Co-creating secure attachment imagery to enhance relational healing

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Abstract: All treatments for adult attachment insecurity include in some form a set of principles and methods that can be termed *therapist-as-good-attachment-figure*. This relational context is widely and appropriately accepted as a foundation for any attachment-focused therapy. After highlighting some of the principles of this approach, this article describes a therapeutic model that includes using patient-and-therapist co-created imagery of positive attachment experience. This imagery method is *intrapersonal*, in that it focuses on the patient's inner experience of mental representations of attachment relationships; it is *interpersonal*, in that the process calls upon the therapist to be highly attuned and responsive—as a good attachment figure—to the patient experiencing the imagery; and it is *meta-interpersonal*, in that the patient experiences the imagined interaction with the positive attachment relationships in the context of the therapist supporting and participating in the process. The use of imagery in this way can be a valuable contribution towards relational healing and adult earned secure attachment.

Keywords: attachment imagery, ideal parent figure, IPF, metacognition, collaboration.

There is wide recognition and acceptance that the patterns of secure and insecure attachment are established primarily through early relational experiences (Ainsworth, 1973; Bowlby, 1988). Attachment patterns result *from* experiences in early relationships and appear *in* subsequent relationships. Any attachment pattern indicates a predisposition to expect a particular type of experience when in relationship with others, based on what has been experienced with important others early in life. The principle of "the past is a reasonably good predictor of the present" is operative, not necessarily as a conscious directive but predominantly driven from the domains of non-conscious experiential memory (Bretherton & Munholland, 2016).

The dynamic intrapersonal and interpersonal patterns named as "insecure" reflect particular ways of attempted adaptation to experiences and expectations of relational threat or distress (Bowlby, 1969; Crittenden, 2015). Such adaptations will be more or less effective, and many if not most adults with a pattern of insecure attachment will go through their lives more or less adapted to their relational

adaptations. But when the adaptations are insufficiently effective, or when their secondary consequences become problematic, a person may seek psychotherapy.

As attachment is relationally established during childhood, the general consensus within the clinical field is that attachment problems in adults are best relationally healed. Across the variations of psychotherapeutic approaches for attachment insecurity, a common core element is the therapeutic value placed on the quality of the *relationship* between the therapist and the patient. This focus on the therapeutic relationship was emphasised by the father of the attachment theory, John Bowlby[1]:

> [The therapist] provide[s] the patient with a secure base, from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and on occasion, guidance. (Bowlby, 1988, p. 138)

Research on psychotherapy for attachment insecurity has largely validated Bowlby's clinical recommendation: "Overall, research consistently suggests that developing a secure attachment to one's therapist is a crucial factor in helping a client work collaboratively with a therapist in achieving therapeutic change" (Mikulincer & Shaver, 2017, p. 457). It is the presence of a good-enough secure attachment to the therapist that enables the patient to experience the therapist as a "trusted companion". In their reviews of the empirical research, Mikulincer and Shaver (2017) and Slade (2016) further highlight that the available evidence suggests that therapeutic outcomes for attachment treatment are most influenced by specific relational factors, such as the quality of the working alliance, the nature of the patient's attachment to the therapist, and the interaction of the patient's and the therapist's attachment patterns.

While it is widely recognised that in psychotherapy for any presenting problem "the therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of specific type of treatment" (American Psychological Association, cited by Slade, 2016, p. 764), it is likely that the fundamentally relational aspect of attachment problems makes even more important the relational aspects of therapy for those problems[2].

The *therapist-as-good-attachment-figure* model of therapy

The integration of Bowlby's seminal recommendations with ongoing theoretical, empirical, and clinical developments has led to a component found now in most therapies for attachment problems that I refer to as *therapist as good attachment figure* (for brevity, hereafter TAGAF). The foundation of this approach is simple: because as a child the patient in treatment experienced patterns of relation with caregivers that did not lead to an internalised sense of secure base, the therapist endeavours to be a good (or good-enough) attachment figure to support the development of a secure base experience for the patient in the therapy. If the patient does her or his

part (Crittenden, 2015, pp. 229–230) and comes to feel secure enough in relation to the therapist, then she or he can participate in exploring, understanding, and ultimately modifying the representational models of self and others that perpetuate the attachment related difficulties, which will lead to beneficial change. A core assumption is that the new, positive, secure experiences with the therapist will create new, positive, secure internal working models (IWMs) that will modify or replace the old, negative, insecure IWMs.

> A therapist applying attachment theory sees his role as one of *providing the conditions* in which his patient can *explore* his representational models of himself and his attachment figures with a view to *reappraising* and *restructuring* them in light of the *new understanding* he acquires and the *new experiences* he has in the therapeutic relationship. (Bowlby, 1988, p. 138, *italics added*)

Reappraising is the category of cognitively recognising, exploring, and evaluating the attachment strategies and patterns that manifest in relationships, including in the relationship with the therapist. The therapist acts as a good attachment figure by supporting this process of *exploration* towards self-recognition and "new understanding", parallel in process if not in content with what a good-enough attachment figure would provide for a child. Brisch (2012) gave a clear expression of a direct approach to this cognitive reappraisal process:

> [The therapist] should encourage the patient to think about what attachment strategies he is presently using in his interactions with his important attachment figures … It should be made clear to the patient that his painful experiences with attachment and relationship, and the distorted representations of self and object that arose from those experiences, are probably inappropriate for dealing with current important relationships; in other words, that they are outdated. (Brisch, 2012, p. 102)

Bowlby's assertion of the importance of therapeutic *reappraisal* of the presence and functioning of the patient's internal working models fits well with his early psychoanalytic training. Amidst the many changes within the field of psychoanalytic psychotherapy (some of which were the result of Bowlby's challenges and innovations), the value of *insight* has largely been retained. Making a cognitive connection not previously recognised, developing a new understanding, seeing something in the present differently based on a new view of the past, insight is widely believed to be both a means and a sign of therapeutic progress. The construct of insight itself has evolved over time, and in combination with the analytic view of the benefits of developing self-observational capacity, several therapeutic approaches integrate the basic principles of insight with more modern cognition-focused understanding and methods for the development of skills to recognise, understand, and take perspective on patterns of experience and behaviour. Schema therapy (Young et al., 2003) and mentalization-based treatment (e.g. Allen & Fonagy, 2006) are examples of such approaches that have been applied directly to working with attachment insecurity.

The application of these methods to treatment of attachment insecurity is based on the recognition that *co-occurring* with insecurity is a deficit in the capacities to see oneself and others with an observational perspective. The same developmental conditions that contribute to attachment insecurity also impede the normal development of mentalization. From a mindfulness context, mentalization is *mindfulness of mind, one's own and others'*. A very basic mentalization is "I am reading this article"; a more advanced form is "I am distracted while I'm reading this article, and I wonder if it's because I'm hungry"; or "She seems distracted, and I wonder if it's because she's feeling stressed about her project due tomorrow".

The application of mentalization-based treatment to attachment problems can enhance patients' capacities for engaging in reappraisal. According to the principles behind this approach and some impressive outcome data (especially from applications to treatment of personality disorders, see Bateman & Fonagy, 2016), the more a patient is able to mentalize, or actively take perspective, about his or her and others' experiences and behaviour and the mental and motivational states that create them, the less prominent will be the reactive interpretations and behaviours that can be linked to early attachment representations. Jon Allen (2013) has elegantly highlighted how a focus on developing mentalization in therapy for trauma and attachment insecurity is facilitated by the therapist's relational ways of being with the patient.

Restructuring is the process of *changing the representational models*, the IWMs of self and other in relationships. In principle this change results both from the reappraisal and from the dynamic relationship with the therapist. Dozier and Tyrell (1998) created a schematic representation of the five therapeutic tasks that Bowlby (1988) said are necessary for changing internal working models of self and others. They collapse the five into three co-occurring categories: psychological exploration of relationships with prior attachment figures; psychological and behavioural exploration of current relationships; and corrective experiences with the therapist. The first two are reappraisal processes, and the third is the domain of positive relational experiences that the patient would have with the therapist.

The purpose and goal of corrective, positive relational experiences in therapy is that they are consistent with the *good-enough* principle of what an attuned parent or primary attachment figure would provide to an infant and child. The therapist, following the TAGAF principle, does his or her best to manifest with the patient the security-promoting qualities that Mary Ainsworth (1973) categorised as *maternal sensitivity and responsiveness*, such as interest, attentiveness, protection, careful attunement, comforting and soothing, contingent responsiveness, and reliability. In principle, these new, positive experiences with the therapist will result in the formation of new, positive IWMs of attachment relationships.

Developmentally, the distinction between reappraisal processes and the formation and operation of IWMs makes sense. During the period when internal representations of attachment experience are formed, approximately between twelve and twenty months[3], the capacities required for metacognitive encoding and processing

are not present. Using the metaphor of "top-down" and "bottom-up" for the neocortical, midbrain, and brainstem activity and direction of processing, during the second year of life there is not much "top" and lots of "bottom".

Rather than cognitive elements, the *feeling qualities* of attachment interactions and relationship—safe, threatening, comfortable, tense, etc.—are the prominent aspects of the early IWMs. Infants form and store models of attachment interactions in "dimensions of time, space, affect, and arousal" (Beebe & Lachmann, 2014, p. 34). Over development, the nature of newly forming internal representations themselves change along with the developing cognitive structures and networks and the resulting shifts in the modalities and focuses of processing. Blatt and colleagues (1997) highlighted that "… representations of self and other usually unfold in a gradual and orderly sequence, from enactive, affective, and physicalistic to symbolic and abstract" (p. 352). Later-formed representations are likely to be more symbolic and abstract, and thereby would likely be subject to the symbolic–abstract processes that therapeutic reappraisal entails. But the earlier-formed representations are more "enactive, affective, and physicalistic", and these modes are the core of IWMs.

The later-developed capacities for reappraisal are ill-suited for changing IWMs, for though reappraisal can *operate on* them, the representations seem not to be in the same format as the system that would do so. Changing the attachment-relevant IWMs requires changes to them in a way that matches the format in which they were established, stored, and operate from. The therapeutic corrective emotional experience principle for restructuring IWMs is based on this formal and operative parity. In theory, when an adult patient has direct experiences over time of a therapist being, for example, warm, attentive, and welcoming, the patient's positive affective and visceral experiences can overwrite the, for example, cold, distracted, and rejecting elements of the original insecure IWM of experiences with the primary attachment figure.

The presence and functioning of different forms of representations and operating systems is supported by evidence of two developmentally sequenced, functionally distinct systems of memory. Pillemer and White (1989) described a non-verbal, affective/behavioural-based system that is present from birth and continues to operate throughout life in particular contexts. Another system, verbal and thinking/narrative based, is fully functional at about the fourth year of life. Of the first system, Pillemer and White state:

> Past experiences are evoked by feelings, locations, or people. The memories are expressed through images, behaviors, or emotions … Infants show evidence of long-term retention through behavior, especially following reinstatement of original learning cues; … preschoolers can re-enact past experiences that are "forgotten" in the verbal domain. (1989, pp. 326–327)

Through the second system, developing independently of the first during the preschool years:

> Event representations … are actively thought about or mentally processed and thus are encoded in narrative form … Memories are addressable through intentional retrieval efforts, apart from the original learning conditions … [and] can be accessed and recounted in response to social demands … [such as] when the situation calls for intentional, purposeful memory search—for example, in responding to a researcher's queries. (ibid., p. 326)

Consider these systems in the context of the development and emergence of attachment patterns. Attachment representations (IWMs) are established *prior to* the development and operation of the second, narrative-based system. As such, the IWMs and the memories of experiences that formed them are stored by the original system in non-verbal format, as images, affects, and behaviours. Not only are they *stored* in non-verbal format, they are primarily *cued and remembered* by non-verbal formats as well. These "… stored images, feelings, and behaviours may be reinstated automatically by affective or contextual cues" (ibid., p. 326).

Bretherton and Munholland (2016) reviewed neuroimaging studies of IWMs, and report findings that very much support the non-verbal basis of attachment representations:

> Instead of assuming that representations consist of amodal symbols (e.g., logical propositions, data structures, and procedures …), neuroimaging studies reveal that mental models rely on the same brain sites that subserve perception (e.g., vision, audition, touch), action (e.g., movement), proprioception (balance), and interoception (e.g., visceral, emotional, and cognitive states). (2016, p. 68)

The operational format of the second system described by Pillemer and White—language—appears to limit this system's ability to access experiences that were formed into memories prior to its development:

> Adults usually do not recount events occurring before age 3, and preschoolers do not describe events occurring before the onset of language. Why do early memories remain socially inaccessible after the language performance system is intact? Language is apparently not superimposed on an existing memory system. Rather, a new memory system is constructed in the preschool years, with language as the primary medium of expression. (1989, p. 328)

In therapy, talking with a patient about early attachment experiences and the ways the resulting patterns manifest in the present—the *reappraisal* process—is certainly of metacognitive benefit toward supporting understanding, perspective, and choice regarding those patterns. But as that process entails the narrative memory and processing system, it is unlikely that it can produce *structural change* in what was established prior to that system "going online"—the internal working models of attachment experience are of an entirely different format and engage different brain sites and activity[4].

The presence of these two processing and memory systems validates Bowlby's differentiation of therapeutic reappraisal and restructuring, and it validates the

primary premise of the relational/experiential aspects of the TAGAF approach: that the therapy relationship evokes images, affects, and behaviours from the stored IWMs, which then manifest in the therapy, and that new, positive relational experience with the therapist, particularly the non-verbal, affective, and visceral experience, can operate on and change—restructure—the original IWMs. Even if the cognitive *content* of reappraisal will not change the IWMs, *the relational process* of reappraising can function as a corrective emotional experience, and thereby contribute to restructuring. Through their *shared exploration*, the patient comes to feel that the therapist is *interested* and *attentive*, *values* him or her, and becomes a "trusted companion". These experiences are consistent with the form and operation of the original non-verbal, affective, enactive processing and memory system.

Following Bowlby, there have been many well-developed suggestions for the therapeutic stance that supports restructuring through the therapy relationship. For example, Holmes (1996) suggested that "The therapist tries to behave like a responsive, attuned parent-figure who is neither intrusive nor rejecting, rebuffing nor controlling … overwhelming nor neglectful" (p. 70). Sable (2000) describes the therapist as:

> … being available with regular appointments, interested in and responsive to what is talked about … The therapist offers an emotional availability, a comforting presence, and regulation of affect, all of which increase the opportunity for attachment to develop …. (pp. 239, 333)

And she asserts the fundamental TAGAF restructuring principle:

> The working model of the therapeutic relationship eventually exerts dominance over hurtful experiences and models of the past, countering the patient's image of himself as unlovable and unworthy of secure affectional ties. (ibid., p. 333)

Several therapies consistent with this model emphasise highly attuned moment-to-moment sensitivity and responsiveness by the therapist to the patient. Beebe and Lachmann (2014), drawing from their studies of dyadic *intersubjective exchange* within secure mother and infant dyads, describe a therapeutic process that parallels the way a mother in a secure dyad attunes to and matches her infant's non-verbal behaviour, and rematches that behaviour whenever attunement mismatch occurs. Diana Fosha integrated research on attachment and intersubjective dynamics from Beebe and Lachmann and others to develop her own treatment process for adults (Fosha, 2000). As a central aspect of this method, therapists attentively track, match, mirror, and mark (emphasise) the moment-to-moment fluctuations in the patient's affective state and verbal and non-verbal behaviours, such as facial expression, posture, gaze, gesture, voice pitch and rhythm, and timing of expressions.

We know from infant attachment research that highly attuned dyadic patterns of parental sensitivity, attunement, and responsiveness are associated with infant attachment security. The therapies developed by Beebe and Lachmann, Fosha, and others that emphasise intersubjectivity are good examples of the integration of such

findings into a TAGAF treatment approach in which the therapist aims to create very specific "corrective experiences" for the patient in order to change the insecure internal working models.

TAGAF elements vary across different therapies, in some appearing more as cognitive *reappraisal* emphases, and in some appearing more as experiential dyadic process focus. All share the goal of modifying patients' insecure IWMs through the creation and internalisation of the new, positive experiences with the therapist. From clinical reports and experience, and from the available empirical evidence, limited as it is (Slade, 2016), it is clear that progress towards this goal can be made.

As clinicians, we are always interested in what might facilitate treatment and promote efficient movement towards therapeutic goals. Below I offer an approach for guiding psychotherapy for adult attachment insecurity that integrates the TAGAF principles and practices with particular developmental considerations, certain inherent psychological resources, and several practical therapeutic structural issues. Inclusion and integration of these elements can make even stronger the relational healing elements of traditional approaches to attachment treatment.

The three pillars model

Building upon the principles that underlie the TAGAF approach, several colleagues and I developed an integrative treatment framework for working with adults who present with attachment insecurity and associated problems. *The three pillars* model (Brown & Elliott, 2016) offers a comprehensive way of both resolving the structural core of attachment insecurity—internal working models of problematic early attachment experience—and strengthening several capacities that were developmentally impeded by the same conditions that contributed to attachment insecurity. The focus of the rest of this article is the first pillar: using co-created mental imagery to restructure IWMs of attachment from insecure to secure. But a brief account of the other two pillars of this treatment highlights that together, all three incorporate and develop further what is best from the TAGAF model. Our approach draws from and honours the knowledge and clinical wisdom that many people have contributed through the history of attachment research and healing.

The second pillar: enhancing metacognitive capacity

As mentioned in the section above on reappraisal, mentalization-based treatment (MBT) is a contemporary method that helps patients to develop the cognitive capacity for *taking observational perspective* on one's own and others' experiences and behaviours. We consider *metacognition* to include mentalization skills and to be a broader category that encompasses all forms of perspective-taking, which exist along a developmental continuum (Brown & Elliott, 2016, pp. 397–424). As an alternative to MBT, Dimaggio, Semerari, and their colleagues have developed a

therapeutic method that focuses on the enhancement of particular metacognitive skills (Dimaggio et al., 2007).

Gergely and Watson (1996) detail how the relational dynamic between the infant/child and the primary caregiver is essential for the development of basic metacognitive ability. A secure infant/caregiver dyad consistently embodies what supports this development, including the caregiver's accurate affective mirroring, contingent responsiveness, and *marking*, or "producing an exaggerated version" (p. 1198) of the infant's expressions, which helps the infant to learn about and differentiate self-and-other experience. When such caregiver behaviour is absent or limited, as in insecure infant/caregiver dyads, metacognitive development will be impeded. In adults, low metacognitive ability is associated with personality disorders (Bateman & Fonagy, 2016; Dimaggio et al., 2007); reasonable facility with basic and intermediate metacognitive forms is associated with mental health and well-being (Brown & Elliott, 2016); and skill with those forms and with the most advanced forms of metacognition is associated with advanced levels of cognitive/personal development (Cook-Greuter, 1994; Kegan, 1982).

Alan Sroufe (1997, 2016) has suggested that psychopathology can be seen as *a consequence of development*. When certain healthy capacities do not emerge early in life, the developmental trajectory continues without those capacities, resulting in problematic accommodations and consequences when the related developmentally dependent inner resources for meeting life's inevitable challenges are limited or not available. By including explicit metacognition-building in therapy for attachment insecurity, we help to correct a deficit that exists in parallel to the insecurity and contributes to its continuation. Enhancing metacognition *will not change the insecure IWMs*, but will strengthen an ability that supports psychological and emotional resilience and can facilitate further growth.

The third pillar: fostering collaborative ability and behaviour

Another consequence of the impeded developmental factors that contribute to insecurity is poor collaborative ability. Collaboration involves mutual engagement and interactive contribution in a shared process or task. While infants are inherently collaborative, showing interactive engagement from a very early age (Beebe & Lachmann, 2014), in an insecure attachment dyad, where a caregiver is unresponsive, inconsistent, overinvolved, or rejecting, infants will show much less collaborative engagement (Tomasello, 2010). At the beginning of this article I quoted Mikulincer and Shaver's statement that "… research consistently suggests that developing a secure attachment to one's therapist is a crucial factor in helping a client work collaboratively with a therapist in achieving therapeutic change" (2017, p. 457). An implication of this finding is that insecure attachment makes it hard to work collaboratively in therapy. So, right from the beginning of the therapy for someone with attachment insecurity there must be efforts to cultivate collaboration between the patient and therapist (Liotti & Gilbert, 2011; Lyons-Ruth, 1999). Doing so will enhance the patient's capacity to engage in the therapeutic process, and will

help to correct the collaborative impairment that was a consequence of the same developmental conditions that led to attachment insecurity.

Collaboration is inherently *relational*, and of course is at least implicitly a component of any therapy within the TAGAF framework (and any good psychotherapy). In the three pillars model, we include explicit practices that highlight to both the patient and the therapist the collaborative dynamic. For example, at the beginning of therapy we present and discuss the collaborative nature of the therapy and highlight what the therapist and patient are each responsible for (e.g. attending sessions on time; communicating about changes to sessions), and together establish a set of treatment goals and a mutual agreement about the process towards those goals. Discussion of inevitable therapeutic ruptures also facilitates the relational/collaborative process (Beebe & Lachmann, 2014; Liotti, 2007; Tronick, 1989; Tronick & Beeghly, 2011). Further, throughout the therapy the therapist takes care to notice and point out to the patient any indications of *non-collaborativeness* (e.g. limited eye contact; mumbling or talking into one's hand; excessive talking without pauses for the therapist to respond; speaking without giving context or information essential for understanding).

The first pillar: restructuring attachment representations with ideal parent imagery

The ways that we recommend a therapist to support metacognitive and collaborative development in therapy are detailed in our treatment book (Brown & Elliott, 2016). Though we describe specific methods that can be applied, we also emphasise that *the therapist's ways of being* whilst applying them are very important. We encourage the therapist to behave as much as possible as a good attachment figure, assuming the necessity of a positive relational ground for supporting the patient's process. Upon this ground, we offer a *meta-relational method* that enhances the potential for creating new, positive attachment IWMs.

In a highly collaborative way, the therapist and patient *co-create vividly experienced mental imagery of the patient-as-child interacting with imagined ideal parent figures*. Through the unlimited freedom of imagination, these imagined parents, different from the patient's parents of origin, can embody and express any and all qualities that would most and best support the patient-experiencing-himself/herself-as-child forming a secure attachment bond with them. This process honours the importance for security building of *new and different relational experience*, of corrective emotional experience. But such experience occurs *with the imagined parents*, who can go beyond the constraints of the person of the therapist or of the role of the therapist with the patient. The method is both *intrapersonal*—the imagery is experienced within—and *meta-interpersonal*—the imagery is of interacting with imagined parents, and is done in collaborative interaction with the therapist.

The ideal parent figure (IPF) imagery method has a sequence of steps, each with a developmentally based rationale. Though these steps are specific and are best learned in their prototypical form, experience from practising them and understanding the principles that underlie each one allows ultimately for creative and

patient-specific modifications in therapy sessions, just as facility with musical scales supports improvisation. For the purposes of this article, I present less how-to detail and more of the underlying principles. Extensive detail can be found in the three pillars book (Brown & Elliott, 2016).

Collaborative context

Right from the beginning of treatment, the therapist takes a collaborative stance and emphasises the ways that both the patient and the therapist contribute to the process. When it has been determined that the patient has an insecure attachment pattern, the therapist provides some psychoeducation about attachment and insecurity. Then he or she introduces the IPF method and describes each step in a general way, encouraging questions and any concerns the patient may have. The therapist liberally uses the words *we*, *us*, and *together* in phrases such as "we will explore this together", and "your experience will tell us important things that we'll use to figure out the next steps together". This way of being supports collaboration, and also builds metacognitive perspective about the roles, activities, and experiences in the therapy.

Body-based experiential ground

Recall Pillemer and White's (1989) description of the earliest memory system, that which is functional during the period when attachment IWMs are formed.

This system is pre-verbal, and relies on images, feelings, and body-enacted behaviours for both encoding and retrieval. As the central purpose of the IPF process is to access and restructure insecure IWMs, it is helpful during the imagery for the patient to be less "in the head" with the later-developed verbal, linear, narrative cognition, and more "in the body" and experience-near to the early modes of experiencing and being, from which the IWMs are assumed to continue to operate. This principle is also fundamental to several somatic-focused psychotherapies, such as Peter Levine's "somatic experiencing" (Levine, 2010), Pat Ogden's "sensorimotor psychotherapy" (Ogden & Fisher, 2015), and the work of Bessel van der Kolk (2015).

Any way of enhancing focus on immediate bodily experience serves to support this ground. Breath awareness, a body scan, and mindfulness focused on the body are examples, and I often engage a combination of these for five minutes or more so that the patient has the opportunity to come back to the body several times after the inevitable internal verbal narrative distractions.

Visceral imagination of being a young child

Following the same principle as above, the patient is encouraged to imagine being a young child, "to feel yourself as a young child, in whatever way that occurs to you now". In the clinical hypnosis field, this step would be referred to as an age regression[5]. This step also facilitates access to the IWMs, as Pillemer and White (1989) highlight that access to material encoded by the early memory system is done through affective and contextual cues. The patient's immediate, first-person, bodily

felt experience of being a young child are the experiential contextual cues that make more accessible the IWM material, and which I assume make that material *more amenable to restructuring*.

For those patients who have difficulty evoking imaginal experience, whether because of a particular defensive structure or simply being in the lower range of the population curve of imaginative ability, the therapist may engage the patient in talking together about *what it would feel like* to be himself or herself as a young child. Often, such a focus brings forward in the patient some degree of felt sense of child self. This principle and practice also applies below, when patients have difficulty imagining ideal parent figures. More discussion of this issue appears in the Brown and Elliott book (2016, pp. 360–368).

Evoking imagery of ideal parent figures

As IWMs are mental representations, what better way to modify and restructure them than with direct engagement with different mental representations? Bretherton and Munholland's (2016) review of neuroimaging studies of IWMs provides compelling support for this approach:

> … several neuroscience teams almost simultaneously discovered that *envisioning future episodes* activates the very same cortical network as *recalling past personal* episodes (p. 76, *italics original*) [and the same structures] are recruited when humans perceive and simulate (remember and *imagine*) complex scenarios that, in our view, are important in IWM construction … This makes it possible to relive/refeel them in memory and even *pre-live/pre-feel or vividly imagine fictive events*. (p. 78, *italics added*)[6]

Amidst the IPF process, when the patient is feeling as a young child, the therapist suggests something like:

> Now notice that you're not alone. Through the creative freedom of your imagination, you can now be with parents—not the parents you grew up with—but a new and different set of parents, parents who are just right for you and with whom you can feel absolutely safe and secure in your connection with them. Notice what these parents are like, the ways they're being with you that feel so very right for your security and well-being.

While we often first think of imagery as *visual*, the therapist does not use visual terms when setting up the imagery frame. If the therapist were to say "Now *picture* yourself being with new and different parents" or "Imagine yourself in *a scene* with parents …", these visual terms would tend to evoke a third-person or observing stance in the patient. The experience will be most effective if the patient has a *first-person* experience of *being* self-as-child in relation with the ideal parents. So more helpful are phrases such as "Now *imagine and feel* yourself being with these parents" and "Imagine yourself in a *circumstance* together with them".

While some patients feel some conflict about imagining new and different parents rather than their own parents with more security-enhancing qualities,

engaging with *different* parents reduces the presence of problematic parent-of-origin associations during the imagery. Also, this approach differs from the various forms of *inner child* work, as one's adult self taking care of one's inner child self can reinforce the dismissing/avoidant defensive adaptation of hyper-autonomy.

Collaborative elaboration of IPF imagery

When the imagery frame is set, both the patient and the therapist contribute to the elaboration of the imagery. During the first few IPF sessions, the therapist may choose to not make suggestions of specific qualities of the ideal parent figures. Though we know what caregiver qualities tend to promote attachment security (see below), for any particular patient we may not know what is most wanted or needed from the imagined caregivers. So the therapist may say something like, "These parents are with you in all the ways that you would *most want* and need them to be." I continue to be amazed by the clarity with which most patients experientially know what they want and need from their imagined caregivers. As we hear from the patient what those ways of being are, we mirror those and include them specifically in subsequent suggestions for the imagery.

There are three other sources of attachment-promoting qualities that the therapist can incorporate into the patient's experience with the imagery. First, branching from Mary Ainsworth's seminal work describing the forms of *maternal responsiveness* that contribute to secure attachment, various authors have offered to parents what they consider to be most fundamental (Hoffman et al., 2017; Hughes, 2009; Siegel & Payne Bryson, 2020). From my work with colleagues, we have suggested "the five conditions that promote secure attachment" (Brown & Elliott, 2016, pp. 288–292). These conditions are pairs of what an infant and young child ideally experiences and the consistent behaviour of the caregivers that contribute to such experiences:

Infant experience	*Caregiver behaviour*
Felt sense of safety	Protection
Feeling seen and known	Accurate attunement
Felt comfort	Soothing, comforting, reassurance
Feeling valued	Expressed delight in the child
Supported for exploration	Encouragement for discovery

In the imagery, a therapist includes these without suggesting *how* they appear. For example, "Something about these parents helps you feel so very *safe* with them; notice how it is they *protect you* so that you feel so safe"; "These parents are absolutely delighted in you, in your very being … you don't have to do anything in particular…they are so happy just to experience you as you are. What is it about them that lets you know how delighted they are by you?"

Following Blatt's (2008) model of the developmental interplay of *relatedness* and *self-definition* and of the value to psychological well-being of their balance, I include in the imagery something like, "When you're with these parents, you can experience *just the right balance* between closeness and distance … when you want to be

closer to them, they're very available and welcoming, and when you want more space, they support that too."

A second source of ideal parent qualities is the *positive opposite* of problematic care experiences that the patient experienced as a child. For example, if a patient's father was cold and aloof, the therapist might say, "This father is very warm and present with you; what is it about him that makes that so clear?"; if a patient's mother was frequently anxious and full of worry, the therapist might say, "Notice what it is about this mother that lets you know that she's so calm and at ease and confident." The therapist can determine the positive opposites from learning of the patient's early history with caregivers, and/or from questions 3 and 4 from the Adult Attachment Interview (George et al., 1996), which ask for five adjectives to describe the early relationship with mother and then father.

The third source is based on what we know about caregiver behaviours that differentially contribute to each of the subtypes of attachment insecurity[7]. For example, as dismissing or avoidant attachment is associated with parental active rejection of a child's attachment behaviours, the therapist guiding the process would suggest that the IPFs would be *fully welcoming* of the child. Anxious–preoccupied attachment is associated with caregiver inconsistency, so IPFs would be *very consistent and reliable*. Parents being *frightening and frightened* often contributes to disorganised insecurity, so IPFs would be *stable and comforting and confident and calm*.

The therapist mirrors and amplifies (*marks*) the patient's positive experiences with the IPFs, and makes adjustments as needed to support the process and the patient's safety amidst it. Also, throughout the imagery, as the therapist endeavours to maintain a high level of attunement to the patient's moment-to-moment experience, a powerful *relational meta-process* can occur. For example, when a patient immersed in the imagery shows a change in facial expression or a bodily shift, the therapist might say, "These parents see that something has shifted in you, and are here to be with you in a way that feels just right for this moment." The patient has the experience that the IPFs *and the therapist* are attuned and beneficially responsive.

Co-created imagery allows for the patient to experience caregivers in ways that a therapist cannot be expected to provide. Most particularly, the patient-as-child can be *physically* protected, cuddled, and comforted by the IPFs as much as she or he would like. Whereas in secure infant–caregiver dyads the norm is extensive physicality, such as cuddling and physical forms of protecting, soothing, and playing, in psychotherapy contexts there are clinical, ethical, and legal reasons for significant limits to physical contact. So an experiential domain that is likely central to a secure IWM is not able to be engaged in the therapy. For some patients, the strictures against contact with the therapist–caregiver may reinforce an insecure IWM from experience with a parent who was physically rejecting or unavailable. During the IPF process, if the patient spontaneously experiences welcome physicality from the IPFs, the therapist mirrors that (e.g. "Yes. Really feel how it feels to be cuddled with such tenderness and warmth"); if the patient does not, after a while

the therapist can suggest that some "safe, just-right-for-you" physical support can happen in the imagery. Indeed, elaboration and engagement with "just right" imagined parent figures allows for transcending, during the imagery, of *any* particular limitations or challenges that can arise within the therapy relationship (see Talia et al., 2014).

The patient's vivid visceral experiences with the IPFs are very different from her or his actual early experiences with caregivers. Essentially they are positive opposites. As such, the IPF process is very consistent with the elements that promote *memory reconsolidation* (Ecker et al., 2012). Engagement and interaction with IPFs provide *juxtaposition experiences*—here, the contrast between experience with IPFs and with caregivers of origin—which are integral to reconsolidation, and in this context, to restructuring IWMs. Specific methods for enhancing memory reconsolidation developed by Ecker and his colleagues can easily be applied within the IPF work.

Enhancement of positive felt experience in relation to IPFs

Throughout each imagery session and especially as part of coming to the session's closure, there is very direct focusing on bodily and affective experience. For example, if a patient indicates she feels "calm" when with the IPFs, the therapist might say something like, "Yes. *Really feel* how calm you feel. Notice what it is in your body that lets you know you feel so calm." Highlighting the patient's positive physical and affective experiences with the IPFs supports the linkage of these experiences with the experiential, affective, behaviourally enactive memory and processing system that likely underlies IWMs. "Mental simulation can spill over into bodily activation" (Bretherton & Munholland, 2016, p. 81), and intentional attentional enhancement of both best supports the goal of restructuring IWMs.

When attention is highly focused and engaged with internal imagery, it is possible to expand the sense of time. For example: "Even though only a short amount of clock time will pass, it now seems like much longer time goes by, long enough for all your positive feelings with these parents to form a clear and deep and good impression within you." By including time expansion in the imagery, the limitations of the actual duration and frequency of therapy sessions can in part be overcome.

Re-orienting to adult-self experience

Because patients can become deeply immersed in and engaged with the imagery, a smooth transition from patient-as-child to patient-as-adult in the present is very important. One way a therapist might guide this transition would be: "As I count gradually from five down to one, with each number feel yourself gradually and smoothly returning to your adult self, here in the present with me; when I reach one, you can open your eyes and feel refreshed and alert as your full adult self."

Integration

Of note is that this process contributes to healing and transforming the effects of early painful relational experience without requiring focus on that experience. Many patients engage with very positive states amidst and after the imagery sessions. Inherent to deep, safe, supportive experience with IPFs (and to the imagery session being held and guided by an attuned therapist guided by TAGAF intentions) is activation of the autonomic *ventral vagal, social engagement system* (Dana, 2018; Porges, 2011). Repetition of activation and access over time can contribute to autonomic reconditioning and a reduction in oversensitivity of relational threat perception and reactivity.

Of course, this work is not all fun and games. Difficulties within the imagery can and do arise, as attachment insecurity produces challenges in any relationship, real or imagined. Many of these challenges can be resolved *within the imagery*, as the therapist can suggest that the IPFs recognise the patient-as-child's difficulty and say that they "know just the right way to respond to help you with this now". The imagery can also be used beneficially to revisit actual painful childhood experiences, this time with parents who protect and support and help the patient-as-child exactly as needed. Patients relive/refeel, and IWM elements from those experiences can be modified/reconstructed.

In therapeutic practice, much creative variation in the application of the IPF method is possible and valuable. A true collaboration between the therapist and patient will reduce the experience of IPF as "a method", and supports the co-creation of the process in ways that incorporate and adapt to both the particular strengths and limitations of both the patient and the therapist.

Signs of progress include a reduction of insecure patterns, increases in emotion regulation and metacognition, and increases of secure base phenomena[8] within the imagery, in the therapy relationship, and outside of therapy. Restructuring of early IWMs can be assumed to be happening when these positive changes become more consistent and are more stable in response to relational stressors. There is of course wide variation in the rate of change across patients, depending among other factors on the severity of the relational wounds, but in my practice I have seen many patients show shifts toward stable security within a year of consistent IPF work.

As of yet there is only one empirical study specifically focused on the effects of the IPF method. Parra and colleagues (2017) administered a standardised IPF script[9] during five sessions with each of seventeen patients with complex PTSD and histories of childhood trauma. Treatment effects were assessed with several measures of symptom severity and quality of life. Though patient attachment status was not determined, the level of attachment dysregulation related to trauma was assessed pre- and post-treatment. After the five sessions there were significant positive changes in all measures, which persisted at eight-month follow-up.

The IPF method, and the three pillars method as a whole, awaits further assessment. As Slade (2016) points out, the entire field of attachment treatment suffers

from less-than-desired availability of rigorous research and clinical evaluations. In the meantime, our theoretical and practical understanding of attachment can continue to develop and help us in our treatment of attachment insecurity in adults. For the reasons detailed in this article, I believe that the use of positive attachment imagery, in the context of a good-enough therapist-as-good-attachment-figure, has great clinical value. Through the use of such imagery, it's never too late to have a happy childhood!

Acknowledgements

The three pillars model was first envisioned and established by Daniel P. Brown, PhD. I am grateful to have learned from him and to have worked closely with him and several colleagues to develop the ideas and methods of the model further.

Notes

1. The mother of attachment theory is Mary Ainsworth.
2. Because problematic attachment patterns underlie many mental health problems, the robust finding of the outcome value of the therapy relationship in *any* therapy may at least in part reflect the benefit of attending to the relational, attachment-relevant contributions to the presenting problems, whether or not attachment issues are recognised and directly addressed by the therapist.
3. The formation of attachment representations, or internal working models of experiences with attachment figures, occurs during the period when the cognitive capacity to form internal representations develops, roughly between twelve and twenty months.
4. Interestingly, language is the mode through which the Adult Attachment Interview assesses the presence of attachment patterns: the interviewer asks questions about past attachment experiences, and the verbal responses of the interviewee are evaluated for indications of *the state of mind with respect to attachment*. But though verbal content is considered important, even more important are the language *patterns* of the responses, indicating non-verbal reactions to being exposed to attachment-focusing questions.
5. Hypnotic trance is nothing mysterious. It is one term for a state of calm, relaxed, highly inwardly focused state of awareness, and can facilitate access to inner material and resources that can be very beneficial for psychological healing and growth. The process of "guided imagery" benefits from the same state, whether it is called "trance" or not.
6. Bretherton and Munholland (2016, p. 76) point out that Tulving redefined *episodic memory* as "a neurocognitive mind/brain system underpinning the *capacity to re-experience or mentally relive* personal events that had occurred in the past at a particular time and place, or to *pre-experience or pre-live* events that might occur in the future" (p. 76).
7. Any phenomenon can be divided and subdivided differently depending on what is sought after, looked at, and seen. Attachment phenomena have been differentiated into three, four, five, and up to twenty-six theoretically and practically meaningful subtypes. Continuum or spectrum models that honour gradations of attachment patterns also have much validity and value.

8. Internalised secure base is indicated by an overall balance of proximity-seeking toward closeness with others and feeling comfortable being apart from close others.
9. In clinical practice, it is most beneficial for the therapist to not use a script, but to create the imagery frame freshly during each session based on attunement and contingent responsiveness to the particular patient in the present.

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