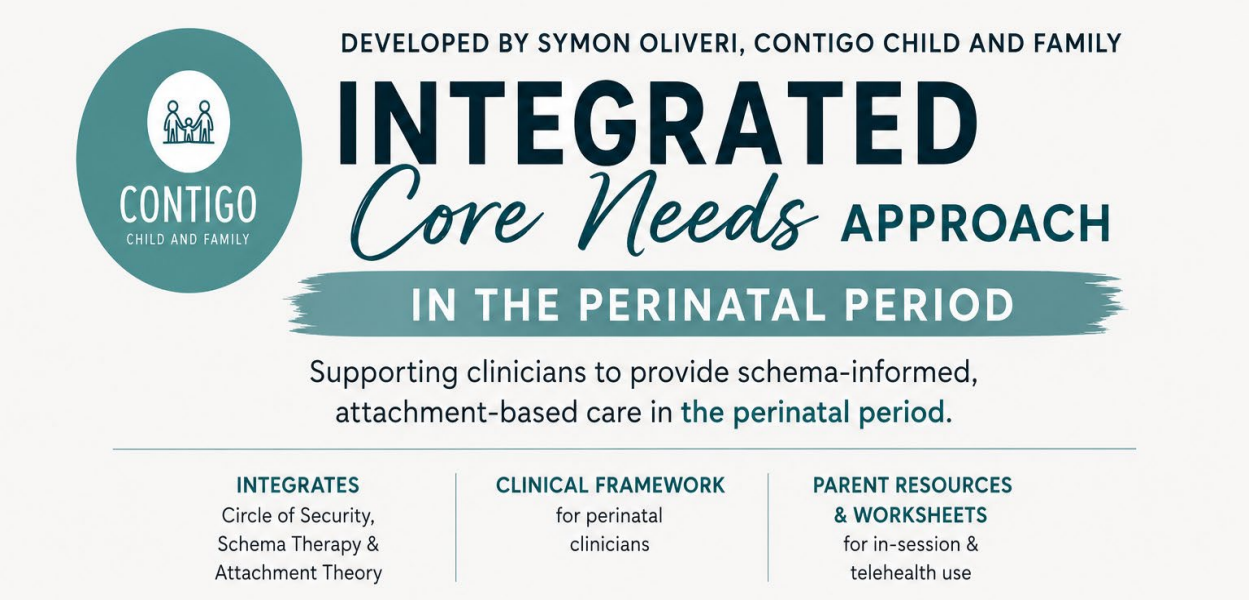


STATES OF MIND IN THE THERAPY ROOM

This practice paper explores how state of mind may show up in the therapy room and influence the way parents engage in reflection, respond to emotional material, and experience the therapeutic relationship. It also considers how state of mind can shift for both parents and clinicians as attachment needs, emotions, and relational dynamics become activated within therapy.

The aim of this paper is to support clinical and reflective practice by helping clinicians recognise and respond to different states of mind, understand how they may influence the therapeutic process, and consider how attachment-informed principles can be applied within therapy.

This paper provides important foundational knowledge for clinicians intending to use the Map of Wellbeing Reflection Tool with parents. Using the New Beginnings resources and Core Needs Approach often involves parents reflecting on core emotional needs, attachment experiences, and aspects of their childhood history. This kind of reflective work can open important and sometimes tender territory for the parents and caregivers we work with.

What is State of Mind and Why Does it Matter

State of mind refers to how a person currently understands, reflects upon, and organises their attachment experiences. It includes the way thoughts, feelings, memories, and beliefs about important relationships are held and communicated, as well as the degree to which these experiences have been integrated into a coherent understanding of self and others.

The concept of *state of mind with respect to attachment* was introduced by Mary Main through her work on the Adult Attachment Interview. Throughout this paper, the term *state of mind* will be used as a shortened form of *state of mind with respect to attachment*.

Why This Matters in Perinatal Work

Understanding state of mind has particular clinical significance during the perinatal period. The transition to parenthood is one of the most powerful activators of a person's own attachment history. Earlier attachment experiences, unresolved trauma, grief, loss, and unmet attachment needs may become more readily activated as individuals care for a completely dependent infant.

Selma Fraiberg described how unresolved experiences from a caregiver's own past can enter the nursery uninvited, shaping how they see and respond to their baby in ways they may not be fully aware of (Fraiberg, Adelson, & Shapiro, 1975). In Map of Wellbeing terms, these "ghosts in the nursery" can be understood as danger signals, unmet needs, and unresolved experiences that have followed the parent from their own map into the map they are now creating with their child. The work of perinatal therapy is, in part, helping parents become aware of these patterns so they have greater choice in how they respond.

At the same time, the perinatal period can introduce new experiences that may themselves contribute to an unresolved state of mind, even in individuals who previously demonstrated a largely secure and integrated way of understanding their attachment experiences.

Experiences such as infertility, pregnancy loss, reproductive trauma, pregnancy complications, birth trauma, NICU admissions, feeding difficulties, sleep deprivation, and the demands of caring for a dependent infant can place significant strain on emotional wellbeing and attachment systems. These experiences may challenge existing ways of coping, activate attachment-related fears and vulnerabilities, and contribute to experiences of loss, fear, helplessness, or trauma that remain insufficiently integrated.

Mental health difficulties, attachment experiences, and state of mind are often closely intertwined and can be difficult to separate. Attachment experiences may influence how parents respond to adversity, while current stressors, trauma, grief, and mental health challenges may in turn influence state of mind. For this reason, clinicians are encouraged to consider both historical and current experiences when seeking to understand a parent's wellbeing, relationships, coping responses, and parenting experiences.

Research suggests that a caregiver's capacity for reflective functioning is one of the strongest predictors of secure attachment in the next generation (Fonagy, Steele, & Steele, 1991; Slade, 2005). Supporting reflection, meaning making, and coherence is therefore central to the New Beginnings approach. By helping parents better understand their own attachment experiences, current state of mind, and core emotional needs, clinicians can support both parental wellbeing and the development of secure parent-child relationships.

A Quick Snapshot: Attachment Theory in Clinical Practice

A Brief Overview of Attachment Theory

Attachment theory was developed by John Bowlby in the 1960s and 1970s, drawing on observations of how young children respond to separation from and reunion with their caregivers (Bowlby, 1969). Bowlby proposed that human beings are biologically wired to seek closeness to a protective other, particularly under conditions of stress, uncertainty, or threat.

Mary Ainsworth extended Bowlby's work through careful observation of mother and infant pairs, identifying distinct patterns in how infants organised their behaviour in relation to their caregiver (Ainsworth, Blehar, Waters, & Wall, 1978). These patterns were understood not as

fixed traits within the child, but as adaptive responses to the relational environment in which they developed. Each pattern makes sense in context.

Over time, attachment researchers became increasingly interested not only in how attachment was expressed in infancy, but also in how attachment experiences continued to influence relationships across the lifespan. Rather than focusing solely on what happened in childhood, state of mind refers to how attachment experiences are currently understood, organised, reflected upon, and integrated.

This shift moved attention away from categorising childhood experiences and towards understanding how people make sense of those experiences in the present. Research suggests that it is this capacity for reflection, coherence, and integration that is most strongly associated with attachment security in the next generation (van IJzendoorn, 1995; Steele, Steele, & Fonagy, 1996).

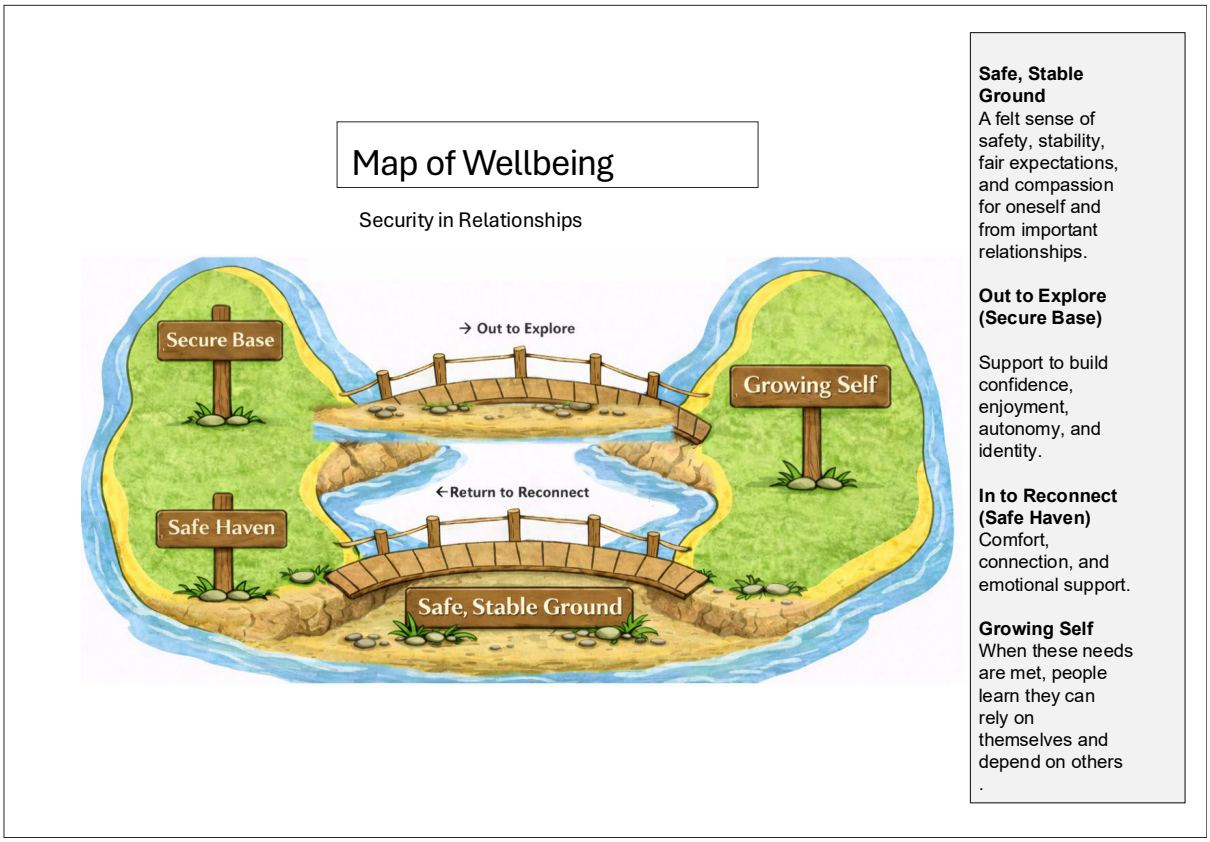
Daniel Siegel's work on interpersonal neurobiology further expanded these ideas by highlighting the importance of integration in mental health and relationships. Siegel proposes that wellbeing is supported when experiences, emotions, memories, and different aspects of the self can be linked together into a coherent whole (Siegel, 1999; 2012). From this perspective, coherence is not about having a perfect childhood or a life free from adversity. Rather, it reflects the capacity to make sense of experiences, hold both positive and painful aspects of relationships in mind, and develop an organised narrative that connects past experiences with present functioning.

This understanding aligns closely with the concept of state of mind. Parents who have experienced significant adversity may nevertheless develop coherence through reflection, meaning making, supportive relationships, and therapeutic experiences. Conversely, experiences that remain fragmented, unresolved, or difficult to integrate may continue to influence emotional wellbeing, relationships, and parenting. The goal of attachment-informed work is therefore not to determine whether difficult experiences occurred, but to support greater awareness, integration, and coherence around those experiences.

Map Of Wellbeing: A Visual Guide of Attachment and State of Mind

The Map of Wellbeing is a clinical framework used within the New Beginnings Core Needs Approach that gives attachment security and emotional wellbeing a visual language. It identifies the core emotional needs children rely upon caregivers to meet in order to develop a sense of safety, security, belonging, competence, and connection.

The map is organised around four interconnected areas:



The Internal Alarm System and State of Mind.

In New Beginnings, the concept of an **internal alarm** system helps parents understand why creating security for their baby can feel harder than expected, even when the intention is clearly there. The internal alarm system is the brain's built-in threat detection response. It operates below conscious awareness and is activated not only by physical danger but by emotional threat as well, including past experiences where needs or feelings were met with rejection, anger, or discomfort from caregivers. Understanding this helps both parents and clinicians approach these moments with curiosity and compassion rather than shame. The danger and alarm signals on the maps below are the body's memory of what once needed protecting.

*In New Beginnings the term **cue** refers to when a child shows their emotional need directly, such as crying when sad.*

Miscue *is used to describe what happens when a child hides, disguises, or sends a confusing signal about their need.* Instead of expressing the need directly, the child may behave in a way that protects the relationship to avoid triggering discomfort in the caregiver. The need is still present, but it is no longer expressed clearly.

The concepts of the internal alarm system, old maps and cues and miscues enable parents to understand how trauma and attachment security can be passed down intergenerationally.

Early Attachment Experiences and Adult States of Mind

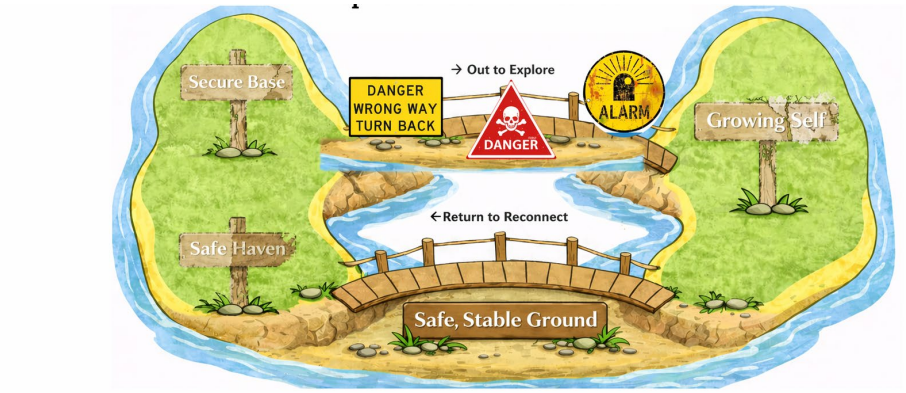
Secure State of mind

Secure attachment is supported when a caregiver is available and responsive enough that the child can trust their emotional needs will be met (Ainsworth et al., 1978; Bowlby, 1969). The child is supported to explore and to return for connection and emotional support. Moments of rupture and disconnection still occur; however the caregiver can take responsibility for reconnecting and repairing the relationship.

As adults, people with secure state of mind tend to have a coherent and flexible relationship with their own emotions. Safe, Stable Ground holds steady, the Growing Self is confident and curious, and the person can rely on both themselves and others.

One of the most hopeful findings in state of mind research is that early patterns are not destiny. Adults can develop earned security, a coherent and reflective relationship with their own history, even when that history was difficult (Hesse, 2008This is at the heart of what New Beginnings is designed to support. When a caregiver can begin to make sense of their own history, they become more available to their baby, not because the past has been erased, but because it no longer has to be repeated.

Dismissing / Avoidant State of mind: When Emotional Vulnerability Feels Unsafe.

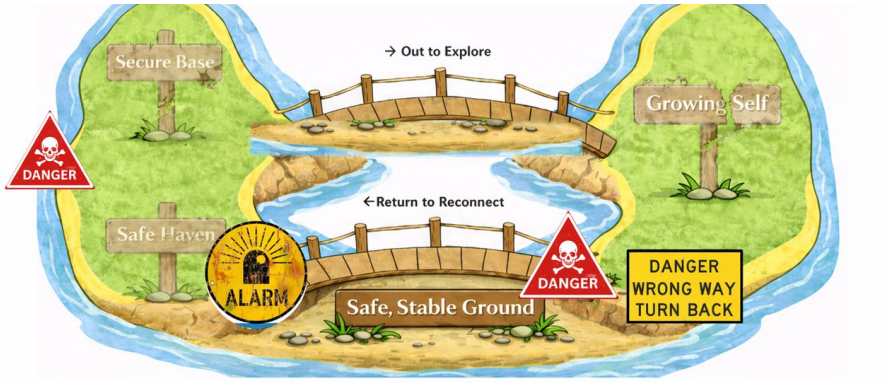


In childhood an avoidant attachment is likely to develop when a child learns that expressing emotional needs leads to distance, withdrawal, or discomfort in their caregiver (Ainsworth et al., 1978). This is an adaptive response where children learn to turn down the volume on those needs, to become self-reliant, and to prioritise thinking over feeling.

This pattern is also referred to as avoidant and dismissing in adulthood and is sometimes called insecure-avoidant or Type

In adulthood a dismissive state of mind is reflected in a focus on self-reliance and an avoidance of intimacy, closeness and vulnerability. As adults, people with this state of mind often minimise distress and find emotional closeness less comfortable

Preoccupied / Anxious State of mind: When Separation Feels Unsafe.

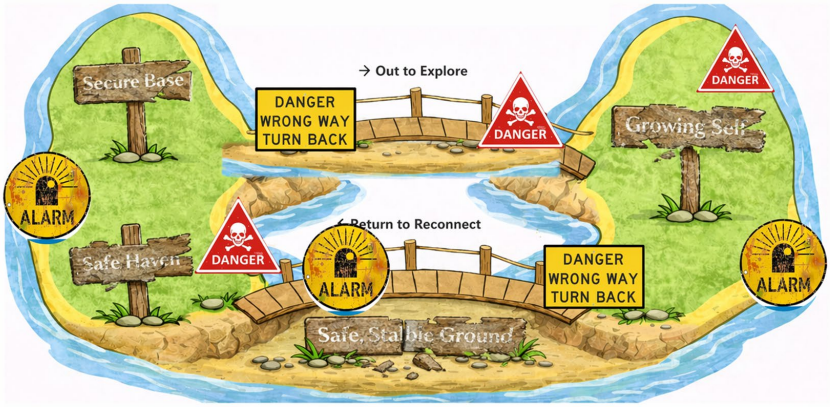


In childhood an ambivalent attachment is likely to develop when a caregiver is inconsistently available, sometimes warm and responsive and sometimes not (Ainsworth et al., 1978). This pattern is also referred to as anxious or ambivalent in infancy and preoccupied in adulthood, and is sometimes called insecure-ambivalent or Type C. The child learns that the way to keep the attachment figure close is to amplify distress and stay alert to any sign of disconnection.

A parent whose anxiety makes them hypervigilant about their baby's safety or wellbeing may inadvertently communicate that the world is a threatening place or may have difficulty tolerating their baby moving away to explore, which can contribute to a more preoccupied or anxious pattern.

As adults, people with a preoccupied state of mind may remain emotionally entangled with their own past, often in ways that feel very present and alive. Relationships can feel urgent and absorbing. There may be a strong pull toward closeness alongside a persistent fear that it will not last or will be suddenly withdrawn. Self-doubt is common, as is a tendency to seek reassurance and to find it hard to settle even when reassurance is offered.

Unresolved State of mind: When Nowhere Feels Safe.



In childhood a disorganised attachment to a caregiver develops when the person who is supposed to be the source of safety is also a source of fear (Main & Hesse, 1990). The child is caught in an impossible position with no coherent strategy available. This pattern is also referred to as disorganised or disoriented in childhood and may be called Type D in research.

As adults, people with this history may have an unresolved state of mind in relation to attachment. find that closeness and fear become tangled together in complex ways. Unresolved trauma, grief and loss may also result in a parent having an unresolved state of mind. This often impacts their attachment relationship with their own child. The parent may appear frightened or frightening to their child in ways that are outside their awareness. This can result in the handing down of attachment trauma from one generation to the next.

On the Map of Wellbeing, this corresponds to the nowhere feels safe map. Danger and alarm signals appear across all pathways, including on the Safe, Stable Ground itself. The Growing Self is fragmented and inconsistent. Neither self-reliance nor reliance on others offers predictable comfort. The person may swing between both or collapse into neither.

Schema Therapy and Attachment

The theoretical and empirical links between attachment theory and schema therapy are well established at a foundational level. Jeffrey Young drew explicitly on attachment theory in developing schema therapy, proposing that early maladaptive schemas develop primarily when core emotional needs go unmet in childhood, and that the attachment relationship is the primary context in which this occurs.

Research by Cecero, Nelson and Gillie (2004) found significant associations between insecure attachment and early maladaptive schemas, particularly those in the disconnection and rejection domain, including abandonment, mistrust and abuse, emotional deprivation, defectiveness and shame, and social isolation.

Thimm (2010) found that anxious attachment was most strongly associated with schemas in the disconnection and rejection and impaired autonomy domains, while avoidant attachment was more strongly associated with emotional inhibition and self-sufficiency schemas. This maps well onto the preoccupied and dismissing attachment patterns respectively.

More recent research has continued to reinforce that attachment patterns in childhood predict schema development, supporting the view that the two frameworks are measuring related but distinct constructs that can be usefully integrated in clinical practice.

The therapeutic relationship in schema therapy, sometimes described as limited reparenting, functions as a corrective attachment experience, which is conceptually very close to what attachment-informed therapists describe as the therapeutic relationship as a secure base. This shared mechanism sits at the heart of the Integrated Core Needs Framework and its integration of both approaches in perinatal clinical work.

Am I Safe Here?

Whatever pattern a parent brings into the room, the underlying question their nervous system is asking is always the same: is it safe to have needs here? Is it safe to feel things here? Will this relationship hold? In Map of Wellbeing terms: which pathways feel safe, which are blocked, and what happens on the Safe, Stable Ground?

The work across all styles is to slowly provide the relational conditions that make the old strategy less necessary. Not by naming it or pointing it out, but by showing up in a way that gradually offers a different experience.

State of mind and the Therapeutic Relationship

Before exploring how different attachment patterns and states of mind may emerge within the therapy room, it may be helpful to briefly revisit some of the key ideas discussed so far. Attachment patterns develop within early caregiving relationships and shape how people organise experiences of closeness and separation, as well as the implicit lessons learnt about which needs can be expressed safely and which needs may need to be hidden in order to maintain connection. These early relational experiences also shape the development of schemas and the body's internal alarm system over time.

Within the New Beginnings approach, these patterns are represented visually through the different maps shared earlier, including when separation and vulnerability feel unsafe and when nowhere feels safe. As discussed earlier, attachment patterns are not fixed categories. Attachment patterns and states of mind can shift depending on the relationship, the context, and what is becoming more active within the moment. Mary Main described this as state of mind with respect to attachment (Main, Kaplan, & Cassidy, 1985).

The transition to parenthood can make these patterns more active, particularly as experiences of vulnerability, dependency, emotional need, and distress emerge within the parent-infant relationship. The therapeutic relationship can also become an important place where these patterns become more visible. Different states of mind can shape not only how parents experience relationships outside the therapy room, but also how they experience the clinician and the therapeutic relationship itself. At times, clinicians may notice recurring patterns emerging within sessions depending on what state of mind becomes more active within the parent.

State of Mind, Regulation, and Patterns of Coping

As discussed earlier, attachment patterns are not fixed categories but states of mind that can shift depending on the relationship, the context, and what is becoming activated within the moment (Main, Kaplan, & Cassidy, 1985). At times, parents may move between more reflective and more protective ways of responding within the same session. A parent who had appeared open and reflective may suddenly become quieter, more overwhelmed, more focused on practical detail, or less able to stay connected to emotional experience.

These shifts can also be understood through the lens of nervous system regulation, including concepts from polyvagal theory and the window of tolerance (Porges, 2011; Siegel, 1999). When people remain within their window of tolerance, they are generally more able to reflect, stay emotionally connected, think flexibly, and remain present within relationships. As emotional arousal increases and the nervous system begins moving outside this window, earlier patterns of coping organised around protection, connection, predictability, or self-preservation may become more active.

For some parents this may involve moving away from emotional experience and becoming increasingly organised around thinking, practical detail, humour, routines, or problem solving. For others, emotional experiences may become more intense, urgent, difficult to slow, or harder to reflect upon. Some parents may move rapidly between different states within the same session.

Clinicians may also notice corresponding shifts within themselves as these states emerge within the therapeutic relationship. There may be a growing pull toward reassurance, problem solving, emotional closeness, maintaining stability, or moving away from particular topics. At times, clinicians may notice changes within their own body including tension, urgency, tiredness, or difficulty remaining reflective within the session.

The following sections explore how these patterns may emerge differently within dismissing/avoidant, preoccupied/anxious, and disorganised/fearful avoidant states of mind within the therapy room.

Dismissing / Avoidant States of Mind in the Therapy Room

When working with parents in a more dismissing state of mind, clinicians may notice sessions becoming increasingly organised around thinking, practical detail, routines, or problem solving. Emotional experiences may remain brief, quickly moved away from, or reflected on in a more detached or analytical way. Attachment-related themes may become redirected toward information, humour, or practical solutions. There may also be less focus on bodily or emotional experience within the session.

For some parents, moving away from emotional vulnerability may have been an important way of maintaining connection, stability, predictability, or self-protection within earlier relationships. Emotional needs may have been experienced as uncomfortable, overwhelming, criticised, ignored, or unhelpful within important caregiving relationships. Over time, thinking, self-reliance, practical problem solving, or staying emotionally organised may have become safer and more familiar ways of managing distress and maintaining relationships (Main et al., 1985).

Clinicians may notice different responses emerging within themselves depending on their own state of mind and what is becoming activated relationally. Some clinicians may notice a pull toward working harder to access emotion or reflection within the session through asking more questions, overexplaining, or deepening emotional exploration. Conversely, clinicians may also find themselves matching the parent's state of mind, with sessions becoming increasingly organised around strategies, humour, practical solutions, or more surface-level conversation. At times, clinicians may notice a sense of distance, flatness, or uncertainty about whether they are emotionally reaching the parent at all.

Being able to step back and notice these shifts can support clinicians to respond more reflectively to what the parent may need within the moment. At times, this may involve slowing the pace, allowing more space within the session, remaining curious about both strengths and emotional experience, or not pushing emotional exploration more quickly than the parent's nervous system can comfortably manage. The parent's attachment history, trauma history, neurodiversity, cultural experiences, current stressors, and broader relational context may all shape how emotional closeness and vulnerability are experienced within the room.

Preoccupied / Anxious States of Mind in the Therapy Room

When working with parents in a more preoccupied state of mind, clinicians may notice sessions becoming increasingly emotionally detailed, urgent, or difficult to slow. Parents may move quickly between memories, emotions, and experiences while finding it harder to step back into reflection. At times, there may be a strong focus on whether the clinician fully understands,

agrees with, or remains emotionally connected to their experience. Emotional experiences may feel highly present and difficult to settle within the room.

For some parents, emotional intensity and heightened attention toward relationships may have developed within caregiving environments where connection felt inconsistent or unpredictable. Staying highly aware of emotional shifts, signs of disconnection, or changes within relationships may have become important ways of maintaining closeness and safety over time. Under stress, these patterns may become more active, making it harder to slow emotional arousal or maintain reflective distance from difficult experiences (Main et al., 1985).

Clinicians may notice corresponding responses emerging within themselves depending on their own state of mind and what is becoming activated relationally. Some clinicians may notice pressure to reassure, clarify, settle, rescue, or maintain emotional closeness within the relationship. Others may notice feeling emotionally flooded, overwhelmed, or pulled into the urgency of the parent's emotional experience, with a growing need to slow the pace and focus on grounding, steadiness, and containment within the session. Sometimes a clinicians may also find themselves matching the parent's urgency and emotional intensity, with sessions becoming increasingly emotionally focused, fast paced, or difficult to slow reflectively.

Being able to step back and notice these shifts may support clinicians to respond more thoughtfully to what the parent may need within the moment. At times, this may involve slowing the pace, supporting enough space for reflection, or helping the parent move between emotional experience and reflection rather than remaining fully immersed within one state. The parent's broader relational history, trauma experiences, neurodiversity, cultural context, and current stressors may also shape how emotional closeness, reassurance, and connection are experienced within the room.

Disorganised / Fearful Avoidant States of Mind in the Therapy Room

When working with parents in a more disorganised or fearful avoidant state of mind, clinicians may notice rapid shifts occurring within the same session. At times, a parent may appear reflective and emotionally connected, and at other times become overwhelmed, fearful, emotionally disconnected, confused, shut down, or difficult to follow. Conversations involving helplessness, fear, trauma, vulnerability, or loss may become especially difficult to remain organised around reflectively.

For some parents, closeness and fear may have become closely linked within earlier caregiving relationships. Experiences of safety, protection, fear, unpredictability, or emotional overwhelm may have occurred within the same relationships, making it difficult to develop a consistent strategy for managing distress or seeking connection (Main & Hesse, 1990). Under stress, parents may move rapidly between different patterns of coping, including emotional overwhelm, withdrawal, disconnection, hypervigilance, or attempts to regain control or predictability within the moment.

Clinicians may notice stronger shifts emerging within themselves during these sessions depending on their own state of mind and what is becoming activated relationally. Some clinicians may notice feelings of helplessness, uncertainty, protectiveness, emotional overwhelm, confusion, urgency, or difficulty remaining reflective within parts of the work. Others may notice a growing focus on helping the session feel more organised, steady, and predictable as difficult experiences emerge. Sometimes a clinician may find themselves

becoming more disorganised, uncertain, emotionally flooded, or pulled into the intensity and confusion emerging within the therapeutic relationship itself.

Being able to step back and notice these shifts can support clinicians to remain more reflective about what may be occurring relationally within the session. At times, maintaining enough steadiness, predictability, emotional organisation, and Safe, Stable Ground within the relationship may become more important than moving quickly toward insight or exploration. The parent's trauma history, current safety, neurodiversity, dissociation, broader relational experiences, and available supports may all shape how these states emerge within the therapy room over time.

Conclusion

Attachment patterns and states of mind can shape not only relationships outside the therapy room, but also how parents experience reflection, emotional closeness, vulnerability, and safety within the therapeutic relationship itself. At times, these patterns may become more visible as attachment-related experiences are explored and as parents move in and out of different states of mind within the session.

Clinicians may notice corresponding shifts within themselves depending on what is becoming activated relationally within the work. Being able to step back, notice these responses, and remain reflective can support more thoughtful and responsive clinical care.

Across all attachment patterns, the task is often not to remove emotional activation from the room, but to support enough safety, steadiness, and reflection that difficult experiences can gradually become more manageable to stay connected to within relationship. Remaining curious about the many factors shaping these responses can support a more compassionate and individualised understanding of what may be occurring within the therapy room.

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