Chapter 2

The six domains of attachment theory

As a therapeutic modality, attachment theory has had a long gestation, partly because of its ambivalent relationship with psychoanalysis, which, with ethology, was one of its principal forebears. This has been as much a strength as a weakness. Half a century of research now underpins attachment approaches to therapy, and practitioners can feel confident that their interventions are based on evidence rather than unsubstantiated authority or persuasion. The aim of this chapter is to summarize the contribution of attachment ideas to psychotherapeutic practice. Implicit is the view that general or 'non-specific' factors are equally as important in producing good therapy outcomes as the specific features often claimed by 'brand-named' therapies to be the secret of their success. Patients seeking therapy are typically torn between the need for secure attachment and a terror of intimacy. Like Fisher-Mamblona's (2000) goose Feli, they fear aloneness but, at the same time, are terrified of getting close. They want to run away, but have no secure base to run *to*. For people to form a trusting relationship – an external secure base – and then to internalize it so that they feel secure in themselves is a developmental as well as a cognitive process and, inevitably, takes time.

Van Ijzendoorm and Sagi (1999) usefully summarize the findings of attachment theory under four main headings:

- *The universality hypothesis*. In all known cultures, human infants become attached to one or more specific care-givers.
- *The normativity hypothesis*. About 70 per cent of infants become securely attached; the remainder are insecurely attached. There are three main categories of insecure attachment: avoidant, ambivalent and disorganized. Securely attached infants settle more easily in response to stress. Thus, secure attachment is both numerically and physiologically normal.
- *The sensitivity hypothesis*. Attachment security is dependent on sensitive and responsive care-giving.
- *The competence hypothesis*. Differences in attachment security lead to differences in social competence; securely attached children are more likely to relate successfully to peers and teachers and are less likely to be bullied or to bully.

To these we can add three further hypotheses:

- *The continuity hypothesis* (see p. 28). Attachment patterns in childhood have far-reaching effects on relationship skills and their mental representations in adult life.
- *The mentalization hypothesis*. Secure attachment is based on, and leads to, the capacity for reflection on the states of mind of self and others (Fonagy 1991; Meins 1999).
- *The narrative competence hypothesis*. Secure attachment in childhood is reflected in adult life by the ways in which people talk about their lives, their past and in particular their relationships and associated mental pain (Holmes 1992). Table 2.1 summarizes the connections and continuities between childhood attachment patterns as measured in the Strange Situation and adult narrative competence as revealed in the Adult Attachment Interview (Hesse 1999).

Based on these hypotheses, attachment theory provides a set of linked overarching concepts that embrace many aspects of psychotherapeutic practice. Six main attachment domains can be delineated, each of which can be applied to individuals, couples and families. These comprise secure base, exploration and play, protest and assertiveness, loss, internal working models, and reflective capacity.

The six domains

Domain 1: Secure base

The first, and most important, domain is that of the secure base (SB). 'Secure base' originally referred to the care-giver to whom the child turns when distressed. That secure base may provide secure *or* insecure attachment depending on circumstances. Thus, confusingly, a secure base may provide an *in*secure attachment experience. The point here is that, without *some* sort of secure base, survival is impossible.

The early attachment thinkers tended to see the secure base in behavioural terms, referring to the care-giver to whom the infant visibly turns when threatened or ill, and who is able, to a greater or lesser extent, to provide the essential protection needed if the infant is to survive. This concept seemed to have limited application to adults until it was realized that the secure base can be seen not just as an external figure, but also as a *representation* of security within the individual psyche.

The original care-giver/child secure base experience can be thought of as

Table 2.1 Adult Attachment Interview classifications and corresponding patterns of infant strange situation behaviour

Adult state of mind with respect to attachment	*Infant strange situation behaviour*
Secure/autonomous (F) Coherent, collaborative discourse. Valuing of attachment, but seems objective regarding any particular event or relationship. Description and evaluation of attachment-related experiences is consistent, whether experiences are favourable or unfavourable. Discourse does not notably violate any of Grice's maxims	**Secure (B)** Explores room and toys with interest in pre-separation episodes. Shows signs of missing parent during separation, often crying by the second separation. Obvious preference for parent over stranger. Greets parent actively, usually initiating physical contact. Usually some contact maintained by second reunion, but then settles and returns to play
Dismissing (Ds) Not coherent. Dismissing of attachment-related experiences and relationships. Normalizing ('excellent, very normal mother'), with generalized representations of history unsupported or actively contradicted by episodes recounted, thus violating Grice's maxim of quality. Transcripts also tend to be excessively brief, violating the maxim of quantity	**Avoidant (A)** Fails to cry on separation from parent. Actively avoids and ignores parent on reunion (i.e. by moving away, turning away or leaning out of arms when picked up). Little or no proximity or contact-seeking, no distress and no anger. Response to parent appears unemotional. Focuses on toys or environment throughout procedure
Preoccupied (E) Not coherent. Preoccupied with or by past attachment relationships or experiences, speaker appears angry, passive or fearful. Sentences often long, grammatically entangled, or filled with vague usages ('dadadada', 'and that'), thus violating Grice's maxims of manner and relevance. Transcripts often excessively long, violating the maxim of quantity	**Resistant or ambivalent (C)** May be wary or distressed even before separation, with little exploration. Preoccupied with parent throughout procedure; may appear angry or passive. Fails to settle and take comfort in parent on reunion, and usually continues to focus on parent and cry. Fails to return to exploration after reunion
Unresolved/disorganized (U) During discussions of loss or abuse, individual shows striking lapse in the monitoring of reasoning or discourse. For example, individual may briefly indicate a belief that a dead person is still alive in the physical sense, or that this person was killed by a childhood thought. Individual may lapse into prolonged silence or eulogistic speech. The speaker will ordinarily otherwise fit Ds, E or F categories	**Disorganized /disoriented (D)** The infant displays disorganized and/or disoriented behaviours in the parent's presence, suggesting a temporary collapse of behavioural strategy. For example, the infant may freeze with a trance-like expression, hands in air; may rise at parent's entrance, then fall prone and huddled on the floor; or may cling while crying hard and leaning away with gaze averted. Infant will ordinarily otherwise fit A, B or C categories

Sources: Adapted from Hesse (1999).

Notes: Descriptions of the adult attachment classification system are summarized from Main *et al.* (1985) and from Main and Goldwyn (1984a, 1998a). Descriptions of infant A, B and C categories are

comprising: (1) a set of behaviours activated by threat; (2) a response to those behaviours by the care-giver; and (3) a psychophysiological state that is the end result of those behaviours. Care-giver responses associated with secure attachment include responsiveness, sensitivity, consistency, reliability, attunement, the capacity to absorb protest and 'mind-mindedness', the ability to see the distressed child as an autonomous and sentient being with feelings and projects of his or her own. The psychophysiological state includes such physiological elements as relaxedness, warmth, closeness, feeling soothed, satiation, a full stomach, steady breathing, reduced pulse rate, calmness and a psychological component with thoughts such as 'all's well with the world', 'everything will be alright', that where there was chaos and confusion there is now order, and that everything is 'under control'.

Adults, however seemingly autonomous, as well as making physical contact with loved ones at times of stress, also have an *internal* SB zone – which can also be conceptualized as a schema or object relationship – to which they turn when needed, especially as part of affect regulation. Activating internal SB may come about through comforting thoughts or images and/or behaviours including resorting to self-soothing resources, such as hot baths, bed, favourite foods, music, books or TV programmes, duvets and alcohol. A measure of security must be achieved whatever the cost: psychological survival requires some kind of SB experience, compromised though this may be by the limitations of the care-giver's capacity to give and the recipient's capacity to elicit appropriate care. The internal representation of the secure base can be activated by different parts of the SB cycle – that is presumably why the softness and warmth of baths and bed produce the desired states of calmness.

Pathological variants of SB behaviour include binge eating or starvation, substance abuse, compulsive masturbation or deliberate self-harm. How can apparently self-injurious behaviours produce security? They recreate some element of SB cycle described above and this, in turn, has a soothing function, however self-destructively it has been achieved. For example, escalating chaos followed by relief is characteristic of self-harming episodes in people suffering from borderline personality disorder. Many will describe a temporary feeling of peace and calm when they see blood flow after self-cutting, or when they lie down after taking excessive tablets, or the nurturance they feel following a stomach wash-out. In the starvation behaviour of anorexia, the sufferer struggles with the longing for food – a SB element – and, paradoxically, by temporarily mastering her desire to eat produces comfort: she is not at the mercy of a need for a secure base over which she has no control. The ingredients of these behaviours are also to be found in unhappy couples, for example those for whom sex is only possible after a major row.

The Strange Situation and Adult Attachment Interview delineate insecure patterns of the secure base. Although as used in research both are categorical

measures, it is possible to imagine two separate axes: one a horizontal bipolar continuum from dismissing/avoidant through secure attachment to preoccupied/ambivalent, and the other a vertical unipolar axis running from coherent/autonomous to incoherent/disorganized (Figure 2.1). These can be related to what I have called the triangle of attachment (see Figure 2.2; Holmes 1996). Insecure variants are essentially trade-offs. The avoidant individual stays close enough to a rejecting care-giver to get a measure of protection, but not so close as to feel the full pain of rejection. Ambivalent people cling to their care-givers so that they are less at the mercy of their inconsistency. Neither perhaps achieves the full SB state of security and so a sacrifice has to be made. In infants, exploratory play is inhibited; in adult avoidants, intimacy is compromised, while the preoccupied restrict their autonomy in the service of security.

In both variants of insecure attachment, self-esteem is precarious. In ambivalent attachment, it is dependent on the proximity and positive regard of the clung-to attachment figure; if they are lost or critical, ambivalent individuals will suffer. In the avoidant pattern, self-esteem is short-circuited within the self; external validation has little impact, and the avoidant person does his best to be in control and to keep intimacy at bay as it threatens this self-contained system of maintaining self-esteem. At best he can only feel good about himself when giving to others. The secure individual has a balanced self-esteem system that is open to external validation, but not completely dependent on it; a reciprocal relationship, in which giving and getting both play a part, and is sought as the most reliable source of good feelings about the self.

Disorganization and incoherence are so disruptive of the care-giving environment that people will go to great lengths to create some sort of order, however problematic and sub-optimal those efforts may be. For example, there may be attempts at control via obsessionality (as in the anorexia cycle described above); by a switch from responsive to an aggressive and coercive form of care-giving or care-eliciting; by the use of dissociative strategies in which overall chaos is reduced by splitting; by delusional attempts to impose

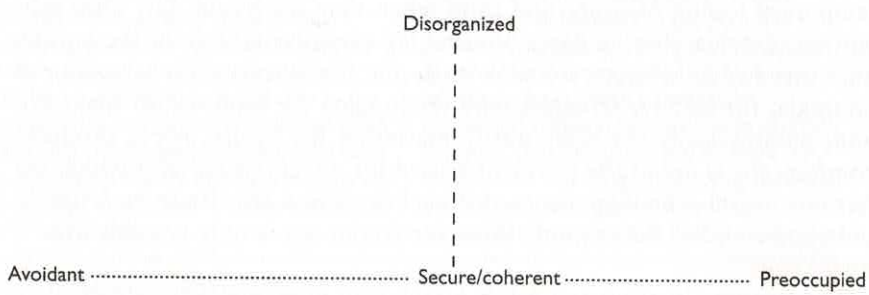

Figure 2.1 Dimensions of secure and insecure attachment

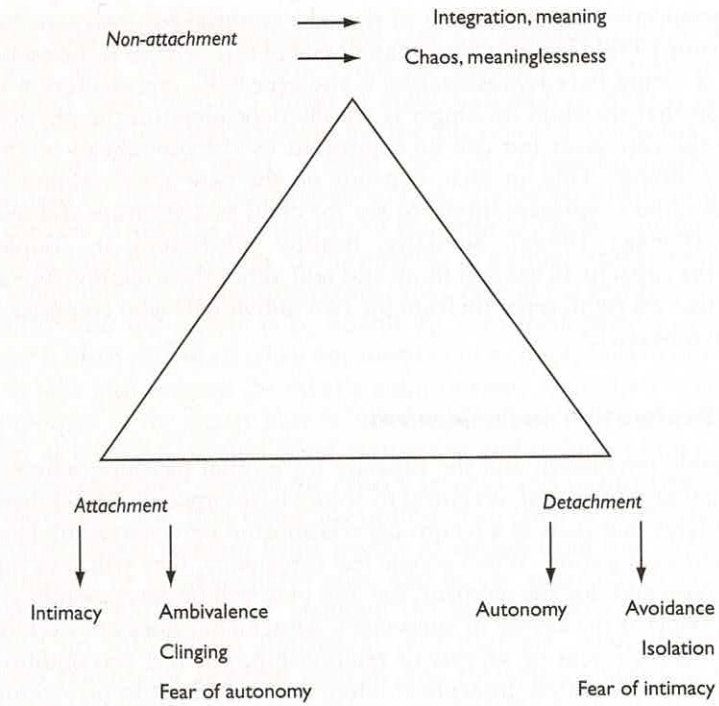

Figure 2.2 The triangle of attachment (Holmes 1996)

coherence from within in the face of either physiological disorganization (i.e. 'genetic' schizophrenia), or environmental confusion (i.e. communication deviance in the family); or through the predictability of clinging to a sick role.

Secure and insecure variants of SB phenomena are to be found within adult relationships. In couples, each adult acts as the secure base for the other, and each brings his or her own internal SB representation and expectation – with varying inbuilt insecurity – into the couple relationship. If the partnership is stable, then out of these representations a 'third element' can be forged, which provides far greater security than either member of the couple can achieve on their own – the relationship itself and the pattern of mutual expectations that implies.

Seeing a relationship as separate from each of its component parts is a point of contact between the psychoanalytic and the attachment perspective. Intimate relationship in adults offers the possibility of moving from a two-person, pre-Oedipal position to a three-person, Oedipal constellation. From a neo-Kleinian perspective, the Oedipal situation is seen as a developmental step where, if the child can tolerate the separateness of the parental couple

and the loss of exclusive possession of mother that implies, he or she gains a decentred perspective and a freedom of thought essential for interpersonal success (Britton 1998). The attachment analogue of this process is the establishment of a secure base *representation* – and especially representation in language – so that the child no longer is wholly dependent on the physical presence of the care-giver but can be comforted by the thought of 'mum-and-dad', or 'home'. This, in turn, depends on the care-giver's ability to represent her child's representations; to see the child as a separate and sentient being (Fonagy 1999a). Similarly, healthy functioning in couples depends on the capacity to see and think and talk about their relationship as an entity in its own right, separate from the two individuals who comprise it (see Domain 6 below).

Domain 2: Exploration and enjoyment

Companionable interaction and the capacity for mutual pleasure, whether playful, sexual or intellectual, is central to secure base capacity. Attachment theory postulates that there is a reciprocal relationship between secure base behaviour and exploration. When people feel threatened, they will seek out their secure base and, for the moment, fun and play will be correspondingly inhibited. Anxiety is the enemy of enjoyment. Attachment does not exclude other motivational forces or aspects of relationship, but is a precondition before they can be activated. Insecure children find it difficult to play. Similarly, in adult life, if one member of a couple does not feel secure – for example, worrying that her partner will abandon her at any minute – it is unlikely that she will be able to enjoy their sexual relationship. Helping couples to grasp this very simple concept is often a gateway to understanding sexual difficulties, or their inability to profit from the 'quality time' so beloved of agony aunts and informal advice-givers.

In general, Bowlby (1988) had little to say about sex; perhaps he was keen to emphasize 'his' instinct, as opposed to that of psychoanalysis. There is now a large literature on adult relationships and the ways in which they are shaped by different attachment patterns (Cassidy and Shaver 1999). People may avoid emotional closeness in sex as in all relationships, or may attempt to 'short-cut' to the physiological aspects of secure base while splitting off the emotional and psychological aspects. 'Compulsive' sex may be a manifestation of ambivalent attachment, a form of clinging in which the primary aim is physical proximity rather than pleasure or procreation. A successful sexual relationship involves a number of features relevant to attachment: mutual emotional attunement, the capacity to contain and not feel overwhelmed by mounting excitement, overcoming fear of transgression while retaining repect for boundaries, the capacity to regress and re-integrate, and the ability to separate and cope with loss, secure in the knowledge that a sexual couple as an internal representation will survive.

Domain 3: Protest and anger

Rows with a partner, violence and rage are common reasons for people seeking help, especially men. From an attachment perspective, anger is triggered when there is a threat of separation and, in what is essentially a negative reinforcement schedule, has the function of ensuring that the attachment bond remains intact. A child who runs across a dangerous road is chastised by the care-giving parent to keep him by her side in future.

The role of anger as an attachment regulator can be seen in many different ways in adult relationships. If one member of a couple threatens it by having an affair, this will straightforwardly evoke rage in the betrayed one, as their security and self-esteem is so bound up with their partner. More subtly, anger is often provoked when one member of a couple fails to be considerate or to take into account the other's point of view. As we have seen, a crucial component of the secure base is 'mind-mindedness', the capacity to see the other as having a psychological perspective and feelings of his or her own. 'Inconsiderateness' ignores the other's feelings and so threatens this aspect of the secure base, thus triggering protest in an attempt to re-establish it.

Assertiveness training helps people to escape from the traps of passive submission or uncontrollable rage, and to use anger effectively to restore attachment bonds and to maintain the secure base. Good self-esteem is bound up with secure attachment. For example, relationships, whether within families or between patients and therapists, consist of a series of intimate moments and separations, interspersed with 'ruptures' in communication. People with good self-esteem are usually good at 'rupture repair': they are confident that closeness can be restored, just as the secure infant in the Strange Situation expects that his protest will be heard, his distress will be dealt with and he will be able to return to exploratory play.

Another attachment perspective on anger views unexplained outbursts of rage as a form of 'displacement activity' triggered when an individual is torn between the need for a secure base and the fear of achieving one (Fisher-Mamblona 2000). For example, a spouse might suddenly attack his partner on discovering that she is having an affair. Here the threat to the relationship would activate attachment behaviour, but conflict is exacerbated because the potential secure base is also a source of threat. In this state of unbearable conflict, rage provides some sort of outlet and may possibly help the individual clarify what his real needs are.

Domain 4: Loss

For Bowlby (1988), loss or threatened loss was central to much psychological distress. He viewed the capacity to cope with loss as a key component of psychological maturity. The paradox of intimacy from an attachment perspective is that it can only be achieved if its members can negotiate

separateness more or less successfully. For Francis Bacon, a spouse and children were 'hostages to fortune'. To have something is to run the risk of losing it. Taking *this* path means that one cannot take *that* one. In adult relationships, each member brings with him or her a history of separations and losses and of a more or less secure internal secure base which will colour their relationship. One reason why the death of a child is so devastating for couples, and divorce rates are so high after such a tragedy, is that each is so grief-stricken that neither can provide the comfort of a secure base for the other.

Working through past losses is an essential part of attachment-informed therapy. 'Working through' – a glib term for an often unbearably painful process – can only happen because of the possibility of 'representation'; the lost loved one cannot be recovered in the external world, but can be 'reinstated' (to use a Kleinian term) in the inner world of the bereaved. If the therapist can provide a temporary secure base, then the anger and despair associated with bereavement can be negotiated towards at least partial acceptance.

Domain 5: Internal working models

It is impossible to practise an atheoretical psychotherapy. Any attempt to help people in psychological distress will be underpinned by a set of implicit or explicit models about the structure of the mind, the nature of thought, characteristics of intimate relationships, and so on. Different approaches use different languages and it is often hard to distinguish between points of overlap and real differences. For example, the notion of internal representation is described psychoanalytically in terms of an inner world populated with internal objects and the relationships between them. Cognitive therapy focuses on schemata, fundamental and relatively immutable assumptions about the self and its relationships. Systemic therapists have become interested in 'event scripts', sequences of behaviour of self in relation to others that are laid down in childhood and give colour and shape to subsequent relationships. Bowlby's (1988) version was the notion of 'internal working models', a phrase chosen deliberately as an 'action language' that would capture the Piagetian 'scientist-practitioner' process by which children construe their world (Bretherton 1999).

Bowlby (1988)wrote of 'defensive exclusion' to describe the ways in which unwanted painful feelings and thoughts are kept out of awareness, and the consequent restrictions to internal working models, and therefore adaptability, which that entails. Internal working model is a more 'cognitive' construct than the psychoanalytic internal world, which consists of affective schemas associated with significant others. The distinction between implicit and explicit memory can perhaps help overcome the cognitive/affective gap (Schacter 1992). Implicit or procedural memories are those that are laid down in the early years of life and consist of the 'ways in which things are done' (i.e. patterns of relationship), including, for example, parental responses to infant distress, which are stored within the child's mind and which will influence subsequent relationships even if there is no explicit awareness of their role. Explicit or episodic memories are the specific events and self–other behaviours that comprise people's memory-store.

In adult life, each member of a couple brings to it a complex set of working models, schemata, scripts and/or object relationships. Couples are attracted to one another if there is some kind of 'fit' between their own inner world and that of the other. Each must consciously or unconsciously know the steps of the other's dance. The more intimate they are able to be with one another, the more their own inner world will be exposed. Areas of pain and vulnerability will inevitably come into play. Thus, paradoxically, a certain maturity is needed – confidence in the coherence and survivability of the self – for the child-like regression that is inherent in intimacy to take place successfully.

The three main variants of insecure attachment provide a useful framework for thinking about the vicissitudes of this process. The avoidant individual sacrifices intimacy for an exaggerated form of autonomy, while the ambivalent person gives up autonomy for the sake of a dependent form of intimacy (Holmes 1996). Each will seek out a partner who can tolerate the pattern dictated by their internal working models, but each is also unhappy with the restrictions it brings, so every relationship also contains the hope that old patterns will be transcended. Individuals and couples need to come to understand how the 'trigger' points in their relationships – for rows, disappointment or misery – arise at these nodal connections between one person's set of painful assumptions and the other's.

Trauma destroys part of the security regulating system altogether (Garland 1998). If internal working models are partially inactivated, such people become 'immunologically incompetent'. They over-react to minor stimuli reminiscent of the traumatic event, no longer confident that their secure base will protect them, or they fail to react at all to threat and so become embroiled in more and more risky situations. Internal working models are not just restricted but have lacunae, for example in the area of sex or physical violence. People with disorganized attachments, typified in patients suffering with borderline personality disorder, find it hard to provide a consistent relationship pattern for their partners to adapt to, and, except when partners are excessively avoidant, tend to have radically unstable relationships.

Domain 6: Reflexive function and narrative competence

A key finding in the attachment literature is the relationship between 'reflexive function' as revealed in the Adult Attachment Interview – the capacity to talk cogently and coherently about oneself and one's difficulties – and security of attachment (see Chapter 3). The importance of this for psychotherapy is self-evident: psychotherapy is essentially a narrative process in which

therapist and patient together develop a dialogue both about the patient's life and the nature of the therapist–patient relationship itself. Therapy is an *in vivo* experience in which the patient learns to become self-reflexive. This is exploited in particluar by the transference-based approaches. When representations can be made explicit in language, they are available for metacognition, or 'thinking about thinking', and so modification. This is the cognitive aspect of the neo-Kleinian conceptualization of the Oedipal situation already referred to.

In summary, attachment theory has a number of features which comprise its unique contribution to psychotherapeutic practice:

- With its ability to move from external observable behaviours to mental representations, attachment theory is able to integrate psychodynamic, cognitive and behavioural perspectives.
- Attachment theory provides a coherent theory of the patient–therapist relationship, seeing it as informed primarily by the patient's need to seek out and find a secure base figure. The attachment model of a responsive care-giver who is likely to promote secure attachment corresponds with that of the good therapist: sensitive, responsive, consistent, reliable and psychologically minded.
- Attachment theory provides, via the Adult Attachment Interview, a theoretical underpinning for the story-telling, story-listening and story-understanding that form the heart of psychotherapy sessions.
- The classification of secure, avoidant, ambivalent and disorganized attachments provides an important evidence-based nosology for psychotherapeutic formulation.
- The notion of the secure base enables some of the apparently self-defeating behaviours found in psychiatric patients, especially those suffering from borderline personality disorder, to be understood, thus informing treatment approaches.

Attachment in practice

The application of these themes to therapeutic work forms the central preoccupation of this book. They form the theoretical background to an attachment-based approach to psychotherapy. But what does it mean to work with attachment in practice? The reader will find in the Appendix details of a Brief Attachment-Based Intervention (BABI) based on the six domains described in this chapter, devised by the author and currently being pioneered in the setting in which I work. At the time of writing, it is in the pilot stage and has not been validated or subjected to controlled evaluation.

There are many case histories in this book, which represent the fruits of psychotherapeutic work informed by attachment over the past 20 years, long preceding this more explicit model. Working from an attachment

perspective emphasizes several key aspects of day-to-day practice. None of these are peculiar to attachment approaches, but taken together they form a consistent integrative stance that is characteristic of attachment-based interventions, whether brief or prolonged.

1 *Attunement*. Empathic responsiveness to the patient and one's own emotional state, or 'attunement', is an essential part of any therapeutic intervention. Listening to patients' feelings and, simultaneously, to one's own feelings as they arise in an encounter is essential. Trying to put oneself in an other's shoes and, when necessary, using one's own feelings as a guide to theirs are part of this process.
2 *Emotional proximity*. A secure base in adult life arises out of emotional proximity – rather than, as in childhood, physical closeness – to an understanding and protective care-giver. The arousal of affect, whether sadness and tears, anger or fear, in sessions is a crucial means by which emotional proximity is achieved and arises out of the therapist's efforts at attunement.
3 *Forming and maintaining the therapeutic alliance*. The first task of any therapy is to create a working alliance, in which the patient feels committed to the therapy and has confidence that the therapist can help. Different attachment styles will require different strategies here. The avoidant patient will be wary, and the therapist must respect this caution and allow the patient gradually to feel safe in sessions and to 'come in' at her own pace. The ambivalent patient may mask her anxiety by a too-ready acceptance that therapy is valuable, and may need to be helped to find her own investment in it, for instance by being asked to think carefully about entering therapy before committing herself. The disorganized patient lacks a consistent attachment strategy and may oscillate, miss early sessions, drop out, etc. This must be tolerated and if necessary, the therapist must approach the patient by writing, telephoning or even occasionally visiting until, for instance, the borderline patient is ready to enter treatment. Once formed, the alliance will at times be subject to strains and fracture. 'Alliance rupture repair' is another crucial therapeutic task: without the alliance there can be no secure base, and without secure base there will be no exploration.
4 *Challenge*. Within the context of a secure base, the therapist's task is to challenge habitual assumptions and relationship patterns and create sufficient turbulence for new structures to emerge. Interpretation, confrontation and clarification are all technical means to achieve this end.
5 *Balance*. The aim of attachment-based therapy is always to bring patients into a balanced position *vis-à-vis* themselves and the world. In relation to the therapist, they must neither be too close nor too far; they must be able both to laugh at and take themselves seriously; they must be neither too fearful nor too bold; and so on. The therapist achieves

this balance in different ways with different aspects of attachment style. The avoidant patient is helped to get closer emotionally and to be more open to his feelings; ambivalent patients to get a distance on themselves and to see their feelings in perspective; the disorganized patient to find coherence. It is as though patient and therapist are on a see-saw and, once firmly, safely and trustingly established there, the therapist will always move patients in the opposite direction to the one they habitually take.

6 *The therapist's freedom of movement.* Another helpful metaphor is that of the boxing ring. The ring itself with its containing ropes represents the secure base of the therapy itself – the regularity of time and place and consistency of therapist behaviour. Within the ring, the therapist must always have freedom of movement, never allowing himself to be 'boxed in' or cornered by the patient. The insecure patient wants to hold onto the therapist, to know where he is at all times and to control him. This is typical of insecure attachment patterns, especially ambivalent strategies. The therapist's aim is to help the patient to trust himself, to know that security can only arise from the realization that there is no absolute security, and that being able to choose is what makes for freedom, not clinging on either to oneself or another. Thus the patient who asks, for example, 'Do you like me?' or 'Do you believe in God?' feels that security will flow from a definite answer to her question. The technically correct response is not 'yes' or 'no' as that would be to box oneself in, but rather, for example, to explore why the question is so important to the patient. As recorded by several distinguished therapists (e.g. Symington and Symington 1996), sometimes extreme measures are needed – jokes, outbursts of controlled anger or even shouting – if the therapist is to release himself from being trapped in this way and regain the centre ground within the therapeutic ring.

7 *Negative capability.* This is Keats' well-known prescription for approaching poetry – the capacity to tolerate uncertainty and doubt and to 'stay with' the material. Often one does not know what is going on with a patient. The therapist needs to be able to tolerate that state, secure in the knowledge that meaning will eventually emerge. Sometimes this can be used consciously as the 'Colombo principle' (Margison 2001), after the American TV detective who feigns confusion to trap his quarry. Saying, necessarily with a grain of truth, 'I don't quite understand what you mean by that . . . ' in a humble and apparently simple-minded way can help the patient to feel more secure, thoughtful, powerful and in control, as the care-giver asks the care-seeker for help.

8 *The thinking mind.* Finally, and perhaps most importantly, the therapist has to communicate to the patient that she is *there*, using his mind to think about what is going on in the patient's mind, trying to understand, and contain his mental representation of her feelings, to put them into words, and that this is part of a coherent care-giving strategy. Ultimately, emotional security comes from the experience of being understood in this way. This will inevitably involve struggle. Patients are often trying *not* to think about their pain, or to project it into others who will act on it rather that re-present it to them. To be thought about is both relieving and terrifying. The therapist has to be able doggedly to carry on with the thinking task without persecuting the patient with his thoughts. Thus at times he is a quiet presence, at others actively engaging the patient in debate about the nature of the patient's own thoughts.

Clearly, many, or all, of these strategies form the bread-and-butter of psychoanalytic psychotherapy, enhanced with the 'jam' (in the sense of something both enriching and bonding) of an attachment perspective. The next chapter explores in more detail the complex interaction between psychoanalytic ideas and those of attachment theory, and argues for narrative as a linking concept between them.