Coding Summary sheet for Mike's stories. Mike's attachment status was classified as dismissing from the AAP because of his prominent use of the defense of deactivation. All seven of Mike's stories contained Ds markers. However, as can also be seen, all of his stories also showed evidence of cognitive disconnection (coded E in the table).

Here is the transcript of Mike's story to the AAP card labeled Departure, which shows a man and woman standing together with suitcases:

Um, it looks to me like a couple, perhaps traveling together, um with their hands um in their pockets. They're giving me the idea that they're either in an argument or under stress of some kind, um maybe trying to come up with a plan of some kind about what to do next. Maybe they missed their plane or one of their bags didn't get on the plane and they're waiting, trying to figure out what to do next, wondering if they should get a taxi somewhere. I don't sense they're in a fight; generally you would see one of their hands being out showing expression if they were in an argument or something. Both act like they're in some kind of a pickle and trying to figure out what the next move is going to be. (**SF: What might happen next?**) Well, um, something tells me they're going to come up with a plan of action, and eventually pull their hands out of pockets, pick up their bags, and go somewhere but they're not to that point yet of knowing what to do. (**SF: What are they thinking or feeling?**) I don't know . . . sadness maybe is a word for it. It looks like both are unhappy and um sort of resigned to the fact that something has gone wrong or is going wrong or something not so pleasant is happening to them and they're just trying to figure out what next the move is. **(SF: Anything else**?) No.

You can see in this story Mike's tendency to approach relational events intellectually, by trying to "figure out what to do next." The couple is functionally involved in trying to solve the problem they face, but there is little sense of their being connected emotionally. You can also see the uncertainty Mike shows over how to handle emotional scenes.

Here is Mike's story to one of the alone cards, called Bench, which shows a person sitting on a bench with his or her head bowed and knees up.

Um, looks like a young lady sitting on a bench, uh, it looks like she's trying to deal with a problem or is sad and um not sure how to handle it maybe trying to hide her grief that she's feeling from other people that might be nearby so they can't see her crying. Her head down kind of implies she's alone with her thoughts and trying to figure out how to handle her situation. Um, it looks like it must be in public place of some kind, I wouldn't expect to see a bench like that in someone's house, so maybe she's in a park or on a bench on the street somewhere. It looks like she's barefooted but can't really tell about what her clothing is, but it definitely looks like features or body shape of a woman, maybe in mid-teens to mid-20s and she just appears sad and lonely. **(SF: What led up to it?)** Um I sense that she had been walking, having a lot of thoughts in her head, confused, and just couldn't take it anymore and finally just had to sit down and cry it out. (**SF: What might happen next?)** Well I think in a while the grief will pass to some extent and she will put her feet down on the ground, sit there a few minutes, figure out what to do next, and eventually get up and walk away. **(SF: Anything else?)** No.

In this story it is easy for us to see Mike's consternation about how to handle grief and sadness, and his belief that he has to hide such feelings from others. Notice that no one comes to help the character with her feelings; she handles them on her own and eventually just "puts her feet down on the ground" and walks away. For me, the loneliness in this story mirrored the loneliness and isolation in both Mike's childhood and his adult life.

Summary/Discussion session. With previous clients, I had taken the case summary that Dr. George has written and then used it to talk to the clients about their AAP results. This time I wanted to do something different, and at my request Dr. George

TABLE 3.—Excerpts from client Adult Attachment Projective Picture System report written for Mike by Dr. Carol George.

What Your AAP Results Mean: The Dismissing Attachment Adaptation

The Adult Attachment Projective (AAP) assesses an individual's fundamental experience and expectations for him- or herself in caring and protecting relationships. Research has shown that what we expect to happen in such relationships is established first in early childhood through experiences with parents. It's as if such relationships help us construct an internal "map" or "picture" of how caring relationships are likely to go . . .

A good metaphor to use for early attachment is that of a protective "dance." In the early years, child and parent are dance partners on life's stage, a stage that confronts every child with challenges, stress, illness, and danger. The young child's role in the dance partnership is to let the parent know clearly and directly that he or she desires or needs care. The parent's role in the dance partnership is to respond promptly and appropriately, thinking carefully about what the child and situation require in order to help the child manage his or her distress . . .

In many instances, the attachment dance happens easily in a way that appears to be "programmed" by our biology, and an individual is left with what is called a "secure" state of mind regarding attachment . . . In other instances, however, the early attachment dance does not happen easily or smoothly. This produces individuals whose attachment state of mind is what we call "insecure" . . .

Mike, the AAP indicates that your attachment status is what psychologists call "insecure-dismissing." People with this attachment classification generally had early caregivers who were—for various reasons—unresponsive or not well attuned to their children's needs for care and protection. The expectation dismissing individuals developed was, "When I am scared or in need of comfort or protection, it's best if I take care of my needs on my own. I'll reserve asking my parents for help to those times when I feel really distressed. " As a result, such children learned to "armor their hearts" against longing, and deal with emotional upset all by themselves through various practical and functional behaviors . . .

As adults, the internal "map" of dismissing individuals automatically leads them to select relationships, activities, and life paths that prioritize work, achievement, and intellect over intimacy. Relationships with friends, parents, spouse, and children *are* important to them, but family and friends may complain that they don't *feel* that important to dismissing individuals. This is because dismissing individuals value their individual strengths and abilities to solve problems—qualities that are not balanced with emotional connections in relationships . . .

There is a paradox about the emotional life of many dismissing individuals. On the whole, they seem to be strong, confident, capable people who have very little emotional distress. "Negative" emotions, such as sadness, distress, loneliness, anger, and even fear, are considered private and sometimes seen as unimportant, unnecessary, or interfering with the problem-solving process. As a result, many dismissing individuals push such feelings aside, and are no longer aware of them fully . . . Avoiding negative emotions also creates a dilemma about becoming more connected emotionally to themselves and other people: If they do so, dismissing individuals may first have to deal with underlying feelings of insecurity, rejection, unworthiness, sadness, and anxiety.

wrote a "client report" for me to use with Mike. He and I had already spent a session talking about his MMPI–2 and Rorschach scores when I handed him this report and asked him to read it. (See Table 3 for excerpts.)

Mike read Dr. George's report silently, then put it down and exclaimed, "This is amazing! It nails me!" We then went through the report slowly and talked about it and its relevance to Mike's main assessment question of why he couldn't let himself get close to others. We agreed he would take the report home and read it and come back later in the week. I got the following e-mail the next morning:

Dyadic	***Personal Exp***	***Synchrony***	**Ds**	**E**	**Seg**	**Alone**	***Agency***	***Personal Exp***	***Connected***	**Ds**	**E**	**Seg**
Deprt (3)	0	1 Couple Functional	Ds	E		Window (2)	"2" Girl contemplate s	0	1	Ds	E	
Bed (5)	0	1 M/son Delay Functional quality	Ds	E		Bench (4)	"2" → 1 get up Lady Problem solving "thinking"	0	3	Ds	E	
Ambul (6)	0	1 Fractured functional comfort by a stranger Woman/boy/ several ideas as to who is in ambulance	Ds	E	R	Cemtry (7)	"2" Man Reflect, remembers	0	*not coded father → parent or grandparent*	Ds	E	
						Corner (8)	1 Kid Rej	0	*not coded*	Ds	E	R

FIGURE 3.—Coding Summary Sheet for Mike's Adult Attachment Projective Picture System. Classification: Dismissing, with a lot of underlying cognitive disconnection.

Steve,

Had a pretty tough sleep last night. Been thinking about all of the strategies that I have used for so long to control my feelings and it all feels like it has been kind of a big sham. I am feeling better now but am realizing that I am not quite sure who I am any more if I am not the image that I created for myself . . . I even questioned last night as I tossed and turned whether I really might suffer from depression. As I reflect on my childhood and my life, I think I have had these feelings of suffering and inadequacy my whole life. Should I consider medicine?

I went for a bike ride and of course feel much better. I am unsure of how to cope. I don't want to run away from these feelings and want to experience them. Any thoughts?

See . . . I can reach out for help.

Mike

I wrote back to Mike immediately and reassured him that his coping mechanisms were not a big sham, but represented his best effort over time to handle a difficult and complex situation. I praised him for reaching out for support and told him it was okay to take "breaks" from the feelings, and to call me if he wanted to talk before our next session.

Postassessment Phase of Psychotherapy

For a year after the AAP assessment, Mike worked steadily in therapy with me—with no breaks! The reassessment, and specifically the AAP report and our ensuing discussions, were a catalyst that helped him access the grief and painful affect he had been avoiding. During this period, Mike felt a lot, including—as I think was unavoidable—some pretty significant depression. He did start taking an antidepressant, and joined a psychotherapy group for added support. He started to rely on me regularly as an emotional support and this gradually generalized to his turning to friends. He even took a break from dating during this period while we worked on the issues detailed in the AAP write-up. In some of our sessions, we went through Mike's AAP stories in detail, so he could see his own defensive operations at work. This period of therapy was also incredibly productive in terms of Mike's remembering more about his childhood. I remember one session in particular where we sat with a scrapbook of pictures from Mike's early years, and he sobbed as he recalled how alone and lost he had felt during those years. He even asked for a hug at the end of the session.

My therapeutic goals during this period of our work were (a) to help Mike access split-off anger and grief that he had had to put aside while growing up to survive, (b) to support Mike as he got in touch with these emotions, so that he would not be overwhelmed and retraumatized by them, (c) to teach Mike that turning to me and other people for emotional support helped him and that it addressed his dilemma of being a solo flier versus being emotionally overwhelmed, (d) to help Mike construct a coherent narrative of how his early upbringing related to his difficulties in adult intimate relationships, and (e) to help reduce Mike's shame. My sense was that we made good progress on all these goals.

Unfortunately, this "working through" phase of Mike's psychotherapy was cut short, in my opinion, by my telling Mike that I would be ending my long-term psychotherapy practice the following year (10 months later). (I continue to do assessments and brief psychotherapy.) Because of Mike's background, I wanted to give us ample time to say good-bye, and I fully expected that we would continue our work for the next 10 months. However, several weeks later, Mike called and left a phone message saying that he "was doing extremely well" and would be taking a break from individual therapy while continuing with group therapy. I called and urged him to come in and talk about his decision, but Mike did not call back. I also contacted Mike's group therapist, who promised to follow up with Mike; I heard back that Mike denied that his decision had anything to do with my closing my therapy practice. Mike apparently insisted that he just did not need the individual therapy at that time. I felt sad, frustrated, and guilty, but I also trusted that the work Mike and I had done would have a positive impact.

Follow-Up

To my surprise and delight, Mike e-mailed me 11 months later, 2 weeks after the day I officially closed my therapy practice, and asked to meet for a "check-up" session. I agreed, and when we met, he joyously told me about a new development in his life. He had been dating a woman steadily for 9 months, and they were starting to talk about getting married. Mike was happy to report that he felt no panic about the commitment, and he was clear in attributing this to our work together and thanked me profusely. I asked Mike what he felt had made the most difference, and he said he was still amazed by the accuracy of the AAP report and how "many tears" he had "locked away" without knowing. He said he had a much larger support network, and that he was setting good limits with his parents and with his ex-wife. I gently brought up his precipitous departure from the individual therapy, and he somewhat abashedly admitted that he had "had all he could take." He denied any anger about my closing my practice, and I let the topic go, satisfied that Mike and I had done what we could do given the circumstances, and that our work was enough to impact a major stuck point in his life.

Of course, I was aware that Mike had started dating his new woman friend shortly after he quit therapy with me. Did this mean that the new relationship was questionable? I did not think so. I reasoned that I had served as an auxiliary attachment figure for Mike during the latter phase of our therapy, and that he had learned that it felt good to lean on someone emotionally. When I announced that I would be leaving, Mike became aware of the pitfalls of using a therapist as an attachment figure. (For example, the relationship is a business relationship and therefore can be terminated by the therapist.) Mike's finding a new attachment figure—in an adult romantic partner—was a healthier, more natural choice. I believed the work we had done made it possible for him to attach to his girlfriend, and that in fact, he no longer needed me or another therapist as he had previously.

Six months after my meeting with Mike, I heard from a colleague (who saw a friend of Mike's in psychotherapy) that he was engaged to the woman he had been dating. I was delighted with this news, and of course, hope the best for Mike and his new wife. I am hoping that he might come to see me again in the future, and that if so, I might convince him that we should redo the AAP.

Summary and Conclusions

In summary, the AAP was incredibly useful to me and my client, Mike, in a number of ways. First the AAP—and the theory it is based on—gave me a coherent and parsimonious way to

understand his relational challenges. Although some of information derived from the AAP was also contained in the MMPI–2 and Rorschach, the AAP spelled out the likely origin and nature of Mike's difficulties in detail, in a way that other tests could not. The AAP write-up seemed to lessen his shame, it resonated with him deeply, and it helped him see through his defenses. Of course, the slow and careful work I had done with Mike previously set the stage for his being able to use the AAP results, but Dr. George's write-up spoke to him forcefully and was the opportunity for an "optimal disintegration experience" (Dabrowski, 1967) that led him to his next piece of work in therapy.

Second, the AAP cards were "experience near" for Mike, and he and I did very meaningful work as we discussed his stories and what they revealed about how he handled relationships. As I have done with other clients, in several therapy sessions, Mike and I "tried out" alternative stories to some of the cards, for example, with the girl in the bench card reaching out to others for help. In this way, Mike was able to feel his way into his own dilemma of change, to track the internal shifts he was experiencing, and to notice where he was still blocked. We both found these sessions extremely moving and Mike repeatedly said that they were valuable. Of course, similar work can be done using the Thematic Apperception Test (Murray, 1943) or other picture story cards with clients, and I have previously published cases in which I did so (Finn, 2007). I find, however, that the AAP cards are extremely useful in stimulating discussions of attachment issues, because the cards were specifically designed to stimulate the attachment system (George & West, 2001).

Third, the AAP feedback helped direct Mike to material he had resisted bringing in to therapy—the shortcomings of his early years. When I had gently approached this material earlier, Mike had always assured me that he had no resentment toward his parents and knew they had done the best they could. The even-handed neutrality of the AAP client report reassured Mike in a way that I had not been able to, that we could discuss ways his parents had failed him, while also not judging them. Dr. George's report was also perfect for a man who used intellectualization as a major coping mechanism, in that it rationally and coherently explained the connection between his childhood experiences and his current life struggles; it was also based on solid research.

Based on this case and other experiences with clients, I heartily recommend the AAP as a clinically rich assessment tool that has much to offer in a multimodal personality assessment battery. My colleagues and I now routinely include the AAP in adult assessments that concern relational issues, and find it extremely valuable in framing clients' dilemmas around close relationships in ways they can understand. Because of its empirical grounding and its connection to the vast research on attachment, the AAP offers insights and information beyond what can be derived from other tests. The AAP is also useful in predicting the way clients will relate to psychotherapists, and I have been able to help other therapists with dismissing clients be patient with those clients' needs to "come and go" in therapy, as Mike did with me. The AAP is also accessible to clients and the cards are quite emotionally arousing for many clients. In Therapeutic Assessment this provides many opportunities to dialogue with clients about their stories and their emotional experiences of the cards, which can lead to powerful assessment interventions.

Last, I would add that even if one chooses never to administer the AAP to clients, I believe that training in the instrument affords a wonderful way to learn deeply about attachment theory, which is useful in understanding many of our clients' dilemmas. I have found that my AAP training made me more empathic to clients. And there is growing agreement in our field that early attachment experiences are related to many of the difficulties experienced by our clients, and that when these difficulties are understood, they can be effectively addressed in psychotherapy (Fosha, 2000; Schore, 2003; Siegel, 1999; Stern, 2004). Many of us believe that the current integration of attachment theory, developmental neurobiology, and psychotherapy represents the cutting edge of clinical practice (Finn, 2011a). The AAP provides a wonderful entrée into this body of knowledge.

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