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ABSTRACT

This article proposes that recent developments in attachment theory, especially the move towards the study of representations, offer some helpful new directions for systemic family therapy. Some of the findings of a close association between early attachment experiences and the coherence of the corresponding narratives are reviewed. It is suggested that this offers a useful link for systemic approaches in showing how early interactions in families promote, not only particular emotional attachment patterns, but also shape the content and style of the narratives that are formed. These implications are then explored in the context of work with anorexia nervosa. It is suggested that commonly observed patterns, such as avoidance of conflict and apparent difficulties in discussing relationships and feelings, is consistent with trans-generational experiences of insecure/dismissive attachments. Some implications for systemic therapy with families are outlined and an illustrative case study is offered.

KEYWORDS

attachment, eating disorders, family therapy, narratives

The voice goes on in my head. I call it the anorexic minx. It's like a little person that gets inside my mind and takes control of my thoughts. The voice tricks me into believing that I am in control but I am not, it's in control of me. Dictating what I can and can't eat and how much exercise I should do. It never lets me rest. Being anorexic takes up all my time, it becomes a way of life. . . . Everything is controlled . . . Life is filled with thoughts of this illness. Anorexia has become my way of life. It is what I know. (Lucy, 1999)

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THIS ARTICLE CONSIDERS the contributions that attachment and narrative theories and therapies can offer to our understanding of the development and treatment of problems, with particular reference to eating disorders. More broadly, it offers an invitation to readers to think about how recent ideas from attachment theory can add to our understanding and use of narrative therapeutic approaches with families.

Narrative approaches

Drawing extensively from social constructionist theory, narrative approaches emphasize, for example, how problems in families can be seen to arise from 'problem saturated' conversation (Anderson, Goolishian, & Windermand, 1986). Similarly, White and Epston (1990) describe how pathologizing stories may come to dominate and restrict people's potential avenues of action. These stories, or narratives are fuelled by the underlying beliefs held by a family (Dallos, 1996). A major contribution of narrative approaches has been to locate these stories, not simply as internal to the family, but as drawn from the pool of culturally shared beliefs.

Family members and others may come to describe the young person in terms of pathologizing and totalizing language as seen, for example, when people are referred to as 'anorexics' or 'bulimics'. Such terms (as in the account above) may become internalized and over time come to shape and eventually consume the whole of a person's identity to the point where aspects of their lives, other than that related to problems of food, become marginalized. In families, some of the processes whereby this occurs have been described as 'problem saturated' conversations (Anderson et al., 1986). As a difficulty comes to develop, the focus of the family conversation may move towards a 'pathway to pathology' in which the talk shifts to an identification of problems to the exclusion of any talk which can recognize exceptions and competencies (Dallos & Hamilton-Brown, 2000; Eron & Lund, 1993).

A central ingredient of narrative therapies is to help people to resist this process by 'externalizing' problems and seeing them as destructive visitors, rather than as an indication of an inherent weakness. Individuals and family members are invited to consider ways that they can gather strength together to resist the problems. Such an approach is particularly pertinent to eating disorders in the light of the powerful processes of 'body fascism' – the pressures on women to conform to culturally valued ideas of beauty as slim youthfulness.

However, for many of us with a deep commitment to social constructionist ideas and a great affection for narrative approaches, using these ideas is not quite so straightforward. For some time, I experienced difficulties in enabling families to engage in conversations about their difficulties, their feelings, the impact of the problems on their relationships (and vice versa), where anorexia was the presenting problem. An exploration of the literature on eating disorders, revealed that many practitioners also reported these experiences. This suggested that possibly there was something about the willingness or the ability in such families to engage in therapeutic conversations. Although wishing to avoid the temptation to typologize families the following questions have been raised for me:

- Is it possible that there is some commonality in families with anorexia?
- Is it possible that part of this commonality is that they are more unwilling or anxious about engaging in such conversations than other families?
- Is it possible that they have some cognitive difficulty, which makes it harder for them to engage in such conversations?

Apart from these specific questions there is a broader, more fundamental question about how narratives develop in individuals and families. Even more broadly, there are some uneasy questions about the lack of developmental models in systemic theories. Family life-cycle models may be offered as an exception, but arguably they only offer a general and speculative account of the formation of each family member's internal worlds and narrative faculties. In contrast, recent developments in attachment theory focus on the development of narratives and people's ability to engage in reflexivity (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Main, Kaplan, & Cassidy, 1985). Attachment theory, despite its apparent emphasis on biologically based propositions, has come to offer some useful ideas about narrative processes.

Attachment theory and narratives

Attachment theory, like early systemic theory, employs a biological metaphor which views families as similar to self-corrective, homeostatic biological processes. Likewise, Bowlby (1969) described the attachment; for example, between a mother and a child as acting to maintain a comfortable level of proximity, safety and affection. Attachment theory is supported by a wealth of empirical studies and observations for example, Ainsworth (Ainsworth, 1989; Ainsworth, Blehar, Waters, & Wall, 1978) illustrated through the 'Strange Situation' (an observational/experimental study in which the mother and child are temporarily separated) that, on reunion, infants exhibit one of four main patterns of attachment styles: secure, avoidant, ambivalent and disorganized. Further to this, mothers in the 'Strange Situation' studies were seen to differ in how attuned they were to their babies' needs while engaged in play with them prior to the period of separations.

Bowlby (1969) emphasized that the accumulation of early experiences become internally represented for the infant as a system of enduring, emotionally toned beliefs and expectations about relationships – the child's 'attachment model'. The evidence from the 'Strange Situation' studies suggests that the infants appeared to have learned a set of expectations or a 'working model' regarding their mother's responses. For example, infants who consistently experience the parent as available, appear to develop a representation of the carer as available when needed and of an ability to deal with threat and distress. However, if the child repeatedly experiences the parent as unavailable or insensitive then the child appears to remain in a state of arousal and anxiety. This is seen again to lead to corresponding internal representations and, along with them, different coping strategies.

Attachment theory suggests that a central task for a child is to monitor the emotional availability of their parents. As this information is processed, different strategies are developed according to whether the parent has been found to be readily available as opposed to unavailable. The interesting point here is that insecure attachment strategies involve an excessive amount of cognitive and emotional effort:

> . . . because a secure strategy develops from confidence in the attachment figure's availability and responsiveness, children employing this strategy spend less time monitoring the whereabouts of their parents. This frees the child to deploy attention to other matters including play, exploration and experimentation. At a more cognitive level, the freedom to deploy attention allows the individual to step outside the attachment action loop and to meta-monitor internal models of self and parents. (Kobak & Cole, 1994, p. 275)

In contrast, both the avoidant and ambivalent strategies constrain a child to be excessively involved in attempting to dismiss attachment-related experiences or, alternatively,

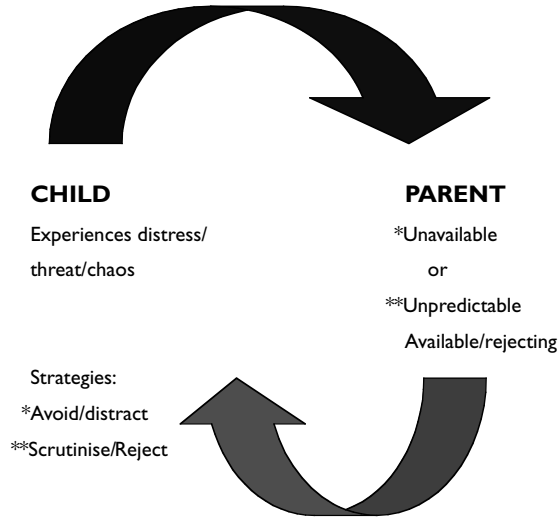

Figure 1. Attachment process shaping insecure attachment strategies.

to be hypervigilant about the potential to gain some affection and reassurance. The avoidant strategy can be seen to incur a similar cost despite a child appearing to be disinterested. Dozier and Kobak (1992), for example, found that adolescents who displayed dismissive strategies reacted with the greatest increases in physiological measures of stress (increased skin conductance – sweating) when taking part in the Adult Attachment Interview (AAI). This suggests that they continually attempt to avoid such topics and emotional encounters at a high emotional cost.

This process is illustrated schematically in Figure 1.

Similarly, Byng-Hall (1995) points out that, although it is useful to consider the nature of the primary attachments in a family, especially between the mother and her children, each family consists of a web of interconnected attachments. In particular, a child may play a role in regulating the nature of the attachments between his or her parents – the near/far distance regulation (Byng-Hall, 1995). At times, one or other child and a parent may 'emotionally capture' each other so that other family members are excluded. The nature of the attachments may also shift and alter according to a variety of crisis-inducing factors, such as inevitable life-cycle transitions, the birth of other children, children leaving home and other events including losses, illness, problems at work and so on.

Attachment narratives

> Every situation we meet with in life is constructed in terms of the representational models we have of the world about us and ourselves. Information reaching us through our sense organs is selected and interpreted in terms of these models, its significance for us and for those we care for, are evaluated in terms of them, and plans and actions conceived and executed with those models in mind. How we interpret and evaluate each situation, moreover, turns also how we feel. (Bowlby, 1980, p. 229)

For Bowlby the cumulative effect of our early experiences, especially of others' responses to our requests for care and protection when threatened or distressed,

becomes represented as a 'working model'. This can also be seen as a belief system, construct system or as dominant narratives (Dallos, 1996; Procter, 1984), reflecting a view of the world in terms of whether people are likely to be able or willing to meet one's needs, and a view of the self as worthy or unworthy of love and affection.

Research using the AAI fits with the earlier behavioural observations in that the accounts adults give of their childhood experiences can be similarly classified into corresponding styles: secure, insecure/dismissive, insecure/preoccupied, and unresolved. There is a considerable body of research which shows that there is a high level of agreement between childhood attachment experiences and classifications in terms of behaviours, for example, in the Strange Situation and the narrative styles that adults hold (Cassidy & Shaver, 1999; Main et al., 1985). For example, children who appear to have had experiences of avoidant attachment experiences later develop narrative styles which are dismissive. The experience of consistently not having our attachment needs met appears to predictably lead to a narrative style in which the importance of attachment needs, feelings, hurts and vulnerabilities are dismissed and people seem to find it hard to recall or to reflect on their experiences and the reasons for their parents' actions (Dallos & Laville, 2003; Ward, Ramsay, Turnbull, Steele, & Treasure, 2001).

Importantly, the work of Mary Main (Main et al., 1985) suggests that not only the *content*, but also the *form* of adult's accounts of their childhood experiences is shaped by their attachment experiences. The study of attachments as internal representations has largely been conducted through the analysis of accounts of early family experiences in the AAI which is a semi-structured interview, consisting of questions about memories and perceptions of the nature of relationships in one's family, including memories of how one's parents responded/ helped one deal with fears and anxieties. The interviewee is asked to provide specific memories to illustrate the relationship with each parent, possible explanations about why the parents acted as they did, and asked for their thoughts about the effects that these experiences may have had on them and their relationships with others.

Transcripts of the interviews are analysed for both the *content* of the accounts and their *form* or structure.

Coherence: A most significant aspect of the *form* of accounts has been found to be the degree of coherence, especially discrepancies between general descriptions and specific illustrations offered (Holmes, 1999). For example, some accounts start with statements that the attachment with a parent was close and good but, in contrast, considerable effort is required for the person to produce any examples and, when offered, these may appear to be quite contradictory:

> . . . a parent described her mother as 'wonderful', but then said that when she had broken her arm she could not tell her because her mother would be angry . . . the narrative is incoherent because it denies the unpleasant implications about the care given. (Byng-Hall, 1995, p. 49)

Reflectivity: accounts vary in the extent to which people are able to reflect on their experiences, for example, to remember how they felt, why they felt like this, how else they might have felt. Importantly, this also relates to their abilities to form ideas about other's internal states; for example, to be able to consider what might have been going on in their mother's or father's minds – their feelings, intentions, needs and explanations which may have guided their actions (Fonagy et al., 1991; West, 1997). This has variously been termed psychological-mindedness, sociality (Kelly, 1955; Procter, 1981, 1984) and 'theory of mind' (Baron-Cohen, 1997):

> The development of the reflexive self is, thus, intrinsically tied to the evolution of social understanding. It is through the appreciation of the reasons behind the actions of caretakers and siblings that the child can come to acquire a representation of their own actions as motivated by mental states, desires and wishes. (Fonagy et al., 1991, p. 203)

Eating disorders and disruptions of attachments

A number of clinicians and researchers have argued that attachment disruptions play a central role in the development of serious eating disorders (Bruch, 1973; Masterson, 1997; Palazzoli, 1974). A consistent observation has been that anorexia nervosa develops from significant disturbances in the relationships between the child and the primary carer (most typically the mother). Broadly these can be summarized as:

- the failure to develop autonomy from parenting figures, especially the mother, because of parental intrusiveness and over-control;
- rewarding of dependency of the child so she develops a compliant 'false self' – a 'good girl' as a defence against parental intrusiveness;
- a vulnerability and inability to express emotions, especially anger, which tend to become apparent in adolescence due to the stresses and demands of that period;
- an early confusion for the child about his or her bodily signals, e.g. need for food becomes confused with the parent's wishes and needs so that the child finds it hard to separate physically or emotionally.

More broadly, Minuchin, Rosman, and Baker (1978) have argued that although family dynamics are invariably complex and to some extent unique, some common features are observable. For example, it is suggested that there is a tendency towards a fear of expression of conflict and a tendency to attempt to avoid expression of feelings. A range of empirical studies (Chatoor, Egan, Getson, Mienville, & O'Donnel, 1987; Humphrey, 1989; O'Kearney, 1996) appears to offer some support for the clinical reports that see the development of eating disorders as being related to an experience of attachment for the child of intrusiveness and low emotional care. However, there is a great danger in offering a blaming and critical model of families, and especially mothers. Not least, there is the need to identify and pursue the possible origins of the mother's own anxieties and insecurities in clinical work (Byng-Hall, 1995; Doane & Diamond, 1994). For example, many mothers experience considerable anxiety at not being a 'good enough' mother. This notion may be shaped by culturally shared, but unrealistic, expectations about self-sacrifice, unflinching availability and consistent positive emotions towards their child. Such social pressure for women to conform to certain traditional stereotypes of thinness, concern with food and self-sacrifice (nurturing others rather than the self and denial of pleasure) can be seen to conspire to make this particular disorder more likely for young women. White (1983) has argued that:

> Vulnerability to the symptoms of anorexia is considered the outcome of a certain rigid system of implicit beliefs. This view is in conflict with opinion that the symptoms . . . are a mechanism of denial and rebellion, tantamount to personal survival or related to a battle for control. Instead, it is considered that the symptoms of the anorexic member reflect the way in which she is inadvertently putting her 'self' to one side and unknowingly colluding with, rather than rebelling against, family tradition . . . all family members . . . are considered victims of these oppressive beliefs. (White, 1983, p. 259)

Narrative styles and anorexic narratives in families

Typologies of attachment styles can become restrictive and simplistic unless we see them less as a 'truth' and more as a framework for thinking about the possible interpersonal dynamics that may have shaped the style and content of families' narratives and, most importantly, how these experiences may make it hard for families to engage in the process of therapeutic talk. Research by Ward et al. (2001) shows that there is a trans-generational pattern of insecure/dismissive attachment narrative styles in families with a young person suffering with anorexia (80% of the young women, and 70% of their mothers were rated as insecure/dismissive in their narrative styles). This confirms my own current research and clinical experience.

The cumulative experience of insecure attachments in childhood is represented in the types of narratives that people hold about these experiences. The most striking connections in the context of work with anorexia appear to be:

- *Difficulty in accessing memories of early experiences* – Results employing the AAI with this group suggest that memories of early attachments and relationships in families are hard to access and sparse in detail. This suggestion is based upon my own clinical experience and ongoing research with interviews of young people with anorexia and their parents. This suggestion is also supported by a number of related studies, as well as the recognized clinical problem of motivating this group to engage in therapy (Candelori & Ciocca, 1998; Fonagy et al., 1996; Kobak & Cole, 1994; O'Kearney, 1996; Treasure & Ward, 1997).
- *Difficulty or reluctance to engage in an expression of feelings and emotions* – A widely documented observation is that many of the families appear to be extremely wary of expressing any feelings, especially conflicts. Arguably, the level of distress may make this difficult but the parents, also, often appear to find it extremely difficult to describe and acknowledge positive emotional experiences with their own parents, and more generally appear to see such a discussion as irrelevant.
- *Denial of needs and pleasures* – There seems to be a tendency for family members to engage in self-denial and self-sacrifice. For example, Palazzoli (1974) has described the mothers as displaying an attempt to conform to rigid gender roles of nurturing others and denying pleasure and enjoyment of sexual intimacy. The repression of feelings and conflict, apparently so deeply embedded in anorexic dynamics, may relate to the deeply terrifying prospect that by admitting to intimacy needs the person once again risks rejection, denial and frustration. Furthermore, this experience of denial also leads to low self-esteem which is characteristic of anorexia and the feeling of being worthless and not deserving of pleasure including, centrally, pleasure through food.
- *Lack of coherence in the narratives* – Typically, the early childhood of the member of family with anorexia is described as having been happy and with no problems; they were well behaved, contented and well-functioning despite evidence of events to the contrary (Bruch, 1973; Kobak & Cole, 1994; Palazzoli, 1974). For example, the impact of the loss of a grandparent or crises for one or other parent are skated over and instances, or periods, of the child clearly not being happy are minimized or excluded from the over-arching view of them as functioning well up to the start of the disorder. The counter-evidence to the all-encompassing story of well-being often emerges in fragmented, sporadic admissions over several sessions.
- *Lack of reflexive narratives* – Both the person suffering with anorexia and family members typically display an apparent difficulty in contemplating possible alternative narratives (Kobak & Cole, 1994). There is considerable difficulty and seeming resistance to contemplating narratives that are alternative to the dominant medical and

intrapsychic explanations. It seems that there may be difficulty in an ability to reflect on one's own thought processes, to consider the possibility that others may see things differently and the ability to adopt a propositional position to one's own beliefs. This may go some way towards explaining the apparent difficulty that such young people and their families appear to have for example, with circular, hypothetical or empathetic questioning. Questions about how other members may feel and think, or how the interactions/conflicts between two members may influence the feelings of a third often elicit very brief replies if any.

These descriptions contain a suggestion of deficit or inadequacy, but this is not wholly the intention. In fact, the behavioural attachment styles, and the content and form of narratives can be seen to *'fit'* the interpersonal context in which the child is immersed. For example, if care is reliably not available (for a variety of possible reasons which are not the 'fault' of the carer) then it makes sense for the child to develop ways of avoiding disappointment and feelings of rejection.

Attachment narrative therapy

Although it is possible to consider people's childhood experiences as predominantly tending towards a particular style it is also likely that their experiences are more complex and unique. However, a consideration of attachment styles can help therapists to think about the content and form of the therapeutic conversations that they invite families into. For example, with a family showing predominantly dismissive styles the therapeutic orientation may be to encourage expression of feelings and thinking about relationships; whereas, with ambivalent attachment styles, towards attempts to generate more coherent and less contradictory narratives. However, these attachment styles are not exclusive and need not promote a prescriptive or simplistic approach based upon rigid classifications of families and their members in terms of attachment styles.

A tentative therapeutic approach is offered which has been developed with families in which a member is displaying eating disorders. This attempts to take into account attachment dynamics and the internal representations of these in each member of the family in the form of a set of family narratives or constructs (Dallos, 1996; Procter, 1981, 1984; White & Epston, 1990). This therapy consists of four stages:

- creating a secure base;
- exploring attachment narratives;
- considering alternatives;
- maintaining the therapeutic base.

The following is an example of the application of this approach in a family in which the predominant attachment disruption appeared to be with the father (Figure 2).

At the time Mary, aged 19 was attending an eating disorder unit, as a day-patient, for treatment of anorexia following a three-month period as an in-patient. She was living at home with her father and her older brother who was drinking quite heavily, which caused some concern – especially to his mother. Mrs M was living with her parents nearby having 'moved out' approximately six months before the start of Mary's anorexia. Mary had gone to university some distance away from the family home about four months after her mother left. She quickly lost weight and had to return home after six weeks and was admitted to a local eating disorder unit. After eight sessions of therapy with the family Mary left home to work in a hotel some distance away from the family. During this time

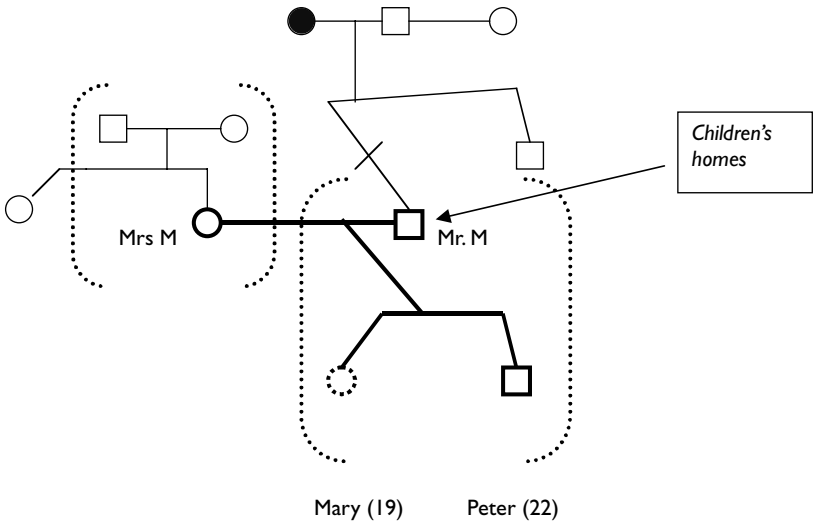

Figure 2. Case study – The M family.

monthly sessions continued with the parents. When Mary returned home, occasional sessions at intervals of six weeks or so continued to offer support and to monitor progress.

The relationship between Mr and Mrs M was complex. Mrs M came to the house every day to cook, clean and shop as if she had still been living with Mr M. Sexual intimacy had apparently ceased but there was considerable confusion as to the nature of the marital relationship. Although neither of them had a new partner it was not clear whether their relationship had ended or was current. Consistent with this Mary indicated that she felt confused about her parents' relationship and confided that she was very angry with her mother, partly because she thought that her mother had spread a false rumour that she and her father might have had an incestuous relationship.

A characteristic feature of the early sessions was that Mary seemed very distressed and cried continuously. Neither parent made overt attempts to comfort her. When asked what her sadness was about she repeated that 'people are lying to me, I don't know what is going on'. We wondered whether this was a comment on the ambiguous nature of her parent's marriage. It also seemed that she was 'triangulated' – caught in the middle. She was closely attached to her father, perhaps meeting his emotional needs and having consoled him when his wife separated from him. However, her position also appeared to elicit anger and jealousy from her mother who wanted to resume a relationship with her husband and had moved out as a protest at his emotional distance. It transpired that both of them had indulged in short affairs and Mr M confided in an individual session that Mary was the only person that he had ever told about his brief affair, assigning her an important role as his confidant.

An attachment perspective suggested that perhaps Mary was attempting to meet the emotional needs of both her parents, and especially her father. Part of our approach was to try to help her to move out of this triangulated position so that she could be more independent of her parent's relationship. Also, it seemed appropriate that the she could develop a more age-appropriate role with her parents in which she could both offer and expect some emotional care-giving without becoming consumed by trying to take care of her parent's attachment needs.

The narrative style of each of the family members was that Mary spoke very little and seemed angry and frequently fearful; Mr M minimized the possible emotional impact of

his childhood and generally presented as if there was not much to be concerned about; Mrs M seemed more positive about the value of discussing feelings and relationships but appeared to find it hard to formulate ideas about the possible connections between Mary's difficulties and their relationships with each other. There was a powerful process of Mary repeatedly showing extreme distress at points at which difficult feelings were raised (for example, regarding conflicts between the parents). Mr M would typically smile as if to say 'it is no big deal, I don't get emotional' and Mrs M would also halt the expression of feelings by 'giving up' and showing an 'it's hopeless' exasperation. Overall, there was a sense of shared 'rules' flowing from their dismissive narrative attachment style of 'it's best to avoid difficult feelings and it's dangerous to express our needs and vulnerabilities'. However, in contrast to many families in our experience with such problems, they shared a commitment to attending for therapy and did not appear to view us with a high level of distrust.

The therapy is described employing the phases indicated above.

Creating a secure base

In the first phase of the therapy a non-blaming framework was offered including an externalizing framework as to how we could all work together to resist the anorexia (see also Byng-Hall, 1995). It was made clear that the purpose of the sessions was not to look for blame and that we might never fully discover the causes. However, we would try to find ways of resisting the problem. The family were also asked how they felt about an approach in which we did not spend all of the time in the sessions looking at the anorexia but also spent time on other matters:

Therapist: You have probably spent quite a bit of time trying to understand how the eating problems have come about. One of the things we find often is that the anorexia can start to eat away at the young person's life until there is hardly anything left. So, if it's OK with you maybe we could spend some of the time talking about the anorexia and some talking about other things, friends, work, education, the future, so that when eventually we do manage to help Mary defeat the anorexia she will have a life ahead of her. In fact, anorexia is more likely to linger or try to come back into your lives if a person is bored, lonely, frustrated or dissatisfied with the rest of their life. How does that sound to you all?

Mary: Yes, that sounds reasonable to me.

Mr M: Whatever you think will help.

Mrs M: Yes, she does want to do things . . .

Therapist: I am not talking about these things changing quickly, . . . anorexia is very persistent and will keep trying to come back into Mary's life. It's a little bit like a spiral you feel like you are going round in circles but at each turn you are going forward a little bit as well. Anorexia likes to divide families and we find that working together, offering a united front can be helpful in keeping it at bay. . . .

Mr M: We will do whatever you think is helpful . . .

Exploring attachment narratives

Building on the general frame of needing to work together to resist the anorexia, the next phase of therapy can move into an exploration of different aspects of the relationships in the family, such as emotional closeness, divisions and conflicts; how they are able to meet each other's needs, offer support and help each other to manage stresses and problems. This includes exploration of how anorexia has come into their lives and what changes it has made to these relationships. Mary appeared to be very distressed in the early sessions

and repeatedly mentioned feelings that things were 'unreal' and that people were 'lying to her'. Eventually, she confided that she was particularly angry with her mother:

Mary: I would like to spend some time on my own with dad but it's not allowed.
Mrs M: I don't stop you . . .
Mary: But you give me such a hard time about it . . . I know you are angry about it . . .
Therapist: (to Mr M) It appears sometimes that you are sort of caught in middle, both Mary and your wife competing for your affection, . . .
Mr M: (smiling) I don't think so really . . . well perhaps
Mrs M: Yes, it does feel like that sometimes . . . I'm not sure that Mary likes us to be together.

Following this exploration of the current family dynamics there was an attempt to connect these to the parent's attachment histories. This was framed in terms of how their experiences might be influencing their ideas about Mary and what they could apply to help build a life for Mary and themselves without the anorexia. Part of this exploration attempted to discuss Mary's difficulties as not just related to the anorexia but as part of 'normal' development, for example, that becoming a young adult, moving away from home and becoming more independent involves difficulties for all families. This led into a discussion, with the aid of a genogram, of how each parent left home and, more broadly, into the nature of their relationships with their parents. During this discussion Mrs M described that she had moved out to start work and that her family had been close and warm. There had been few problems she felt. This sort of blandly positive account with lack of detail, or any memories of conflicts, is characteristic of dismissive narrative attachment styles. However, to our surprise Mr M had quite a different story to tell:

Therapist: So can you tell me Bill, how was it for you, becoming adult, leaving home . . .?
Mr M: Well I didn't really have a home. I was brought up in various children's homes, it was OK I suppose.
Therapist: Could you tell me a little bit more about that, where were your parents . . .?
Mr M: My mother was very ill and in hospital, she died in hospital when I was 5. My father drank a lot and carried on with various women. His answer to every problem was to have a drink. I thought it was terrible my mum lying in hospital while he was doing that, but what can you do?
Therapist: So what happened when your mother died?
Mr M: His girlfriend moved in with us and she couldn't stand me so I was put in a children's home . . .
Therapist: That must have been pretty tough for you?
Mr M: No, not really, I don't think about it, it doesn't really matter to me. You just have to get on with life . . . no point crying about it.
Therapist: Have you ever talked to anybody before about these experiences?
Mrs M: He has told me, but I'm glad he is doing it now . . . he keeps it all bottled up I think. . . .

This revelation from Mr M suggested that he had experienced an extremely insecure and sad childhood. His predominant way of coping had been to deny his feelings which Mrs M complained had driven her away. She remarked in a later session that, 'I love him but he won't let me get close to him, I don't know what is going on with him'. Despite attempts to deny his needs and distress, Mr M eventually admitted that he had been hurt by his wife's departure and we hypothesized that possibly Mary had stepped into the role of surrogate wife to meet her father's emotional needs. Mr M nevertheless denied that he needed emotional support from his daughter but at the same time described a daily ritual of massaging her feet to 'help her to relax'. We were concerned at the potential sexual

implications of this ritual. Even if sexual abuse had not taken place there appeared to be a confusing dynamic for Mary who may have been aware of her father's need for physical and emotional contact, but in providing this was incurring the wrath of her mother. In fact Mrs M had made allegations to this effect but appeared to be blaming Mary as much, if not more, than Mr M. These dynamics involving contradictory or denied sexual communications or 'double-binds' have been noted by other experienced practitioners (S. Essex, personal communication, 2003; A. Vetere, personal communication, 2003).

When she tried to leave this situation to go to university Mary possibly worried about both her parents, especially her father. Also, she may in turn have had some of her own attachment needs met by this close relationship with her father and had returned home when these conflicting needs became unbearable.

Considering alternatives

A number of the following sessions were focused on exploring the possible impact of Mr M's experiences and on the parents' relationship. Various narratives were explored; for example, the possibility that Mary may have been trying to keep the family together through the anorexia; that, perhaps, by going into an institution she was being loyal to her father by following in his footsteps; that Mary may have tried to deny her own feelings of loss of her mother by taking a critical stance towards her; and the possibility that they all felt they didn't deserve to have their needs met, sacrificing themselves by looking after each other:

Therapist: What developments have occurred since the last session?
Mary: The way people guessed at what I was thinking wasn't helpful . . . reasons why I won't get better, you said, to keep the family together . . . I don't think that's right. . . .
Mrs M: Mary said in the past she feels more secure with us apart. I don't think that's on the right lines about how I feel . . .

Mrs M developed this theme to indicate that she did want to be back with her husband but that this was hard because he was so emotionally shut off. Eventually, in an individual session and later in a session with the couple, Bill admitted that he still cared for his wife and wanted her back. It seemed that his reluctance to admit this was because he did not want to betray his special relationship with Mary. When Mary went away to work in the hotel the parents agreed that Mrs M would move back and that he would phone Mary to tell her. Meanwhile, Mrs M and Mary had been encouraged to re-establish their closeness and had been going out together. Mrs M had also insisted on taking Mary to the hotel where she worked. Some of these changes in the relationship patterns were explored:

Therapist: (to Mr M) how does it feel that Mary is perhaps getting closer to her mother.
Mr M: I just stay out of the way, it's OK for me
Therapist: How do you think Mary feels about this?
Mr M: She doesn't seem too bothered, she's going her own way now but we do talk sometimes.

An attempt was made to carefully monitor the changes in Mary's ways of relating to her parents and not to go too fast. Gradually, Mary was spending more time with her friends, had started to work again and although still struggling with the anorexia she was managing to avoid a re-admission to the unit.

Maintaining the therapeutic base

Some significant changes appeared to have occurred in the family. Mary seemed to be less triangulated between her parents and was becoming emotionally more independent and more connected to her mother. However, there was a danger that her father was cutting

off too quickly and this was upsetting for her. His history in childhood had been that his needs would not be met and there was a danger that he was feeling this again. Sessions at intervals of about six weeks were offered. The family initially stated that they did not need these and that things were greatly improved. Mrs M was particularly delighted at the changes, Mr M was more reserved but agreed. Mary still showed some doubts but agreed that therapy could halt. After a break of about four months the family took up the offer to have a review. The positive changes were continuing but some issues, such as Mr M working too hard, were raised. The pace of Mary's independence was discussed and the family said that they did do things together and that Mary did not feel 'pushed out' emotionally.

Discussion

An attempt has been made to outline some developments in attachment theory, particularly the exciting work exploring attachment narratives. It has been suggested that this offers a way of linking systemic and attachment models by outlining how early experiences lead family members to evolve different kinds of attachment narratives. In relation to anorexia it has been suggested that the characteristic patterns of early interactions resemble the patterns found in insecure and predominantly dismissive attachment styles. This goes some way to explain the common clinical experience that these families find it difficult to discuss feelings, relationships and conflicts. More specifically, often one or both of the parents appear to have themselves experienced insecure attachments, as in the case study provided. This both leads them to engage with their infants in certain ways and later makes it difficult for them to be able to talk about or reflect on this.

Some implications for therapy have been discussed, but one of particular importance is that, despite acknowledging the parent's role in the development of the disorder, it can help the therapist to take a compassionate view. For example, Bill appeared to have unresolved attachment difficulties from his childhood which left him feeling insecure but also made it hard for him to be able to think about his history. This can imply a pessimistic view – a 'cascade of pathology' down the generations, but this need not be the case. The evidence from attachment theory is that despite painful, insecure attachment histories it is possible to transcend these if people are able to develop coherent narratives about these experiences. It is suggested that a therapeutic approach here can effectively combine narrative and attachment approaches by helping families to start to explore their experiences from a secure therapeutic base. This approach also aims to foster abilities to 'reflect' on their past and current relationships. Specifically, the aim is to foster a move towards 'externalizing the past'. This involves discussing with them how they need no longer be prisoners of their past experiences and can move on to relate to each other emotionally in ways different from the traditions in their families.

The therapeutic context can be seen as offering a secure base from which families can explore their attachments (Byng-Hall, 1995). In part, this can involve the therapist offering a model, or examples, that it is safe to engage in self-reflection – perhaps by inviting family members to comment on how they are feeling about the therapist, whether they are angry with them, think the questions are irrelevant and so on. In addition, work using the AAI suggests that families may need to practice or even gain skills in becoming reflective. We need to think creatively about how we can help build these skills; for example, employing the use of micro-sculpts can make the conversation more concrete and watching videos of other families, or films, to facilitate reflection can also be helpful. It is possible that one of the active ingredients of multi-family therapy is that families find it easier to grasp interpersonal issues and to become more reflective by observing other families. To be both a part of a family system and to be able to

reflect on it is an extremely complex task, especially in the context of heightened anxieties.

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