All in the Family: Integrating Attachment and Family Systems Theories

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ABSTRACT

This article brings together ideas from attachment and systemic family therapy. There is both growing interest among systemic practitioners in the conceptual and empirical base of attachment theory and also the need for attachment theory to expand dyadic patterning to include its context in family functioning. We propose the Dynamic-Maturational Model (DMM) as being the most compatible and useful variant of attachment theory. With its emphasis on the functional nature of behavior, a dynamic view of development and change, and a focus on multiple attachments and representational systems, the DMM fits systemic concepts well. We propose that many apparent discrepancies between the theories will disappear if careful distinctions are made between observed behavior, functional explanations, and attributions. We conclude with theory-based recommendations for selecting treatment strategies. Several case examples that are theory based, counterintuitive, and tied to disorders that are difficult to treat are offered to give substance to our ideas.

KEYWORDS

attachment, dynamic maturational model, family systems, family therapy

ATTACHMENT THEORY AND FAMILY SYSTEMS theory each offer the other crucial areas of knowledge and expertise that, when combined, may yield a more comprehensive and effective basis for treatment. Melding the theories is logical because the theories share substantial common ground. Both conceptualize human functioning in *systemic* terms, avoiding symptom-based and pathology- or disease-oriented definition of problems, understand distress in *functional* terms, and describe *patterns* of dyadic and family functioning that are compatible. Attachment theory brings to this common ground (a) a clear focus on the functions underlying presenting problems, (b) extensive empirical work on developmental processes, including the development of intellect, affect, representation, and identity, and (c) systematic methodologies that translate

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naturalistic observation into empirically validated assessment. Family systems theory (FST) brings a focus on complex family structures and patterns of behavior, description of family dynamics in troubled families, and experience in treatment strategies and change processes. One might say that attachment theory addresses the developmental and diagnostic 'front end' of dysfunction more thoroughly whereas family systems theory addresses the complexity of development gone awry and treatment processes. Together attachment and family systems theories could yield an approach to family problems that is (1) both focused and flexible, (2) developmentally sound, (3) respectful of both individual perspectives and also those of dyads and larger family units, (4) amenable to assessment without pathologizing family experience, (5) relevant to prevention, and (6) structured to promote healing and adaptation.

In the following sections, we address attachment theory, then family systems theory and therapy, and finally ways in which we think the theories can be integrated to improve treatment. We begin with attachment theory because its strength has been early development and dyadic relationships. We proceed to review contributions from family systems theory, thus expanding from attachment theory's emphasis on children to FST's focus on families with children and from attachment theory's focus on dyadic processes to family systems theory's focus on more complex family units. This leads to the application of the full set of ideas from both theories to treatment.

It should be noted that, like other maturing theories, both attachment theory and family systems theory have variants. The variants within attachment theory tend all to agree on a set of ideas drawn from the work of Bowlby and Ainsworth, but their further development heads in incompatible directions. Thus, to discuss current attachment theory, certain fundamental choices must be made. On the other hand, the variants within family systems theory tend to emphasize different aspects of family functioning (e.g. structural, strategic, solution focused, narrative) without these being inherently incompatible with one another. This facilitates exploration of how the ideas generated by FST fit together and can be brought forward into a broader integration with attachment theory.

Contributions from attachment theory

The roots of attachment theory

Attachment theory was developed by John Bowlby (1969/1982; 1973, 1980) out of concerns for children, particularly juvenile delinquents and those separated from their

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parents during World War II. To understand these diverse conditions, Bowlby expanded his training in psychoanalytic theory to include ethological theory, general system theory, and emerging theory on information processing. He proposed that the roots of psychological disorder lay in the unavailability of protective attachment figures and that adults' recall of trauma referred to real events, albeit possibly recalled with distortion. His concern for children set attachment theory apart from other theories of psychopathology by placing development ahead of dysfunction, rather than trying to explain retrospectively how adults' dysfunction might have occurred.

Mary Ainsworth applied Bowlby's theory in two ground-breaking studies. The first used naturalistic observation of mother–infant dyads in Uganda and helped to establish both the importance of individual differences in maternal behavior and also the applicability of attachment theory across diverse cultures (Ainsworth, 1967). The second used naturalistic home observation of American mothers and babies over the first year of life, followed by systematic observation at 11 months in a procedure that would become the 'gold standard' of attachment, the Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth's work underscored the importance of detailed description of behavior and, in addition, provided attachment theory with (a) a firm developmental perspective, (2) a tradition of empirical work preceding applications, (c) an assessment methodology (the Strange Situation), and (d) the ABC patterns of attachment.

Later work demonstrated that differences in mothers' sensitive responsiveness at home were related to differences in infants' attachment to their mothers at 1 year of age as well as to differences in children's later development. Specifically, emotionally rejecting mothers, that is, those who were displeased by infants' negative affect, tended to have infants who turned away from them when reunited after a brief separation. These infants were described as using a Type A strategy of inhibiting the display of negative affect. Mothers whose response was unpredictable tended to have infants who were emotionally labile and mixed in their feelings about closeness to the mother (both desiring it and not). These infants were described as using a Type C strategy of exaggerated display of mixed negative affects. The third group of mothers was both warm and predictably protective of their children. After a brief separation, their infants sought close bodily contact and then explored near the mothers. These infants used a Type B strategy of showing affect without inhibition or distortion.

A number of researchers have modified attachment theory to fit the behavior of populations at high risk, for example, of neglect, abuse, suicide, extreme emotional distress and older children and adults. The most widely used approach, Main's ABCD model (Main & Solomon, 1986), adds disorganization (Type D) as a fourth category. Empirical studies show that Type D is associated with risk, but it does not differentiate risk from nonrisk well and does not differentiate among types of risk (Crittenden, Claussen, & Kozlowska, 2007; Solomon & George, 1999, 2008; Spieker & Crittenden, in press).

One of us (PMC) took the opposite approach of looking for additional organizations that helped children to protect themselves from severe threat. In my dissertation, carried out under Ainsworth's guidance, the threats were child abuse and neglect and the new organization was an alternation of A and C strategies (A/C; Crittenden, 1983). Applying this approach to older children and adults led to the Dynamic Maturational Model of attachment and adaptation (DMM; Crittenden, 1995, 2006, 2008). The DMM is based not only on attachment theory, but also on my training as a behavioral and family systems therapist. We propose that the DMM is more clinically applicable than the ABCD model and also more attuned to the systemic structure of FST. For these reasons, we use it as the basis for integration of attachment with family systems theory and therapy.

The Dynamic-Maturational Model of attachment and adaptation

The DMM applies attachment theory to the experience of endangered people. Bowlby's thinking about separation and loss is expanded to include all kinds of danger, including physical, emotional and sexual harm, and Ainsworth's ABC patterns of attachment are seen as self-protective strategies learned in the context of particular attachment relationships.

The DMM and danger Protection of self and progeny is a biological imperative. It is seen in the DMM as the central goal of psychological and behavioral functioning. That is, if a sufficient number of individuals do not live, reproduce, and protect their progeny to reproductive maturity, not only will the individuals die, but in addition, the species will become extinct. These functions reintroduce sexuality into the notion of adaptation and place adaptation in an interpersonal context.

Attachment as interactive and dynamic It is ironic that Bowlby's discovery of systemic theory and Ainsworth's focus on dyads' reciprocal organization over time has devolved into a broad understanding of attachment as a stable personal characteristic. In the DMM, it is quite the opposite. 'Attachment' is always a relationship term, it always implies reciprocal processes, and it is ever-changing (dynamic!). Indeed, when it becomes too personal (i.e. not adapting to new people) and too stable (i.e. not adapting to new situations), it is almost always maladaptive and less functional in terms of protection and reproduction.

Expanding the array of self-protective strategies The DMM gives neurological and physical maturation a central role in children's ability to construct strategies to cope with threat. Thus, the DMM offers a developmentally increasing array of possible strategies. These begin with Ainsworth's strategies for infants, adding increasingly complex strategies as children mature. These strategies retain the Ainsworth's ABC nomenclature and carry the labels used by Bowlby whenever he discussed the pattern first (e.g. compulsive caregiving, compulsive promiscuity, compulsive self-reliance; see Figure 1). The DMM adds a connecting theoretical structure that (a) suggests a greater array of patterns and (b) explains how these are tied to information processing.

Information processing and strategies Information processing underlies the strategies. Findings from cognitive and trauma research inform understanding of individual differences in self-protection and adaptation. In the DMM, physiology, cognition and affect are three ways of representing experience, each suggesting a response that might protect the self or one's progeny. Somatic information includes genetic, epigenetic, cellular, and organic functioning. Cognition is based on repeated temporal sequences. It operates on principles described by learning theory. Affect is based on intensity of stimulation with arousal-elicited feelings becoming associated with dangerous and safe contexts. When the three representations are congruent, action proceeds unimpeded. When they are different, the individual faces a dilemma: act quickly on one or delay long enough to resolve the discrepancy. Quick action creates risk of error; careful thinking creates risk of danger.

Transformation and representation Physiology, cognition and affect can be omitted from processing (physiology: 'No, I didn't feel anything'; cognition: 'I can't recall', 'I don't know'; affect: 'It hurt my *mother* to see me bleeding'). All three can be distorted by exaggeration (always, never, very, very, etc.) or minimization (a bit, not really, etc.), and

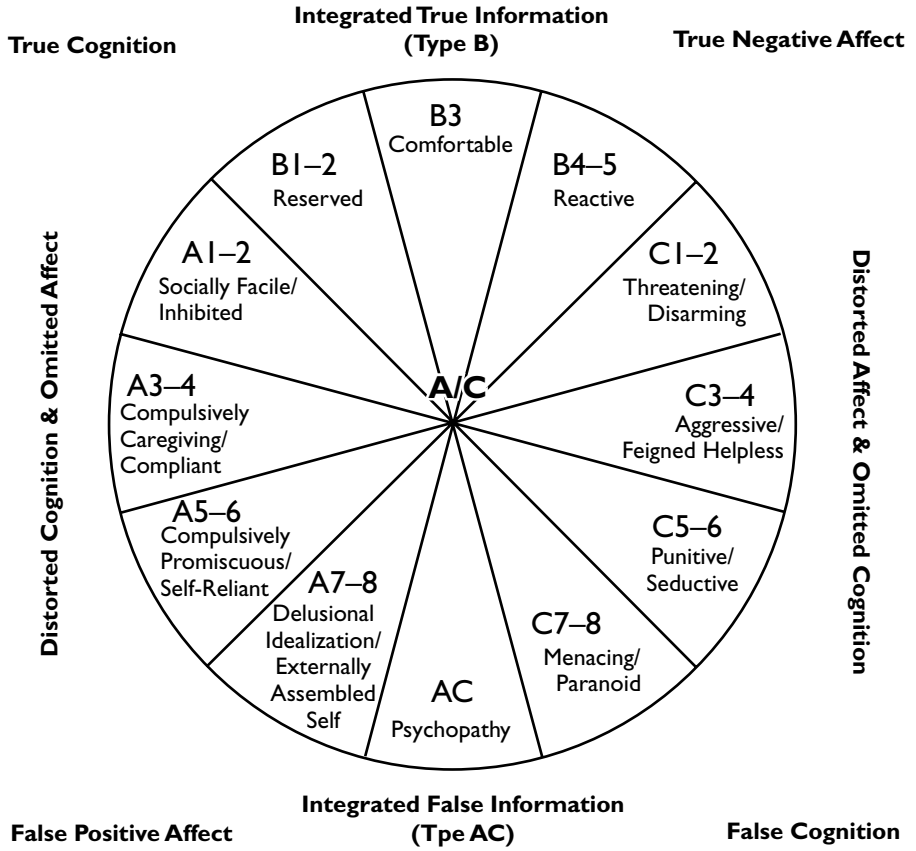

Figure 1. A Dynamic-Maturational model of self-protective strategies.

all can be falsified and used deceptively. False somatic states, false cognition and false positive affect can leave others unprepared if one acts on the hidden information. These transformations are used to organize the various behavioral strategies as shown in Figure 1.

Physiological states (somatic states), cognition and affect can be represented in many ways (see Figure 2). Somatic information can be represented (a) implicitly in organic states, that is, a knotted stomach or skin eruptions or (b) explicitly and verbally in 'body talk' about the physical state of the self; somatic representation is sometimes the only sign of trouble in an otherwise 'adapted' person, one with psychosomatic distress.

Cognitive information can be represented (a) implicitly and nonverbally in action, that is, it can be enacted preconsciously (*procedural* memory), or (b) explicitly and verbally in generalized *semantic* statements. Procedures are routines that one carries out repeatedly without conscious awareness, that is, they are 'enactments' in FST terminology. Semantic memory consists of contingencies and expectations drawn from procedural regularities. The basic semantic form is a when/then or if/then statement such as, 'when my mother has a headache, she becomes angry. If I pester her, then she will scream at me'. Often, however, the descriptive quality of semantic memory is distorted to a prescription, what one ought to, should or must do. Too great a focus on prescriptive

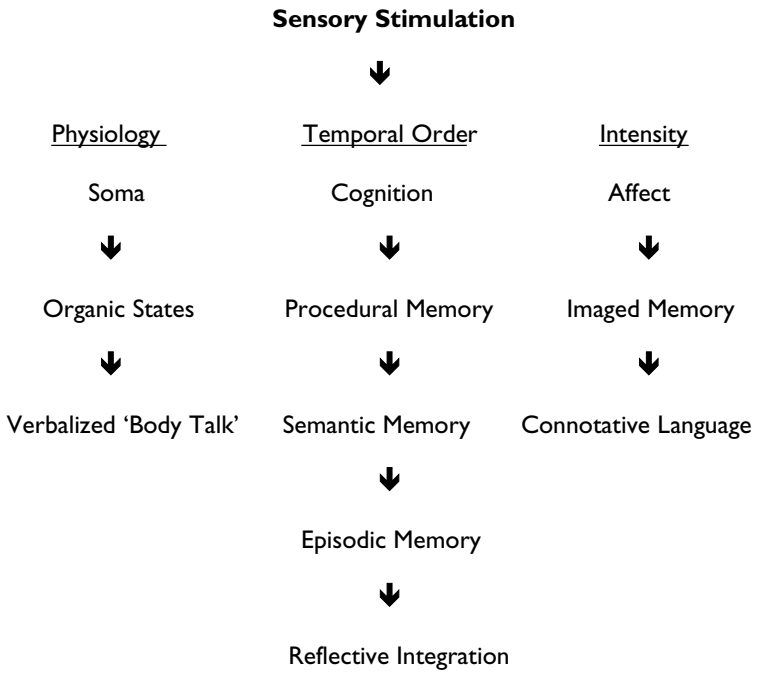

Figure 2. Representational systems as a function of somatic, cognitive and affective information organized in both developmental order and also order of psychological complexity.

semantic statements can lead to discrepancies between what one says and what one does. This can lead to confusion for others to be able to understand and to predict the person's actions and also difficulty for the person in self-awareness and in managing relationships and decision-making processes.

Affect can be represented (a) implicitly in sensory *images* (visual, auditory, gustatory, tactile, and olfactory images) of one's context, or (b) explicitly and verbally in *connotative language*. For example, certain smells (your mother's perfume, alcohol on your father's breath) can trigger powerful feelings of comfort or threat. Use of evocative words (e.g. detest, pighead) can both convey intense feelings and also elicit feelings in others.

These six forms of information can be integrated to create narrative *episodes*. In addition, all can be made conscious and reflected upon to generate new and more accurate information. *Reflective integration* enables us to resolve discrepancies, reduce distortions of information, and adapt our response to our current context. However, because verbal processing and reflective integration proceed slowly, threatened people less often use verbal representations and may resist reflecting.

Development and transformations Only the simplest transformation, omission, can be made in infancy whereas distortion and falsification take greater maturation. Verbal representations cannot be generated until after the third year of life. Reflective functioning first becomes possible at about 7 years of age, but is not fully mature until the mid-30s. Consequently, children's representations are necessarily constrained as compared to those of adults. Management of complex or ambiguous situations requires the assistance of attachment figures. This occurs through open communication in which

positive and negative feelings can be processed and also through scaffolding by the parents to assist children to understand increasingly complex situations. To do this, parents need to be able to see things from the child's perspective, communicate that they understand the child and offer alternative perspectives and elaborated explanations attuned to the child's readiness to develop complex understandings.

Information processing and strategies Variations in information processing combined with Ainsworth's ABC strategies generate a psychological model of the behavioral strategies. Type A strategies are more 'cognitive' in that they rely more on experienced temporal contingencies than on negative feeling states to predict outcomes and organize behavior. Type C, on the other hand, involves organizing strategic behavior on the basis of current feelings states. Type B involves flexibility in being able to choose between cognition or affect to organize behavior. This implies taking the context into account when considering the potential appropriateness of strategies. When somatic information is not integrated into the strategy (A, B, or C), somatic expressions are often observed.

An important attribute of this model is the transformation of a categorical model into a dimensional model (with the horizontal dimension being extent of integration of physiology, cognition and affect and the vertical dimension being the degree of transformation).[1] With a dimensional model, there can be varied presentations of the strategies as well as intermediate strategies. For example, between A1–2 and A4 (compulsive compliance), we can describe compulsive performance (A4, fearing only loss of love and approval and not punitive punishment). This gives the DMM greater flexibility to describe and explain variations in human behavior.

In the DMM, no strategy is necessarily the best strategy for a particular problem. It is the interaction of strategy with circumstance that defines the use of a strategy as adaptive or maladaptive. On the other hand, because life circumstances invariably change, flexibility of strategy and appropriateness of strategy selection become crucial; these are the advantages of the mature Type B strategy.

Danger, information processing and strategies Danger heightens the intensity of learning. However, when learning takes place under dangerous circumstances, the learning may be limited and selective, that is to say, at risk of distortion. That which is learned is given priority and will be relinquished very reluctantly, especially when threat is perceived. Consequently, when children are not sufficiently protected, they learn about danger, but they learn within the limitations of their maturation. In other words, they learn, but in a distorted manner. When conditions are constant, this 'immature' strategy usually functions adaptively. However, when conditions change, for example, through maturation, the strategy may become maladaptive. Major change periods include turning 2 years old, beginning school, puberty, the transition to adulthood, and becoming a parent. Each is marked by an increase in referrals to psychotherapy as well as a change in the sorts of dilemmas that children face and consequently the types of problems that are presented.

Assessment One strength of attachment theory is that its central constructs have been operationalized in assessments (e.g. the Strange Situation, the Adult Attachment Interview). The assessments (1) are developmental (with different assessments for infancy, toddlerhood, the preschool years, adolescence and adulthood); (2) are drawn from careful observation (as opposed to self-report); (3) use regulated mild danger to elicit the strategy; and (4) are always being modified as discrepancies are identified, for example in cases that do not fit the expected patterns. These assessment have been

used to validate theory, provide guidance to therapists and courts, and generate new information.

Taking the DMM to the family level Families are the primary means by which individuals accomplish the functions of protecting the self, reproducing, and protecting the next generation. When these functions are jeopardized, strategic functioning is activated. Knowing in detail how this occurs could help clinicians to cut through the screen of symptoms, problems, and complaints that family members bring to treatment to find their roots in threats to these essential functions.

Some early attempts were made at connecting constructs employed to describe family configurations with the dyadic strategies described by Ainsworth and colleagues (Hillburn-Cobb, 1998). However, such attempts have been limited in number and so far have produced mixed findings. One reason may be that the families are highly complex and an initial starting point should be to limit the focus to processes in triads, which some systemic family therapists regard as the fundamental building block of family life. That said, the DMM notion would be that all levels of organization (from genetic through interapersonal, dyadic, triadic, familial, etc., to political, cultural and societal) are crucial, with none being privileged over the others. Instead, our choice of focus might best be explained by the availability of 'technology' to study each type of organization.

A crucial aspect of moving to the family level is to recognize that families are seen in terms of relationships which operate in terms of *mutual influence.* They are composed of individuals in an array of dyadic and triadic relationships, with each of these consisting of patterns of interaction that are continuing, recursive, mutually influencing patterns (reciprocal causality). Each of these relationships can be conceptualized both in terms of the individual experiences of each member and also in terms of the relationship between them.

A contribution of systemic family therapy has been that it is possible to describe families not only in terms of the sum of their individual experiences, but also in terms of the patterning of their relationships. For example, Watzlawick, Beavin, and Jackson (1967) and Watzlawick, Weakland, and Fisch (1974) described how dyads could show patterns of complementary and symmetrical escalations. They also suggested that any dyad was potentially unstable and needed the input from a third person to achieve stability. The implications of this for single parents with one child could be powerful, informative, and unsettling for current family policy.

The shift in level of organization from individuals to dyads to families means that we cannot apply the same intrapsychic constructs, such as thinking, feeling and reflecting, to families. For example, when a parent speaks to all the children at once, each child hears the parent separately and assigns meaning to the communication based on their unique development and history with the parent. Thus, one communication may affect many relationships and result in several different responses. Nevertheless, we can see how their level of disagreement, polarization of their explanations, intensity of their emotional reactions and so on may escalate and increase. A similar situation can be seen in terms of a family therapist whose behavior is perceived differently by each family member. However, what can also be seen is that there may be an increasing polarization, or alternatively increasing agreement about how the therapist's communications are viewed by the family. An important attachment feature is that the level of trust in the therapist by family members may show an overall increase as the therapeutic relationship – a secure base – develops, or it may decrease if the array of individual and dyadic reactions is not adequately accommodated by the therapist.

As an example of utilizing individual, dyadic and family lenses, we consider the case of some professional women who experience postnatal depression. The women may experience a destabilizing change of role, including anxiety that they have to depend on partners or family when they had previously striven to be independent and self-sufficient. Women in these circumstances are often given medication or CBT, either of which might relieve their symptoms. Our observations of dyadic interactions suggest that sometimes, after treatment, the mother's sad mood will have become false positive affect and her semantic statements will have changed from expectations of futility to false prescriptive statements of enjoying mothering. The proof of the success of the treatment is in the baby's behavior and in the relationship between the mother and the infant. We have found in many such cases that before treatment the babies looked sad and avoided eye contact with their distant and affectless mothers. After treatment, the mothers looked bright, but the babies were unchanged and there were no *mutual, reciprocal and positive exchanges* between the babies and their mothers. Moreover, the mothers' positive semantic statements were often inaccurate. For example, one mother commented brightly on how her silent, sad baby was 'so chatty today'. This mother performed like a good and happy mother, but she did so without reference to her baby. Some of these mothers used a strategy of compulsive performance, trying very hard to please and excel in what was expected of them. After childbirth, they felt threatened by their inability to excel in all their roles concurrently and this underlay their depression.

Individual treatment may relieve the symptoms of depression without resolving the underlying problem. Likewise, mother–infant treatment may only teach the mother to act falsely bright in ways that make her feel like a good and competent mother. This outcome can look, if one focuses on the mother's behavior, as if the interactional process has changed between infant and mother, but we may be deceived by false prescriptive words and false positive smiles. Success at ameliorating the mother's depression and baby's sad isolation depends upon mutuality, shared pleasure, and context-adapted change in the dyadic process. We need to look for subtle cues in both individuals and in how these fit – or do not fit – together at the dyadic level. If the mother's change is only a change in what behaviors she displays and not an interpersonal change, then someone else must adapt to make the mother's appearance of being happy sustainable.

Who? A child! Maybe the baby, maybe an older sibling, maybe both. How? By becoming compulsive caregivers to the mother. That is, by themselves assuming a false positive strategy, children (even infants) can accommodate their mothers' limitations in ways that permit the mothers to slide through this major life change without changing. That is, without lowering their standards of perfect performance, such mothers can perform 'perfectly' in old and new roles – if their children accommodate by asking for little and giving care to their mothers instead.

Alternatively, the father might increase his caregiving of the mother and take over some of her duties, thus allowing her to both retain her compulsive strategy and also perform well. If, however, the father used a Type C strategy of expecting to receive caregiving and resenting the mother's focus on the baby, he might also increase his own demands on her. If, in addition, the baby was too distressed to become a caregiver, then possibly no one will change to accommodate the mother's strategy and someone will become symptomatic.

This example of a triangulating process suggests that the development of each individual and the strategies used within each dyad may need to be addressed to resolve the symptoms of one individual in a way that does not harm other family members. In addition the dyads need to be seen as interwoven within a wider family pattern. Hence, postnatal depression may be both a personal problem and also a family problem

requiring formulation and therapeutic input at several different levels that exceed individual treatment of the women.

Compulsive performance is not a 'bad' strategy and we need to understand the pressures and conflicting demands that many women experience from a combination of their personal history, familial and cultural expectations. Indeed, compulsive performance generates many achievements that society needs and values. We reward such performance well. But, as the example above indicates, it is not the best strategy for all circumstances. Every strategy is adaptive in some context and maladaptive in others. Instead of attempting to eliminate 'bad' strategies, we might want to make their useful application explicit so that their use can be restricted to those situations. For example, enabling new mothers who experience depression to discover that 'good enough' is really enough when one has several important and competing priorities might enable them to employ a more balanced strategy. However, when extreme self-protective strategies have been employed to protect the self from childhood threats, they tend to be applied too widely later. It is the inappropriate application of strategies that is maladaptive and that leads to the need for psychotherapy.

These ideas from the DMM suggest that therapists' attention should be directed toward (a) resolving actual threats to survival and reproduction and (b) correcting misperceived threats when these are the presenting problems. That is, DMM treatment would be 'solution focused', but the nature of the actual problem might not be understood exactly as the family members present it.

Family systems theory and therapy

Background

Both attachment and family systems theories were conceived in the postwar years when limitations of psychoanalytic and learning theory were being articulated and when there was an interest in systemic processes and the biological roots of behavior. Nevertheless the theories have developed separately, because, although integrations have been proposed (Byng-Hall, 1991; Erdman & Caffery, 2003; Johnson, 1996; Kozlowska & Hanney, 2002), the two approaches have never quite merged. Instead, they seem to have met occasionally, talked, noted some similarities, but also differences, and moved on to develop in their own ways.

Systemic family therapy

Family therapy initially developed out of a variety of strands one of which was attachment theory. In fact Bowlby has been hailed as one of the originators of family therapy because he was one of the first clinicians to suggest the idea of meeting with all the members of a family to help resolve their problems. In the 1950s, concepts from the emerging discipline of cybernetics and systems theory were employed by a number of therapists and researchers. Don Jackson (1957) offered a convincing analogy of how troubled families could be seen as self-maintaining systems which had evolved to a point of 'homeostasis' or 'stuckness' in their interactions, with problematic behavior functioning to maintain the problem. This counter-intuitive formulation indicated that, despite the family members' protestations that 'all would be better if they did not have the problem', they could be seen to behave in many ways that served to maintain the problem.

The incorporation of ideas from systems theory into clinical work with families came to be known as systemic family therapy (SFT). It offered a radical move to an interpersonal, relational view of clinical problems and away from the intrapsychic and

individual orientation of the preceding psychodynamic and behavioral models. Rather than viewing maladaptation as resulting from individual deficit or pathology, problems are seen as resulting from relationship processes (Dallos & Draper, 2005). One unifying idea was 'nonsummativity', that the whole is greater than the sum of its parts, a view that the functioning of families could not be reduced to the sum of their individual members. Consequently, concepts such as family hierarchy, boundaries, processes, symmetrical and complementary escalations and shared belief systems emerged as valid conceptualizations to embrace the idea that the family processes were related to, but at a different and distinct level of explanation than individual processes.

Attempts to find links between individuals' internal states and displayed problems to patterns of family dynamics were central to early systemic family therapy. Much effort was devoted to finding such links, for example the double-bind theory (Bateson,1972), Bowen's (1971) notion of psychosis as resulting from trans-generational patterns shaping the development of 'a fragile, undifferentiated ego', Minunchin, Rosman, and Baker's (1978) model of psychosomatic families and Palazzoli, Cecchin, Prata, and Boscolo's (1978) ideas of covert and incongruous communicational processes in families with members with a diagnosis of anorexia and psychosis. These interests also led to the development of various research-based models such as the circumplex model of family life (Olson, 1989) which described families as being organized around two dimensions: Cohesion and flexibility. These dimensions also embraced some early structural SFT concepts, such as enmeshment and disengagement (Minuchin et al.,1978) and attempted to identify which family patterns linked to which problems. It has been suggested that these dimensions map unto findings from attachment research, for example Hillburn-Cobb (1998) offers evidence of a correspondence between disengagement and enmeshment and Types A and C, respectively.

Many of the pioneers of the SFT movement (e.g. Jackson, 1957; Minuchin et al., 1978; Palazzoli, Cecchin et al., 1978) came from psychoanalytic backgrounds and maintained a strong interest in linking individual experience, unconscious dynamics and 'problems' with family processes. A connecting thread was the idea of the 'function' of a symptom for the family which was also linked to homeostasis in families. This reflected the psychodynamic concepts of the 'unconscious function' of sympoms in that the symptoms shown by one member of a family were seen as protecting the family from other greater dangers. For example Palazzoli, Boscolo et al. (1978) described the destructive behavior of a young teenage boy as an attempt to preserve the privileged emotional relationship (attachment) that he had with his single-parent mother. This was seen as being threatened by the arrival of a new man in her life. Ferreira (1963) proposed the concept of the 'family myth', a shared distortion of the situation in terms of a story about the need to cure the symptom. Others, such as Minuchin et al. (1978) and Haley (1976), saw problems as emerging attempts to solve family dilemmas which instead made matters worse. For example, a couple's solution of detouring their marital conflict through a child could hold a solution of not forcing a showdown about their marriage with the risk of potential separation, but had the negative effect of the child becoming psychosomatic (which can be addressed as a somatic representation that is both nonverbal and also unintegrated with outer representations; see Figure 2).

These approaches emphasized family structure, social roles and processes to make sense of the development of particular problems. However, there was also an emphasis on the role of cognition and meaning making in families. Watzlawick et al. (1964, 1974) suggested that people's different individual punctuations, their explanations of events in a relationship, could lock together to produce mutually self-maintaining patterns. In his classic example of a cycle of pursuing and distancing in a couple, one partner may

perceive the other in terms such as 'nagging', emotionally suffocating and consequently see themselves as having to 'respond' to their partner's behavior by 'withdrawing', seeking distance and taking time away from the other. In turn, their partner may see the other as continually 'withdrawing' and organizes their behavior to seek contact, intimacy and 'pursuing' them. Each partner can be seen to be making a personal choice, but it is based on a partial understanding of their interactional cycle. Each omits the wider systemic recursive picture of how their own actions trigger their partner's actions, thus capturing them both in a self-maintaining cycle. It is also important to note that the description of such interlocking cycles of actions and beliefs tended, in the early systemic literature (with the exception of Minuchin's approach and some with psycho-dynamic links), to overlook how emotions fuel such patterns. As examples, the couple mentioned may fear the risk of losing each other as attachment figures, thus using cycles of pursuit and withdrawal to embody core patterns of dismissing vs preoccupied attachment strategies for each partner acquired from their childhoods.

These efforts at linking patterns of family dynamics with particular types of disturbance were eventually critiqued as being reductionist, modernist and potentially family blaming (Hoffman, 1985; Sluzki, 1983). Further, there was a distinct lack of empirical evidence to support them. More widely, the focus on identifying possible connections between family dynamic and distress led to such an outcry that legal injunctions were taken out in the USA preventing research on family dynamics, for example, regarding the potential links between family processes and schizophrenia. This is an extremely sensitive and complex issue, but it is also salutary to note a raft of recent research that has found powerful evidence of an extremely high rate of undetected physical, sexual and emotional abuse in people treated for psychotic problems and, more broadly, of links to a variety of severe psychological disturbances and trauma in families (Read, 2005; Read, Agar, Argyle, & Alderhold, 2003). Perhaps family therapists are in a difficult position here: we wish to work alongside families in nonblaming and neutral manners, but at the same time we may need to acknowledge that family members sometimes also act with each other in ways that result in unintended distress and trauma. Thus, a crucial issue may be differentiating intentions from outcomes (Crittenden, 2008).

Looking at triangles

One of the most enduring ideas to emerge from SFT practice and research was the notion of triangulation. Minuchin (1974), and Minuchin et al. (1978) argued that families may engage in a variety of triangular processes: when parents were involved in conflict, one common process is to detour their conflict by directing their attention onto a child, perhaps focusing on and possibly amplifying his/her problems. It was argued that a child could sense the distress and tension between the parents, for example, in raised voices, and the resulting distress shown by the child would be a point of focus and serve to distract the parents from their conflict. It could eventually become established as a way of avoiding their difficulties. A second triangular process, cross-generational coalition, was seen as when each parent tries to recruit a child unto their side against the other parent, or alternatively where one parent shows excessive concern and involvement (enmeshment) with a child while the other parent becomes emotionally distant (disengaged). The focus on triangles can be an important bridge between systemic and attachment perspectives. It allows us to see a child as functioning in both direct dyadic relationships with each parent and also the relationship between them (Pallazoli, Cirillo, Selvini, & Sorrentino, 1989). In effect, the child can be seen as having an attachment strategy with each parent, but having those strategies function to meet parents' needs in their relationship without the child's awareness. The situation for the child becomes

increasingly complex and confusing, especially when there is no open discussion in the family about what is going on, what people are feeling, what their intentions are and so on. In such situations, children and their parents may become increasingly confused about the causes of events and their own role in the problems.

We can illustrate some of the dilemmas through the experience of a young woman who had been suffering with anorexia. RD worked clinically with her and her family and also as part of a research study exploring shared attachment themes in the family (Dallos & Denford, in press). Carla describes poignantly her experience of a cross-generational coalition regarding her parents relationship and a sense of how this related to the development of her eating problems:

> The only thing I ever hear them talking about is me and if I didn't have this [anorexia] it's kind of like, would everything fall apart, at least it's keeping them talking. And they won't argue while I've got this because it might make me worse. So um . . . that's kind of bought, sort of like, I'm not in control as such but I've got more control over the situation that way. (Dallos, 2006, p. 189)

Carla's account illustrates how she felt herself to be tangled in the relationship and conflict between her parents. Seeing her experience in terms of a triangular relationship provides a powerful bridge between attachment and systemic perspectives. Attachment theory emphasizes that children need and seek protection from danger. In Carla's case, each parent could offer a supportive relationship with her, nevertheless the relationship between her parents negated this, providing a context of fear:

> They used to hate each other so much I always used to be so scared that one of them would do something stupid and I would come home and, I used to hate coming home just in case something happened. And they've both got the worst tempers, even dad . . . dad's is rarely seen but it is really bad.

Her parents' relationship left her feeling anxious and in danger such that her anxiety came to pervade her dyadic interactions with each of them. Moreover, she frequently felt drawn into taking sides:

> They used to really hurt me because they used to play each other off . . . And they would be like 'Go on tell me all the bad stuff about the other one'. And I used to sit there and think to myself I am made up of half of each of these people and they hate each other and do they hate me? That used to play on my mind for ages when I was really young and that was the limit of my thought, I didn't analyse it further.

Moreover, despite showing considerable understanding of her situation, Carla does not take her parents' perspective. Possibly, being inside such a triangle, led to Carla's organizing a C5–6 strategy of insisting, at all costs, on her own perspective and fearing loss of protection altogether if she bent and considered her parents' perspectives (cf Ringer & Crittenden, 2007). At other times, she showed an attempt to distance herself from negative feelings, blaming herself and taking responsibility ('I was a very fussy eater', 'I knew how to press mum's emotional buttons') and acting in a caring parental role towards her mother (A3–4 strategies). She appeared not to be able to employ either strategy consistently and possibly displayed a mixed pattern (A/C) to cope with the conflicting demands. She describes how this led to her feeling that the only solution was her anorexia:

> I worked out that crying doesn't work. No matter how hard I cried, it never worked. Nothing ever changed and I became very good at just crying on the spot, but it didn't do anything so it (anorexia) is just another way of crying.

Transformations and distortions of meanings

SFT has moved to a focus on families as meaning making systems. Families members are seen as holding unique perceptions of their experiences and as attempting to make the best sense that they can of their experiences. This has been variously described as a move to a constructivist and subsequently a social constructionist perspective. These have emphasized the centrality of language in the construction of family's experiences. For example, ideas of what it is to be a 'normal' family, to be a mother or father, what counts as disturbance or 'mental illness' are all culturally constructed ideas that are absorbed by families and come to shape their relationships with each other. A number of systemic therapists and researchers have also explored the idea of shared actions and beliefs in families: Reiss (1980) developed the idea of families as having shared paradigms, essentially a set of shared beliefs that regulate members' actions and feelings. Dallos (1991) and Procter (1981) drew on George Kelly's (1955) personal construct theory to develop the idea of families as organized on the basis of a shared construct system. Likewise, Eron and Lund (1993) have developed an approach in which they conceptualize families in terms of the interplay between their stories or 'viewings' and their actions. Byng-Hall (1991) developed the concept of family scripts which again contained the idea of experience as both shared and unique. He also proposed the idea of 'corrective' and 'replicative' scripts which suggested that family members attempt in their current families to perpetuate what was experienced as good or remedy what was experienced as 'bad' in their families of origin. These approaches make attempts to look at how beliefs develop in families and, more implicitly, they also reveal that emotional processes in families can interact with these, for example, Eron and Lund (1993), and Dallos (1991) indicate how beliefs in families may gradually become more extreme and polarized.

These approaches can be complemented by a deeper developmental perspective offered by attachment theory which can help to track the style of narratives in terms of the transformations of information, extent of verbalization of representations, and self-protective strategies that children develop in their early relationships. An important related point is that SFT, especially in its contemporary versions, is shy of using concepts, such as distortion or falsification since these concepts are seen as having negative and blaming overtones. We suggest that what is needed is a model which helps us to see how the transformations and 'distortions' of available information in families occur and how this relates to emotional states of the members involved. Returning to Watzawick's classic example earlier, it is clear that couples caught in such a cycle become increasingly emotionally aroused and, in fact, extreme feelings can be triggered very rapidly between them (Gottman, 1982). Furthermore, they can be seen to bring with them to the relationship a propensity to see others, and hence also their partner, as avoiding, rejecting, suffocating and so on which is related to their prior attachment histories in their own families (as well as previous romantic relationships and friendships). From a DMM perspective, they would be seen as having distorted probabilities regarding the danger the other implied to themselves and a misunderstanding, sometimes even to the point of a falsely inverted prediction, of the effects of their own behavior on the other.

Transgenerational perspectives

Both SFT and attachment theory share an interest in patterns across the generations. Again for early SFT, this was a major area of interest. For example Bowen (1971), drawing on psychodynamic ideas, offered a powerful model of how problems evolve over several generations. Attachment theory has developed some ingenious assessment tools such as the Strange Situation (Ainsworth et al., 1978), School-age Assessment of Attachment (Crittenden, 1997–2005), and Adult Attachment Interview (George, Kaplan, &

Main, 1986/1996; Crittenden, 1999) and the Parents' Interview (Crittenden, 1982) that can be used to explore transgenerational patterns in detail. Focusing on what is passed across the generations allows us to use concepts, such as distortions and falsification, without 'blaming' parents since we are able to see the struggles and difficulties that they faced themselves and the aspects of these that they have brought to their current family. What is learnt are self-protective strategies that were needed for their emotional survival and, if we can understand and communicate this understanding, we can be authentically respectful and sympathetic to their actions.

Carla's parents, for example, both described emotionally cold childhoods. Carla's maternal grandmother had been depressed, suicidal and not available to Carla's mother. Likewise, Carla's father described his own father as angry and intimidating and his mother as permanently ill, overweight and emotionally unavailable. As if this wasn't enough, Carla's mother had desperately wanted a daughter to repair the sad experiences she had with her own mother. Instead, she had given birth to three boys and had abandoned hope of a daughter when finally Carla came along. This had a powerful impact on the parents' marriage which had been in crisis, and her father described the 2 years after Carla's birth as the happiest period in their marriage. From her birth, it seemed she was meeting not only her mother's needs, but also had been saving their marriage! As has been seen so often in AAIs read by one of us (PMC), strategies intended to repair the old problem often reverse the problem, like the proverbial pendulum, leaving well-meaning parents totally unprepared for the problems they create.

Applying the integration of family systems therapy and the DMM to psychotherapy

Attachment theory is not a theory of treatment. The DMM, however, is a fully articulated developmental theory that can (1) contribute to formulating an understanding of dysfunction; (2) assess individual psychological organization, dyadic strategies and multigenerational relationship strategies; and (3) provide a rationale for selecting among treatment modalities. Further, attachment theory has generated a wealth of data on normative children and parents; this could reduce pathologizing of normative processes and life transitions. Moreover, with input from all the major theories of treatment, the DMM is being developed into a comprehensive theory of treatment inclusive of ideas from all major theories of treatment (Crittenden, 2008).

Family systems therapy can contribute a family perspective, a number of patterns of family organization, and extensive experience with treatment from which to derive hypotheses regarding the effects of specific treatment strategies on individuals and families who differ in psychological organization and self-protective strategy.

Understanding dysfunction and maladaptation

Assessment and formulation The DMM has generated a developmentally attuned array of assessment tools from infancy to adulthood. FST could adapt these to the family context to facilitate description of various types of problems displayed in families, including eating disorders, depression, self-harm, conflict and violence. Further, it is clear that in some families, especially troubled families, family members use different strategies. Furthermore, they are often not able to accept each other's different ways of coping with emotional distress and become locked in cycles of blame and accusations with, for example, one partner seeing the other as distant and unemotional (i.e. Type A) and the other, in turn, seeing their partner as overemotional or neurotic (Type C). The

DMM assessments can help to clarify the different strategies that family members use and consider the impacts they have on dyadic as well as triadic patterns in the family.

Both FST and the DMM benefit from offering a conceptualization of all families (both well and poorly adapted) rather than seeing a separation between pathological and normal families. For the DMM, these constructs include transformations of information and behavioral strategies. That is, what actually happened, what one thinks and feels about it, and how one acts, are conceptualized as being related in predictable, but not necessarily identical, ways. When there is a wide disparity within and among family members, the likelihood of dangerous or endangering behavior is increased.

Case study 1: Rosie

In a case of factitious illness by proxy, parents' excessive zeal in seeking unnecessary surgical treatment for their daughter Rosie was attributed by professionals to intentional and deceptive harm. Using the AAI to offer both an assessment of the parents' attachment strategies as well as the rich qualitative information available from the interview about their childhoods and current concerns, it became clear that both parents had imaged representations of the early and traumatizing deaths of their fathers; both deaths occurred quickly, without forewarning, and with disastrous consequences for their families. A compelling formulation from their interviews was that, in the context of Rosie's transient illness at birth, these nonverbal, imaged representations elicited feelings of fear that, in turn, motivated excessive effort to protect her life. However, the parents were not explicitly aware of how Rosie's illness may have triggered these unresolved feelings and so their effects on behavior could not be regulated consciously by them. It appeared that the mother's compulsive caregiving strategy (A3) pushed her into overdrive, protecting her daughter from illusory dangers while her husband's dismissing strategy (A1) caused him to distance himself and defer to his wife. Both parents did what they believed would protect their child. Professionals, on the other hand, saw only the absence of illness in the child and the parents' irrational attempts to obtain ever more intrusive and dangerous medical intervention (Kozlowska, Foley, & Crittenden, 2006).

This example highlights the importance of learning that occurs in the context of danger to guide later protective behavior in ways that are usually adaptive but sometimes dysfunctional. Further, it demonstrates how multigenerational information can be extracted from attachment assessments and applied to family treatment. It also highlights how implicit information can result in discrepant representations that, when not perceived and reconciled, can lead to maladaptive behavior. In this case, two discrepancies are important: that among the parents' representations and that between the parents' intentions and the professionals' attributions regarding the parents' intentions.

Description, function, and attribution Possibly discrepancy among perspectives can be resolved if description, function, and attribution of meaning are differentiated. Behavior can only be understood if it is *described* accurately and fully.

Case study 2: Albert

At 22 years old, Albert, a White male, had been hospitalized three times with a diagnosis of schizophrenia. Neither supportive therapy nor medication had helped and medication sometimes worsened his condition. Albert lived alone with his mother who appeared to be caring, with no obvious dysfunction. He had suspended his studies and had no friends or girlfriends.

Because his condition was becoming chronic, a consultation was arranged with one of us (PMC). Albert's AAI showed no feelings whatever. Further, he described several childhood events that indicated occasional physical abuse, chronic neglect, and ongoing

sexual involvement and spousification (Minuchin, 1974). Albert himself, however, made no such accusations. Instead, he idealized his mother to the point of delusion and yet it appeared that she might be depressed and that he was her entire life. With the interviewer, he was meek and obedient. His AAI was classified as (a) Type A (compulsive spousification, i.e. needing to attend to his mother's emotional needs as if he were her husband, compliance, and delusional idealization, i.e. A3, 4, and 7) with (b) multiple unacknowledged and unresolved traumas and (c) a pervasive sense of futility, that is, depression.

When the AAI was considered in the context of Albert's history, his behavior during the interview, and his mother's situation, several hypotheses were proposed. First, it appeared that the function of the hospitalizations was to give respite to Albert from his mother without causing interpersonal distress. That is, if Albert had wanted to live alone or with a partner, his mother would have felt abandoned. But if he was ill with a serious and inexplicable disorder, then, of course, she wanted him to have treatment. Second, Albert was in the 'transition to adulthood' when, developmentally, the dominant cultural expectation was that he would be leaving home, but given his mother's needs he could not, nor could this be articulated by either of them. Instead, his behavior expressed both his mounting sense of urgency to be able to move forward in his life and his sense of futility about this. Third, his diagnosis both explained (to everyone) why his life was on hold and also relieved both his mother and himself from any responsibility for change. Fourth, if Albert had access to negative affect, it would destroy his relationship with his mother; without it, he could not be motivated to seek sexual satisfaction or independence. Finally, a developmental perspective suggested that Albert's problems had not come to light earlier because, at younger ages, Albert had needed his mother more than he needed independence and, therefore, the conflict was not yet irreconcilable.

When the unspeakable conflicts became too much, Albert's symptoms became acute and he went to hospital. Attributing his behavior to a disease condition protected Albert and his mother from change at the point in life when change was mandatory if Albert was to move forward (Crittenden, 2008).

The AAI and Albert's behavior in the psychiatric interview revealed an unexpected family process – one that was quite different from the idea of biological anomaly currently used to explain schizophrenia. The new story, however, fits the understanding of early family therapists quite well; it differs in having new methods of data gathering and analysis. The DMM emphasizes the functional nature of all attachment strategies, especially highly distorted strategies, while recognizing that what may have been functional in one context may be dysfunctional or even dangerous in others.

Implications for treatment

DMM theory of attachment and adaptation suggests that there are three related topics to address in psychotherapy: (1) The presenting problem, (2) the underlying threat to survival, reproduction, or survival of one's children, and (3) the information processing that transforms threat to maladaptive behavior. It is proposed that it is the underlying threat that makes the presenting problem stand out against the background of life's many problems. If it is not addressed, the solution may be temporary and another problem, with the same roots in threat, may replace it. Further, it is information processing that brought solutions from the past to the current context where they do not function adaptively. If information processing is not addressed, it may be applied in an unchanged manner to other problems in the future, leading to new misunderstandings and possible maladaptive behavior. Finally, each family member will frame the presenting problem differently, process information differently, and have a different history of threat, development and problem-solving skills. Therein lies the complexity. Addressing

these unique developmental issues can make each family member's behavior comprehensible to both themselves and others. Compassion and forgiveness may be most easily achieved when behavior is understood from each person's perspective and, without these, no solution to a family problem can be lasting. With these, enduring change becomes possible.

Systemic family therapy has tools and experience in the processes of change. These already reflect an integration of psychoanalytic principles with systemic theory and knowledge of family functioning and communication patterns. Attachment shares these conceptual roots, but without the experience in therapeutic technique. In addition, however, attachment brings principles and ideas from behavioral and cognitive therapy. These can expand further the conceptual and applied base of systemic family therapy. The idea is that theories of treatment need not compete, but instead can be integrated around their compatible elements with, in addition, each theory contributing what it addresses best. For SFT, that is working with complex family units to benefit the functioning of all members.

With whom should we work? Specific individuals or dyads within the family might need different therapeutic approaches because they differ in the dangers they face, their developmental maturity, or their preferred strategy. Should we work with the individual, the family, the neighborhood, or the cultural context? In safe communities, individuals living in unsafe families may need psychological treatment whereas families living in unsafe communities may need community-level intervention more than psychological treatment. In countries that are unsafe for everyone or for specific subgroups (for example, for women or religious minorities), intervention at the cultural/political level may be essential.

Presuming that we decide to work with individuals, which individuals should it be? FST reminds us both to focus on larger units that include the patient and also that the effects of treatment can be transferred through systems such that the designated patient is not always the one who should receive the treatment. In what circumstances should we offer parent training to the parents of a disturbed infant? Couples therapy to the parents of an acting-out or withdrawn child? Individual work that will affect family functioning? Family work? Some combination of these? Historically, FST has had the flexibility to convene different subsystems of a family as was relevant and necessary (Minuchin et al.,1978). From the perspective of the DMM, this reflects everyday family experience in which individuals and subsystems are in constant flux while the secure attachment relationships among them make trust in privacy and goodwill possible.

With the advantage of the structured assessment and formulation that attachment brings, together with a refined developmental perspective, systemic family therapy is positioned to make the leap to the next level of competence. Bringing all of its perspectives and skills, from across the range of approaches developed by family therapists, and adding ideas funneled through the DMM could yield a powerful array of therapeutic tools. Were all therapists to become competent in (a) formulating problems in developmental and adaptive terms and (b) selecting and applying tools from the full range of possibilities, SFT might become more effective and also better able to document its efficacy.

A research agenda

Together, FST and the DMM can offer an elegant and cogent way to conceptualize many forms of dysfunction. Application of these ideas to treatment, however, requires accumulating precise knowledge about the effects on different individuals of various psychotherapeutic techniques.

Current research compares randomized treatment groups that are defined by symptom-based diagnoses. However, symptoms can serve different functions. If so, a single form of treatment could be good for those who use the symptom in one manner and harmful to those who use it in another. In other words, the studies suggesting that psychotherapy has only limited effects may average, and thus obscure, substantial effects for one set of patients and, possibly, detrimental outcomes for another.

A new research agenda may be needed. Such research would compare groups defined by patterns of information processing and self-protective strategies. Both positive and negative outcomes would be tested and reported. In particular, the effects on Types A and C individuals would be tested. If carried out systematically, a body of information ('a psychotherapists' desk guide to treatment techniques') could be generated. This would assist therapists to select treatment strategies that were suitable and safe for specific individuals and families.

Posting the banns: A plan for joining attachment and family systems

Family systems theory describes the struggles that occur within families and the symptoms of distress that this generates whereas the Dynamic-Maturational Model of attachment and adaptation provides an understanding of the self-protective, reproductive, and progeny-protective functions that underpin these conflicts. Clarifying and prioritizing the issues underlying distress will promote more effective and efficient treatment with reduced risk of harm. We think the time is ripe for attachment and family systems theory to draw closer together. With so much in common and so much to gain from each other's strengths, union might bring us nearer to a universal approach to psychological treatment. If so, the true winners will be the families who come to us with their hope.

Note

1. Transformation refers to representations of the probability of specified conditions pertaining in the future. For example, an extremely dangerous occurrence can produce a distorting transformation in which the event is never expected (omission), always expected (distortion), expected when an irrelevant aspect of the occurrence is present (error), or expected when opposite signals are present (falsification).

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