Understanding the self and understanding therapy: an attachment perspective

Una McCluskey

Years ago, I remember a Catholic priest saying to me that he kept himself sane through having an interest in dog breeding, dog training and taking part in the competitive sport of field trials both nationally and internationally. He shared these activities with others who were equally interested in these pursuits. He also had serious interests in music, gardening and photography and organised his home accordingly. Much later in his life, while recovering from a major illness, he developed an interest in wood turning which he pursued to a high level of competence.

These interests affected his mood and his vitality, and gave him pleasure and self esteem in his own eyes, and in the world of his peers. When he understood that I was taking a professional interest in the dynamics of human behaviour, he discussed with me the fact that maintaining his interests affected his vitality and well-being and helped him cope with the loneliness inherent in his lack of a sexual relationship, which was as part of the commitment required of a celibate priest.

In these ways, my friend exemplified that the manner in which a person handles a basic biological drive – in this case for sex – can be related to activities and perceptions which we regard as cultural and more distinctively human. In this way, my friend's account resonated with the many years I have spent working as an individual, couple, family, and group psychotherapist. During this time, I have struggled to find a way of understanding the manner in which the different facets of people's lives intertwined and affected the experience and competence of the person(s) I was working with (McCluskey, 1990; McCluskey & Hooper, 2000). I also had a keen interest in developing methods of working with people that were effective at engaging the emotional aspects of the events that happened to them, and the effect of unprocessed emotional experiences on their mental and physical health, their relationships, work and sense of competence, (McCluskey, 1987; 2001; 2003; 2005; 2007; 2008; McCluskey & Bingley Miller, 1995).

I started collaborative work with Dorothy Heard and Brian Lake in the late 1980s and, over the years, have become impressed with the theory of human development that they have devised. Over the last ten years I have investigated this theory intensively and continue to carry out research with Heard and others.

This paper encompasses these different personal, professional and academic experiences, seeking to integrate them into a theory which can illuminate professional practice. To this end, the paper presents a novel way of understanding and working with the self based on the theory developed by Heard and Lake, *attachment based exploratory interest sharing* (Heard, Lake and McCluskey, 2009). A central feature of the theory is its emphasis on biological goals and the way that the self is impacted when the achievement of certain biological goals is blocked. This provides a biologically based theory for understanding the self. Crucially, it also allows one to explore the intricacies of the therapeutic process as illustrated by my research (McCluskey, 2001; 2005).

Origins of Heard and Lake's theory

It was John Bowlby (1969; 1973; 1980) who introduced the idea that human beings have goal-corrected systems that function to enable the species to survive. He identified, what he termed, 'the attachment system' which becomes active at times of stress and whose function is to promote survival through the engagement of a care-giving response from someone who is attached to the infant. He identified two discrete systems involved in the survival process: the care-seeking system and the care-giving system. These systems are social and interpersonal, and require mutual regulation and feedback to achieve the goal of the infant care-seeker. Once the goal of the care-seeker has been achieved, both systems go into a state of quiescence until the next alert. Both systems are goal-corrected – in other words, they cease to be active when they reach their goal.

Mary Ainsworth and colleagues (1977; 1978) developed Bowlby's work and studied the various ways that care-givers responded to infants' distress signals. They discovered that care-givers differed in their responses and that these differences had significant effects on the way that infants sought care from their care-givers, and their capacity to engage in exploratory play. Dorothy Heard, who visited Ainsworth at the time that she was analysing her data, observed a dynamic connection between effective care-giving and the level of the infant's explorative capacity. She called the interdependence between the three systems of care-seeking, care-giving and exploration 'the attachment dynamic' (Heard, 1982). What Heard observed was that it was the *quality* of care-giving that affected the child's capacity to engage in exploratory pursuits

Later, with Brian Lake, she extended these ideas to include a further three biological systems within the dynamic which they called *the attachment dynamic in adult life* (Heard & Lake, 1986). The three additional systems were (i) interest sharing with peers, (ii) affectionate sexuality, and (iii) self defence. They elaborated further on this thesis in their 1997 book, *The Challenge of Attachment for Care-giving*. They added two further systems to the dynamic: the internal environment, which can be either supportive or unsupportive, and the external environment that can also be experienced as supportive or unsupportive.

Theory and research on the therapeutic process

Around this time, I started to research the therapeutic process, based on observations of the perturbation studies by Murray and Trevarthen (1986) and my reading of Daniel Stern (1985) and the work of other developmental psychologists. I was particularly

interested in the phenomenon of 'affect attunement': the way in which mothers communicate to their preverbal infants that they understand the state the infants are in. I got interested in the process of affect identification and regulation, and the way in which one can observe discrete vitality affects when a person feels met or unmet. When adults who are in distress are not 'met' they show particular vitality affects: just like infants, these are visible and can be identified and studied.

My research on affect attunement in adult psychotherapy (McCluskey *et al.*, 1997; McCluskey *et al.*,1999) led me to outline the process of 'goal-corrected empathic attunement' (GCEA), which turned out to be a key dynamic in whether a person seeking help felt 'met or not'. What this indicated to me, was that the act of care-seeking and the activity of care-giving were, themselves, goal corrected, just as had been identified in the literature on infants. In addition, the process of interaction between a care-seeker and a care-giver, itself, was a goal-corrected activity. It was at this point that I began to see the relevance of the theory of the dynamics of attachment in adult life being proposed by Heard and Lake. They were presenting the idea that there was a dynamic process of interaction between seven systems, (care-seeking, care-giving, interest-sharing, sexuality, self defence, the internal environment, and the external environment). These systems resemble physiological ones, in that all are biologically based and – apart from the 'internal environment' – goal-corrected.

Following this insight, I started a series of sessions with professional care-givers to explore the interdependence of these interpersonal social systems (McCluskey, 2002; 2007; 2008). I also began a collaboration with Heard and Lake leading to a recent publication (Heard, Lake & McCluskey, 2009). In this book, Heard and Lake refine their theoretical formulation as outlined in their 1997 publication (Heard & Lake, 1997). They include Le Doux's 'fear system' within their system for 'self defence'; they postulate the existence of a single process, the function of which is to restore well-being, following a threat to the self; and they elaborate the interaction between seven instinctive systems.

The interdependence of the seven systems

As my example of the Catholic priest was intended to show, these different systems are not independent of each other. The care-seeking system becomes active, along with the system for self defence, when the person senses or experiences a threat to well being. The third system – the internal environment – is triggered simultaneously. Once the person's care-seeking system has been activated along with their fear system (which is part of the system for self defence), their capacity for care-giving will be compromised, as will their capacity for developing and sharing interests and engaging in a mutually satisfying sexual relationship. If on their own, and having no access to others, they will rely on their internal and external environment, which they will experience as either supportive or unsupportive.

Our internal environment is particularly important in therapy and is dealt with in more detail below. Our *external environment* is the home we have created for ourselves to live in; it may be as small as one room, but it is created and fashioned in a way that is designed to provide support for the self as a whole, or for a particular specially valued aspect of the self. The external environment we create, may serve to defend the self against the awareness of painful experiences, or may promote our well-being and creative potential.

As already described, the seven systems are biological and six of them are goal-corrected. They are influenced in terms of *motivation to reach their goal* by the memory of how the person has been related to in the past (which is stored in the internal environment). Thus a person's care-seeking system may be aroused at a point of crisis, but may be over-ridden by the fear system (influenced by the internal environment). This may mean that the person does not seek help when needed, or may do so inappropriately. Instead, the fear system will be expressed by the behaviours: flight (submission – avoidance), fight and flight (dominance/submission – ambivalence), flight (dominance), freeze (disorganisation).

If the person has a history of approaching for help when they were frightened or distressed, and have then had the experience of being dismissed, ridiculed, neglected, abused or ignored, they will be left with the job of regulating their state of fear on their own. They may do this by withdrawing into rocking, head-banging, self clasping, self stimulating, collapsing, singing, lulling themselves into a trance-like state, praying, meditating, dissociating – all manner of self soothing and self regulating activities (Tronick, 1989).

In addition to the withdrawal described above (the flight aspect of the self defence system), the person might try and influence their care-giver to attend to them, either through the defensive form of care-giving – where they seek to take care of the care-giver in order to get some positive attention, or they might try to dominate their care-giver into giving them what they want (using the fight aspect of their fear system). All these behaviours are defensive; they defend the self from the unbearable feeling of being left alone and not mattering to anyone else.

In an unregulated state – where the person has not been helped by another human being to cope with unbearable emotion – a person can discover that they can relieve their fear by dominating the other and making them suffer the pain of rejection or abuse (physical. sexual or emotional) either through acting these behaviour out in reality, or in fantasy. Such behaviour has the effect of restoring some sense of control and vitality. If a person adopts this mode of interacting when threatened, then they will discover that by being dominant (the bully) they do not have to experience fear.

In all these behaviours, the proper functioning of the attachment system is lost - the person has given up on care-seeking. The person is at the mercy of their fear system, which is infiltrating all other aspects of their life – their capacity for effective care-seeking, their care-giving, their interest sharing, and their capacity for affectionate sexuality.

A person who has not had their own care-seeking needs met adequately may be capable of sympathy and empathy for other people but to a limited degree. For example, once their care-giving is not well received, or is challenged, the person will tend to experience frustration or helplessness, and resort to either dominance (control) or withdrawal as a way of dealing with their underlying state of fear and lack of competence (included within – or excluded from – consciousness).

There is thus a crucial difference between what happens to the self when care-seeking has been met and what happens to the self when it has not. When it has not been met, all the person's interpersonal systems are infiltrated by the defence system (in the form of the fear system expressed through dominance/submission).

When care-seeking has been met, the person's fear system has been assuaged and the person is reminded of their capacity

to cope, or given the skills to so do. They return to their interest sharing and their affectionate/sexual life; their exploratory, empathic care-giving capacity is restored to optimal functioning, and they engage in a creative engagement with life through supportive companionable relations with others.

The internal environment

There is one system that is not goal-corrected; that is the system described as the 'internal environment'. How does that work, and how does it interact with the other systems? The internal environment (IE) of the self is triggered by reminders in the here and now. The system (IE) is then activated and will be experienced by the self as supportive or unsupportive.

I offer the following as an example of how the internal environment can be triggered and then provide an opportunity for the self to expand consciousness of its own workings. An adult is out walking and decides to pick up a few sticks including a piece of an old hawthorn tree. This triggers a memory of being out on a walk with fellow scholars from boarding school, when suddenly there was a commotion up ahead – one of the 11-year-old children had apparently lost control and the teacher was giving her a horrific beating with a hawthorn stick. What is lodged in the internal environment is not only the incident (which is recorded as a memory – conscious or non-conscious) but, more importantly in terms of how this system works, the internalised experience of seeking or not seeking help to deal with this outrage to one's sensibilities and the quality of the help received or not received.

It is this experience of interaction with one's care-giver that is lodged in the internal environment, providing support or lack of support for the self when one's fear system is triggered at a later date. What will have happened in the above example, is that the child's system for self defence – which includes the fear system and the care-seeking system – will have become activated on witnessing the beating and hearing the sounds of pain. If the child does not receive effective care-giving (which must include attunement to the fear and regulation of the arousal state associated with fear) then they are at the mercy of an over-aroused physiological state that they will have to regulate as best they can (as described above). This they will do instinctively by using other aspects of themselves, such as a defensive form of sexuality, interests, religious practices, or creating a defensive external environment designed to ward off bad and disturbing emotions.

The arousal of the fear system has to be assuaged by a care-giver before the person is available to respond with empathic fear-free, supportive, companionable, educative care-giving. In the example, from the point of view of the child who witnessed the beating, the adult available to sooth the fear system and provide effective care-giving is the same adult who is the source of the fear; a state of affairs likely to leave the child to self-regulate as best they can, especially in the absence of proximity to their regular care-giver (the child being at boarding school). The effectiveness of how the child deals with this scenario will be based on their internal environment, and whether they have sufficient internalised positive regulating and educative experiences with their original or main care-giver to help them to manage the fear aroused by this incident.

The internal environment is constructed out of our experience of relationships with significant others (especially in childhood), how they have related to us, what they have called us, how they have treated us, the attributions they have ascribed to us. If we have experienced a lot of negative attributions – "Do you never listen or take anything in? Are you stupid or what?", "What a nuisance you are – can't you see I am busy?", "You will bring disgrace upon the family – you will kill your mother/father – you are no good at anything – you are a cruel, thoughtless person". These and other negative attributions get lodged in the self and can come to form a core identity – how the self really perceives itself to be.

How is the internal environment connected with the other systems?

Think of the situation where one is at a meeting and discovers one has forgotten to bring certain documents, or to check out important information that one had agreed to do, the consequences of which are likely to anger those present and to disrupt or delay the work. A person with a highly critical internal environment is immediately going to have their system for self defence activated. They will attune to the anger and impatience of the others and, instead of mobilising empathic care-giving and an exploratory capacity to repair and deal with the situation they are in, the person is likely instead to retreat into the fear form of self defence. In this state, he or she loses touch with the capacity for care-seeking (in its internalised form – the sense that there is and has always been a benign other available to help them). In this state, (of not having an internalised effective care-giver who has mostly been able to remind them of their worth and competence), they are likely to lose competence and 'forget' the circumstances that led to them not carrying out their responsibilities. In addition, because they lose the capacity for empathy for those present at the meeting (and simply see them as critical attackers who find fault and want in the self) they are unable to engage in cooperative collaborative problem-solving. Instead, they remain trapped in defence and in the survival of the self, trying to reclaim as much of a 'good name' for themselves as possible, and fearful of the consequences; they are likely to be aggressive, become disorganised or withdraw into a collapse.

Heard and Lake have made a truly original contribution to our understanding of the dynamics of self organisation and development, in the way they have brought many different aspects of people's lives together into one conceptualisation. They have integrated a person's need and desire for care when distressed or frightened, with a person's instinctive desire to care for someone they are attached to. They have linked the natural tendency to develop an interest and share it with one's peers, with a natural instinct to love and express affection. They have linked the development of an effective system for self defence with the way in which a care-giver provides education as well as support for a distressed care-seeker. They have integrated Le Doux's fear system within the system for self defence but add into this system the care-seeking system. They have built on Bowlby's idea of internal working models and have added in people's life-long interest in creating and sustaining a supportive environment in which to live.

So how does all this relate to therapy?

A therapist (or care-giver) first needs to regulate the person's fear system. As long as the fear system is aroused, the person cannot explore. The care-giver needs to help the person to test whether there is a reality basis to the fear and to track with them whether what is frightening them is a memory from the past or a

prediction about the future. If the person is accessing memories from the past, it is very important that the therapist welcomes and validates any accompanying emotion but does not get distracted by it. The therapist should, a) encourage the person to keep communicating verbally, if at all possible, and b) keep attending to whether the person is going into a postural collapse – collapse being a form of self regulation, as noted earlier, and indicates a withdrawal from care-seeking into the unsupportive internal environment, and c) explore with them, whether they can see any difference now in terms of their own competence and abilities between the past and the here-and-now.

People who have had poor experiences of care-seeking are likely to suffer from a vicious, self-attacking internal environment and are not going to trust an external care-giver, professional or otherwise. It is important to remember the interdependence of the systems: what is activated in the internal environment of the person will affect the way in which they seek care.

It is also important to remember that care-givers and care-seekers attune to each other's emotional states and they do this out of consciousness. If the care-seeker's fear system is activated but the care-giver does not have their own system for self defence aroused in response, they will then be able to continue to interact with the care-seeker in a fear-free empathic manner. Over time, the care-giver will be able to promote exploratory work with the care-seeker which should have a knock-on effect on other aspects of the care-seeker's life.

This is not quick work and can only be sketched in brief here. It is crucially important that anyone involved in providing a care-giving relationship to another person has available a continuous supportive companionable care-giving relationship. Nobody can sustain fear-free empathic care-giving without being cared for in this manner themselves.

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Una McCluskey is a registered psychotherapist with the UKCP (psychoanalytic and systemic sections). She works as a consultant, researcher and trainer in the field of attachment in adult life. She is also employed as a part-time senior research fellow at the University of York. www.unamccluskey.com