Attachment narratives and systemic therapy

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‘Emotion is a leading element in the system that organises interactions between intimates’

(Johnson, 1999)

Arguably emotions and attachment have played a curious role in the development of family therapy. We have used the term ‘ideas that keep knocking on the door’ (Dallos & Draper, 2005) to capture the extent to which we are aware of the presence of these ideas, but perhaps we have not quite invited them in as full members of our family of family therapy concepts. Instead, our tool bag of concepts has been full of such things as systems, circularity, feedback, structures, process, problem saturation, narratives, reflection, not-knowing and so forth. These concepts seem devoid of reference to feelings and emotions. However, from its inception family therapy was connected to, and indeed arose from, psychodynamic frameworks that did emphasise the emotional dynamics shaping and informing family processes (e.g. Box, 1994; Byng-Hall, 1995; Satir, 1972; Skyfinger, 1976).

More recently we have seen a movement to re-introduce psychodynamic concepts, such as transference and unconscious emotional processes, back into family work (Boscolo & Bertrand, 1993; Flaschke, 1997; Larner, 2000). For us, attachment theory, and particularly the recent developments in attachment theory that emphasise how early experiences are held as narratives or ‘internal working models’ that shape our experience, actions and sense of self, offer a powerful contribution to systemic and narrative family therapy. More specifically, they emphasise how our narratives embody our experiences not just in their content but also in their form or style. In effect this allows us to apply the distinction between content and process, not only to family patterns but also to how family members are able to talk about these experiences.

Put simply, families and family members differ in how clearly, openly, reflexively and coherently they are able to generate talk about their experiences. In some ways this connects with the early systemic communication models that emphasised communication as multi-layered, contextual and patterned. Attachment theory adds that the emotional context of the family shapes our abilities to talk about and manage our experiences. For example, abilities to develop more detailed, coherent and reflective narratives are linked to family contexts that are emotionally safe and open (Bowlby, 1988; Byng-Hall, 1995; Johnson, 1998; Crittenden, 1998; Dallos, 2005).

Since most psychotherapies involve us in conversation and helping families to be able to become more aware of and articulate about their experiences, this finding from attachment theory is very relevant. In particular we suggest that it helps us to generate some higher order ideas from different therapeutic orientations about new ways of working with families and also to be clearer about what works and why.

As an example we suggest that the idea of scaffolding conversations in narrative therapy fits very well with the idea that many families need our support and assistance to be able to develop narratives about their lives. In short, to be able to tell ourselves and others, coherent, detailed, multi-layered, reflective and balanced stories about our experiences that help us to prepare effectively for our future lives together is a sophisticated skill that requires support and nurturing.

Perhaps in our concern not to be ‘expert’ and ‘controlling’ of families we run the risk of missing how they may benefit from support from us in further developing these skills. As an example we might ask ourselves how much at times the conversations of our reflecting teams go over the heads of family members if they have not had practice in engaging with and attending to such conversations. Without being patronising, how much do we need to adjust our conversation in content and style so that it fits with theirs but also helps them to start to develop and elaborate their ideas?

We have been collaborating over a number of years to develop our thinking and practice as systemic therapists, trying to integrate these three major systems of thought in a process model of change: attachment theory, systemic psychotherapy, and narrative practice (Dallos, 2005; Cooper & Vetere, 2005). For us, integrative and collaborative approaches to formulation lie at the heart of our personal orientation to this model of change (Vetere & Dallos, 2003). Ethically speaking, we take the view that integrative practice broadens the range of choices we can offer those people who seek our services. RD has applied his thinking to practice with young people and their families where the young person has been diagnosed with an eating disorder; and AV has applied her thinking mainly in her work with couples and with family violence.

We are influenced by the research of social psychologists who show that the capacity to identify emotional states and expression is fairly stable across cultural and ethnic groupings, and that differences emerge in the cultural and sub-cultural meanings and rules associated with the expression of emotion across inter-personal settings (Ekman, 1972). Attachment thinking suggests that emotion and emotional expression organise intimate interactions around affiliation and dominance, and there we may see
gender and cohort differences. Accessibility and responsiveness are thought to be the building blocks of relationship security. We owe a debt to many, many people, some of whom are mentioned above; significant among them are John Bowlby, John Byng Hall, Sue Johnson, Pat Crittenden, Barbara Kohnstamm, Jan Cooper, Harry Procter, Mark Hayward, Michael White, and of course the systemic pioneers.

**four-stage model**
We have written elsewhere of how we might maintain a systemic focus in the co-construction of new narrative accounts in therapeutic work with couples and families, and summarise a few pointers here. We have summarised our work in terms of a four-stage model (Dallas, 2005).

1. **Creating a secure base:**
   - adopting an over-arching framework of scaffolding or helping families to explore and elaborate their narratives;
   - understanding that a fundamental part of this scaffolding is to co-create with them an emotionally secure base from which we can work creatively together;

2. **Exploration of narratives and attachments:**
   - exploring the connections and implications for action between the beliefs and stories accounts about relationships and events from everyone involved in the network of concern;
   - maintaining a systemic focus during the co-construction of new narrative accounts, by addressing the psychological and relational implications of these ideas and their implications for action (Vetere and Dallow, 2005; Dallow and Draper, 2006). These broad principles for our shared practice underpin our attempts to weave attachment thinking into our work, using children’s and family members’ ideas about relationships, connection and intimacy.

3. **Exploring alternatives:**
   - generating multi-perspectives about these events and relationships;
   - exploring the systemic fit between older and more current stories or accounts about self, others, events and the connections between them;

4. **Consolidating change and maintaining relationships:**
   - we are aware that for many families and family members creating a relationship of trust is an important and perhaps new step. By maintaining this relationship and continuing to support it we can help break a cycle of professional workers coming in and out of their lives often leaving a sense of ‘no one really cares’;
   - continuing contact, even if it is an occasional phone call or letter, can maintain a positive emotional climate that allows people to feel held in mind by us, cared for and hence more able to continue to hold and build more hopeful and balanced stories about their lives.

**the implications of attachment theory for systemic practice**
For us the implications of attachment theory for systemic training and practice are profound and far reaching. Although it can be said that many of the individual approaches to psychotherapies may focus more on a person’s inner experience and their internal constructions of relationships, and the relational therapies have their focus on how people construct their relationships in dynamic interaction, we have tried to practise within and between, drawing on both sets of understandings, to help us make sense of the complexity of intimate interaction. For us, the implications of attachment thinking for practice include the following.

**i. naming and regulating emotions**
Attachment theory is a developmental theory of the social regulation of emotion in the context of intimate relating. It helps us theorise emotion and emotional responsiveness and validates emotional vulnerability. Attachment experiences are representational, caregiving and affective, and in the context of adult attachment, they may be sexual. In the safety of the therapy alliance, we attend to key emotional responses that maintain relationship distress, such as the anger of hope from a child, ‘what do I have to do to get you to pay attention to me’, or the anger of despair from a partner, ‘you’re a waste of space!’

Emotion can be said to colour the meaning of interaction by evoking key schemas about ourselves, others and the world, at times of attachment threat.

We try to match our therapeutic response with the preferred response style of the families we work with. So, for example, under conditions of attachment threat, if someone has a tendency to respond with anxiety, we would strive initially to create a calming context for reflection and thoughtfulness to counter a tendency to go into ‘overdrive’; or if someone tends to respond with dismissal or emotional avoidance, we would try to create a context that helps illuminate and expand emotional experience. We slow the pace, pause, and reflect, and move between inner constructions and interactions. We try to help people articulate their emotional experience, and explore how this affects their relationships, and how their relationships affect their inner world.

Systemic reflecting processes are helpful at these times, and help to support the developing therapeutic relationship. Reflecting team discussions can gently raise questions and reflections around transgenerational patterns of attachment, current attachment processes, attachment disruptions and ‘injuries’, and support the therapist and family by wondering about how attachment relationships may evolve into the future. Questions such as:
   - I wonder what the parents think they have been able to do differently and/or the same as their
parents? I wonder what have they discovered from thinking about this?
- Looking back over past events, I wonder how they think they have contributed to the way they are as a family now?
- What have they discovered about attachment processes in the past? Do they think history needs to repeat itself? What might help them alter history repeating itself?
- I wonder how family members feel about being in therapy with us? What helps them be able to trust us, and what might get in the way of that?
- In what ways might the children wish to do things differently in the future? How would the parents want to support that wish?

ii. standing in the emotional shoes of the other
This goes beyond empathy, towards helping partners and family members tolerate and bear each other’s negative affect states in the confusion of change. Transition points and times of crisis may provide particular challenges for family members as they seek to re-establish familiar ways of being, or to seek new solutions. Feeling heard is soothing and calming at these times when we may be unhelpfully aroused. We are not suggesting tolerance of aggression and abuse, but rather developing the ability to recognise and understand attachment fears and longing that may have been suppressed, or anxiously pursued, or chaotically expressed.

The implication for therapists is that they too are comfortable with emotional dependency and the expression of emotional experience, and do not move too quickly to change the direction of the conversation, or to calm and soothe. This is often a challenge for beginning therapists. For example, if a family member looks distracted, or upset, or shut down, we might ask, ‘what’s happening for you right now?’, rather than asking what they might be feeling, thinking, or wanting to do, which by nature of the question partly predisposes the response. We try to give people the option to respond within their own preferred representational system when unhelpfully aroused, and then soothe and follow the feedback within that preference.

iii. patterns of comforting and self-soothing
Systemic therapy tracks patterns of comforting and soothing in family relationships. Accessibility and responsiveness are thought to be the building blocks of attachment security. We work towards helping people develop more satisfying and secure connections, as appropriate. Autonomy and dependency are seen as the same sides of the attachment coin, underpinned by a biological theory of how we ensure survival and protection. Attachment theory does not pathologise dependency, rather it posits that we all hold a wish for connection, even in extreme circumstances when someone has no history of knowing a trusting and secure connection with another. They may not know what it looks like, but they know they want it!

We use the following questions in our work with individuals, couples and families. We support and encourage other family members to listen and provide reassurance when remembering is painful and difficult. At times, we make the questions hypothetical, for example, what do you imagine happened? what would you like to happen? When working with younger children, we use drawings, toys and puppets to show how comfort was or could be given.
- When you were upset or frightened as a child, what happened?
  - How did you get to feel better? Who helped you to feel better?
  - How did they do this?
  - What have you learnt from this for your own family?
- What do you try/want to do the same? (replicative script)
- What do you try/want to do differently? (corrective script)
- How do people comfort each other in your own family/relationship/s?
- How do you comfort your children?
- How do they comfort you?

iv. information processing
When we fear rejection and abandonment, and when we have been rejected and abandoned, we can become preoccupied with regulating our fear and protecting ourselves from threat, and in moments of high emotional arousal, we may fail ‘to see’ and respond to relationship cues from our family members. Attachment insecurity is a key factor in maintaining relationship distress (Johnson, 1998). Trauma theory would suggest that fear constrains information processing, so that it takes longer to process affectively loaded material (Herman, 1992). When the need for reassurance is high, and reassurance is not offered, sometimes people protest, and may become blaming and coercive in pursuit of what they want, or they may feel vulnerable and then shut down. In the safety of the therapeutic alliance, we encourage people to slow down, and to illuminate and expand their emotional responses, which then helps family members integrate and regulate their emotional experience in relation to each other.

maintaining a therapeutic alliance
A trusting and secure therapy alliance is believed to be healing in and of itself. It is crucial for creating safety for our work. Whenever we ask a family member to take an emotional risk, perhaps by becoming more responsive and accessible rather than withdrawn, or
by seeking connection after softening a position of blame, they are likely to think of all the reasons why they should not take that risk! Empathic responding is encouraged and developed in the context of a therapeutic alliance that explores the meaning of significant and powerful human experiences, that reaffirms and clarifies family members’ experiences, and that models acceptance of all members’ experiences. We slow down our meetings to help people process their emotional experiences, thus facilitating a difference in the way their experiences can be integrated into a whole, so to speak. We offer comfort in response to difficult emotional experiences, and support family members in seeking and giving comfort to each other.

As systemic therapists we are interested in personal and shared strengths and resources, such as, how people wish for and stay connected to others, how they develop a shared sense of humour, how they balance issues of power and control and develop ways of sharing positive emotions, and how they find ways to manage conflict and reduce hostility. Clearly resilient behaviour in family groups is not likely to be explained by a single process of attachment security (Rutter, 1999). However, a focus on emotion helps us engage with couples and families, and helps create a therapeutic context where people can take risks. Expressing and expanding emotional experience is key to making changes in highly charged or emotionally cut-off interactional patterns. Helping people access their primary emotional responses enables:

- the processing of experience and emotional responses that may have been partly out of awareness;
- a new meaning to be brought to understanding family members’ behaviour; and
- the challenge of long held perceptions about family members.

Helping people create more secure connections provides a sounder basis for inter-personal problem solving. We offer an example of our work with a family to illustrate how these ideas can be useful in practice.

**Case Study: Philip**

Philip, aged 17, came to see us with his parents (Jane and John) who were both teachers and who were concerned because he had taken an overdose, was still depressed and was currently on anti-depressant medication. In contrast to his younger sister, Philip was said by his parents to be a quiet, serious and studious young man, whom I found difficult in studying or taking part in leisure activities.

In our first meeting the explanations for his problems focused on individual factors, for example, his personality style, high expectations of achievement and possible biological factors. As we widened the focus of our conversation to trans-generational issues and a discussion of the family tree it transpired that his maternal grandmother had also been extremely depressed and suicidal following the collapse of her marriage which had been abusive. She had received ECT and medication and eventually found solace in religion. What was also evident was that she had been emotionally absent during much of Philip’s mother’s life and Jane had consequently learnt to be self-reliant, put a brave face on things and eventually give, rather than receive care and comfort from her mother.

Likewise, Philip’s father, John, described a childhood where he had to ‘get on with it’ and sort out his own feelings and problems. Through this conversation a story started to emerge of a tradition of family members stoically trying to cope with adversity by themselves or with the assistance of medication but never comfort from others.

However, Jane and John said that they wanted things to be different, what John Byng-Hall (1995) calls a corrective script. Through their experience, their education and work as teachers they wanted to be more emotionally open and receptive.

Nevertheless, when further exploring the start of Philip’s problems, it transpired that this shortly followed his mother’s diagnosis of thyroid cancer. Philip asserted that he had not been worried or upset by this since the doctor told them that the prognosis was good. We gently discussed the possibility that this is a worrying condition that RD had himself personally experienced and that we could sympathise that it might well have been an anxious time for them all. It turned out that Philip’s sister had been distraught and was a bit angry at him for showing so little feeling during this time.

A discussion followed which ranged over an emotional terrain including feelings, comfort, anxiety and fear of loss, and putting a brave face on things. We also discussed how many emotions we see different family members showing feelings in a variety of ways and there were no right or wrong ways in our view. The family appeared to find the session helpful and agreed to attend again. However, Philip quietly suggested that he would prefer to be by himself.

To us this suggested a number of things: that he was moving to wish to be independent and also that he did not want to burden his parents with his problems.

In later individual sessions he confirmed that this was the case. His mother was still having check-ups and he did not want to burden her. Interestingly, he reflected at one point that it saddened him that his friends thought that he was a bit cold and unemotional. He said, ‘I do have feelings but at the moment I am choosing not to show them too much’.

He made good use of some individual sessions with us, completed his studies successfully and then went travelling abroad with friends.

Philip’s example highlights for us some important attachment issues in work with families. We see many parents bravely attempting ‘corrective scripts’ – to do it differently and better than their parents. However, without the benefits of their own childhood experience of a secure attachment base and comforting it was harder for them to learn how to do this emotionally for their children, even though they wanted to! Perhaps Philip sensed his parents’ core difficulties around this and in the midst of the major anxiety about his mother’s illness, blended in with his own anxieties about emerging as a young man into the outside world he had decided to try and do it alone. An effort that became too much for him.

Our work with Philip raised a number of questions for us. The trans-generational exploration allowed a story to emerge about traditions of difficulties and how emotions were managed in the
family. Importantly, it also allowed us to explore with the family their attempts to do things differently, their corrective scripts. This seems to us to be 'work in progress'. The family and Philip did not predominantly alter their attachment styles but possibly gained a little bit more of an ability to reflect about how they, for example, comfort each other. Importantly, by validating their attempts to try to do things differently, we perhaps allowed them all to feel a little more safe in experiencing a secure base with us from which they might in the future be able to shift their emotional style. As Philip so poignantly indicated to us, he had developed a way of coping which was adaptive for him and not something he wanted to or could easily give up. Our approach in short is not to try and change people's attachment styles but to assist them to have a little more flexibility or choice about whether they may also want to show their feelings in different ways.

References


Arlene and Rudi have been conducting joint workshops on Attachment Narrative Therapy for the four years and are collaborating on a new book for Routledge: Systemic Therapy and Attachment Narratives: Applications across Diverse Settings. Arlene is Professor of Clinical Psychology at the University Of Surrey and current president of the European Family Therapy Association; she has recently edited Narrative Therapies with Children and Their Families with Emilia Dowling. Rudi is Professor in Clinical Psychology at the University of Plymouth and works as a family therapist part-time in the Plymouth Child and Family Service. He has a clinical and research interest in attachment and eating disorders and deliberate self-harm. He has published a number of papers and books including Attachment Narrative Therapy (2006). He came out of Hungary in 1956 as a refugee, has three adult children and lives in the South West of England.

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Brian Cade

Geoff's colleagues were becoming worried about the long-term counter-transference effects on him of his intensive work with children and their early attachment narratives.