listened, the therapist felt the story almost as if it were happening to him, yet impersonally – both fully involved and at the same time watching, observing, still able to protect the boundary of the session, both for himself and the patient.

This is an inadequate attempt to capture an intense moment in therapy – moments which occur regularly but infrequently. Perhaps, in the end, this is what therapy is *about*: the emergence of a story that is both intensely felt (captures 'raw experience') and has an objective validity (congruence, contingency, verisimilitude). The therapist's specific contribution to this process is as witness, holder of the narrative boundary, 'subjective-object' (in Winnicott's terms), facilitator, and one who is able both to lose himself and remain true to himself in the process. Winnicott (1965) wrote of the importance of 'bringing the trauma into the area of omnipotence'. In the transference, the therapist becomes both the longed for and the abusive object – but because transferentially rather than actually so, one that is potentially transformational. Dave's therapist was responsible for creating a dependency and with that the hope that, at last, Dave would have the enduring inner object – the missing father – he so longed for. At the same time, that hope was constantly ('sadistically') dashed by the realization that his father *could* never come back to life again.

Such moments of insight, however significant, can never be points of arrival. Each story is there to be revised in the light of new experience, new facets of memory, new meanings. In this chapter, I have tried to bring to life the cycle of narrative construction and deconstruction which I believe is central to the therapeutic process. I have argued that narrative has its psychobiological origins in the 'marking' and contingency of maternal mirroring. I have traced the links between infant attachment patterns and adult narrative styles. I have tried to show how in psychotherapy the therapist shapes patients' story-telling and mirrors their affective experience in a way that leads to a more secure sense of self. In the next chapter, I turn to a more detailed examination of the relationship between attachment and trauma, especially when it is abusive.

Chapter 9 The Search for The Secure Base

Abuse, trauma and memory

An attachment perspective

Attachment theory starts from the power of adults to protect and provide security for their children. In abuse, this fundamental biosocial contract between adults and children is ruptured: adults use their power for their own ends rather than those of the child. In the first half of this chapter, I look at abuse and trauma from an attachment perspective; in the second half, I consider how these phenomena may influence the workings of memory and the constructions of personal narrative.

The dictionary definition of abuse includes the following synonyms: perversion, improper use, violation, adulteration and defilement. Implicit in these meanings is the notion of a normal or proper use against which ab-use can be measured: violence and the physical or moral rupture of integrity; transgression of sexual propriety; and from defilement the notion of fouling – the introduction of the unclean and excremental into a world of cleanliness and innocence. Any of these meanings, and more, may be triggered off in the listener when abuse is mentioned. To these we can add the Kantian notion of the wrongness of using fellow human beings as a means to an end rather than as an end in themselves.

Classifications of abuse usually list four main types: sexual abuse, physical abuse, emotional abuse and neglect. Implicit in the notion of abuse is the idea that each of these is a perversion of what a child might rightfully expect from his or her parents or care-givers. Equally, it seems likely that abuse will have a powerful impact on a child's attachment style, both as a trauma in itself and in view of the context in which abuse is likely to occur.

I will start with some preliminary remarks on similarities and differences between an attachment and the psychoanalytic perspective on abuse. As mentioned in the Preface, psychoanalysis puts desire at the centre of its thinking. Parents are their children's first libidinal objects. What is traumatic and confusing about sexual abuse is that the adult world, rather than containing and holding the child's desire, reciprocates. The fruit of the tree of knowledge is eaten before the child can digest it – with resultant shame and loss of innocence, and premature expulsion from the world of play and plenitude. This use of biblical imagery shows how the notion of abuse taps

into primal fantasies, and how abuse can become a metaphor for all that is evil and demonic – often one that is uncritically accepted as the cause of all psychic ills.

From Kleinian psychoanalysis came the idea that parents are not just the object of the child's first love, but also of their hatred. Intrinsic aggression and inevitable frustration of desire leads to murderous hatred in the baby, which, as with libido, is ideally contained and detoxified by the care-giver, so that, gradually, the child learns to cope with feelings of disappointment and deferment of gratification. In physical abuse, this process is perverted: rather than absorbing and buffering the hatred, the adult retaliates, using the child as a container for *his* deprivation and pain. In systematic emotional neglect, the adult refuses the inevitable intimacy of the parent–child relationship and the projective processes that implies. In a further perverse twist, the adult may see the child as deliberately inflicting misery upon him. Following the talion law of the primitive psyche, in the perpetrator's eyes abuse then becomes an act of justified revenge. Perversity can also afflict victims of abuse, which, when unravelled, is a form of protest and retaliation. This flows from identification with a bad or useless self, good only for exploitation and abuse. It is as though the abused person says to the world, 'you have treated me as a worthless object, so that is what I shall *be*'.

As we have seen, attachment theory starts not with libido, but from the overwhelming need for adults to provide security for their young if development is to proceed safely. Bowlby (1988) observed the extreme vulnerability of young mammals to predation (as many a fox, which has managed to drag off a newborn lamb for his young only to find his cubs fallen prey to terriers, would testify) and hypothesized that behavioural and psychological mechanisms which ensure proximity between adults and their offspring at times of danger are built into our nervous system through natural selection. The perverse paradox of abuse from an attachment perspective arises from the vicious circle in which an adult, usually a care-giver, is *both* the attachment figure to whom the child turns for protection and the source of threat which gives rise to the need for that protection. The more frightened or in pain the child becomes, the more the child clings to the perpetrator.

Abuse and attachment

It is tempting to speculate that different forms of abuse may connect with different parental patterns underlying anxious attachment. Avoidance arises in the context of parental aggression – child battering is the extreme example of this, and the frozen watchfulness of the battered child is perhaps a caricature of avoidant wariness. Childhood sexual abuse by parents or step-parents may tap into ambivalent attachments in which, as described at the start of this chapter, the child clings to a care-giver who alternates between being sexually intrusive and threatening or rejecting. Parental neglect, which, taken to the extreme, is a form of abuse, might link with disorganized attachment, in which the child despairs of finding any workable strategy for activating protective behaviour in his care-giver.

This is, of course, over-schematic. In clinical practice, the distinction between the different types of insecure attachment is not so sharp, with mixed patterns being common, for example, in eating disorders. This makes psychological sense, since avoidance and ambivalence are mirror images of one another: the avoidant person longs more than anything for intimacy, while ambivalent individuals crave autonomy, but both are too fearful to risk reaching out for what they really want. Thus anxiety lies at the core of insecure attachments (if that statement is not a tautology), and it is the failure of the secure base providing care-giver to alleviate anxiety that inhibits the capacity to develop both intimacy and autonomy.

Two ways of looking at abuse from an attachment perspective are to be found in the literature. Heard and Lake (1997) emphasize the shift from secure/companionable interactions to those organized around dominance/submission. The latter strategy enables the weaker party to afford a measure of protection from a stronger individual, but at a price in terms of intellectual and emotional development. Fonagy (1997) links Bowlby's (1988) notion of 'incompatible working models' with disorganized attachment and dissociative disorders, which are common in those who have been sexually abused. Where the abuser is a member of her family, the victim is likely to dissociate, both as a way of dealing with the pain and fear of the act of abuse itself, and also because the abuser who inveigles her into his room is the same person who behaves 'normally' in the public family context. The child thus has two incompatible internal working models of, say, stepfather-with-family and stepfather-as-abuser, and of herself in those two contexts as well. This will lead to a disrupted or incoherent attachment strategy and, ultimately, to the victim resorting to an aspect of the self or her body as a pathological secure base (cf. Chapter 2).

Aggression and protest

The Strange Situation Test centres around the way in which the infant responds to separation. The 'normal' response involves healthy protest – the parent is 'punished' by the child's cries and sometimes aggressive clinging for the act of abandonment. The capacity to protest, show appropriate aggression and to 'ask for help' (at the age of one by vocalization rather than verbalization) are marks of secure attachment, while insecure children are more likely either to be unable to protest or to be locked into unassuaged aggression. This picture can be linked with the Winnicott–Bion model of a 'breast' (i.e. attachment figure) able to 'metabolize' the rage and hatred of the frustrated infant, and return the feelings to the child in a detoxified form.

Security arises in part out of the ability of the care-giver to accept and contain protest without retaliation or rejection.

This is relevant to abuse in a number of obvious ways. First, a pre-condition of security is the ability to defend oneself when necessary, either by standing one's ground or by recruiting the support of a secure base adult. Secure people are not afraid of their aggression and can express it openly, or, when necessary, contain and soothe themselves appropriately when their anger is aroused by pain or fear. Inhibition of protest and appropriate rage is an almost universal accompaniment of abuse: how can one expect an adult who has harmed one to accept and 'metabolize' one's protests? A second, related point is that potentially abusive parents are in any case unlikely to be able to contain their children's aggression, doubtless because it triggers off their own feelings of uncontainment *vis-à-vis their* parents – the inter-generational pattern of abuse playing itself out here – and so will retaliate against or neglect the protesting child.

A third point concerns a key feature of sexual abuse, the inability of the child to let her parents know what has happened, or, if tentative moves towards disclosure *are* made, to be met with disbelief, rejection or punishment ('how dare you accuse your stepfather of such a thing, go to your bed at once you filthy-minded child'). Here the child's experience is invalidated or disconfirmed, with consequent distortions in self-understanding. In secure attachment the responsiveness, 'marking' and contingent responses of the parent help the child clearly to distinguish between self-experience and that of the care-giver. In insecure attachment, by contrast, especially in ambivalent and disorganized patterns, this differentiation is shaky, such invalidating responses serving to confirm pre-existing confusion and self-doubt.

Developmental pathways

Single episodes of abuse are far less likely to have far-reaching effects on the personality than is repeated abuse, suggesting that context is all-important, both in determining whether abuse occurs in the first place and, if it does occur, what its consequences are likely to be. Insecure or secure attachment patterns describe developmental pathways representing patterns of repeated parent–child interaction in a particular family constellation. These pathways, if suboptimal, do not 'cause' abuse, but represent one of the many factors, which acting in concert, can either promote or prevent abuse. Although what we call 'abuse' can be identified as definably inappropriate use of aggression or sexual transgression between adults and children, single or repeated events take place against a background of ingrained patterns of already established behavioural interaction between parents and children. Where isolated episodes of abuse do not have long-term consequences, these are likely to be secure attachment patterns. Much more commonly, insecure

behavioural patterns are internalized as 'internal working models' – which, in the case of children who are abused, will tend to be (but are not necessarily) maladaptive and hence, in the psychiatric sense, precursors to pathology. An abused child will carry with her into adulthood a set of assumptions – such as 'if anything goes wrong it is my fault', 'intimate contact with men is frightening and disgusting', 'I must submit to others' demands if I am to gain any safety at all', and 'the way to escape from intolerable situations is to split my mind from my body' – that will provide a breeding ground for disturbed relationships and anxiety or depression in later life.

Thus the overall context within which the abuse occurs is equal in importance to the abuse itself: a depressed and unresponsive mother; a stepfather, himself perhaps abused, at the end of his tether; unemployment, chronic ill-health, low self-esteem, and a myriad of other psychological and social factors which provide a backdrop to the abusive act (Belsky 1993).

From a clinical or preventative perspective, this contextual and 'cumulative trauma' must be accorded due weight. Given the dramatic and overwhelming nature of post-traumatic stress disorder (PTSD) symptoms such as flashbacks and phobic avoidance of the psychophysiological correlates of the abuse (the smell, sounds, level of lighting, terror, disgust, unwanted excitement, feelings of being trapped alone, or preparedness for self-sacrifice to protect siblings), it is tempting to focus exclusively on the trauma itself. In practice, both trauma and context need to be addressed. Indeed, in therapy with adult survivors of abuse, many months may be needed to build up a picture of the developmental context before the details of the trauma itself can be talked about.

Post-traumatic stress disorder as a syndrome was originally understood in the context of the Vietnam War and superseded the notions of shellshock and battle fatigue developed by psychiatrists and psychologists in the First and Second World Wars. The long-term effects of sexual abuse have many features in common with PTSD, and some have even tried to conceptualize borderline personality disorder (60–70 per cent of sufferers have experienced sexual abuse) as a form of PTSD (Gunderson and Sabo 1993). Herman *et al.* (1989) wrote of 'complex PTSD' to capture the long-term effects of cumulative trauma and its impact on internal working models. One of the key questions for both PTSD and abuse is to ask what determines whether such trauma will or will not be 'traumatic', in the sense of producing major psychiatric symptomatology or the distortions of personality development found in borderline personality disorder. An attachment perspective can help unravel some aspects of this.

Earlier it was suggested that a number of apparently perverse features of borderline personality disorder can be understood in attachment terms. In self-cutting, for example, the body is used as an 'object' that is simultaneously attacked and acts as a source of comfort – self-cutters regularly

report a temporary period of peace and calm following self-injury. Abuse interferes with the child's acquisition of the capacity to self-soothe: the parent whose soothing actions are normally a template which gradually becomes internalized, instead cause pain and fear. The child then turns to the body as a surrogate secure base for self-soothing. The 'secondary gain' of showing the wound to professional carers further mobilizes attachment behaviours. The inappropriate use of alcohol and drugs similarly blots out pain physiologically, and provides a feeling of being held and divested of responsibility similar to that which is sought when attachment needs are activated and assuaged.

Narrative and attachment

Only a minority of abused children will go on to develop borderline personality disorder. In children faced with adversity, a number of protective factors have been identified (Belsky 1993), including the existence of at least one good relationship – perhaps with a grandparent or teacher – attractiveness, sporting ability and the impact of psychotherapy (Styron and Janoff-Bulman 1997). Another aspect concerns the capacity to 'narrativize' painful experience. As discussed in the previous chapter, neuroimaging techniques suggest that traumatic memories are processed in the brain in different ways from non-traumatic ones (Van de Kolk and Fisler 1996). Most memories are stored in the brain in the form of 'stories', sequences of events that can be verbally recalled and in which the sensory and emotional aspects of the memory remain in the background. Traumatic memories seem to exist in a 'raw' sensory form, in which a coherent verbal account is hard to elicit. They are also often 'near the surface' and easily activated by cues that share features with the traumatic situation, triggering associated emotions such as panic and fear. Abuse can inscribe itself in the very way in which we think and speak about ourselves. The incoherent narrative style associated with abuse presumably reflects traumatic memories threatening to break through into consciousness, kept at bay by only partially successful attempts at verbal papering over cracks.

In the absence of a secure base, the child's capacity to develop self-narrative, and ultimately a self-reliant and positive sense of self may be compromised. If the child cannot rely on the parent to be there consistently, without interference or neglect, then his play and thoughts will be tinged with anxiety; if care has been abusive, the very coherence of thought patterns and the integration of affect with cognition may be disrupted.

Some attachment-inspired authors (Fonagy 1991; Hobson 1993) have linked the above empirical findings with the philosophical question how do we know that other people have minds? They argue that secure attachment experiences can only be provided by care-givers who see their charges as sentient beings, centres of their own personal universe. Conversely, in abuse

the victim is seen as an object without feelings or memory, and indeed may be coerced into denying her own experience. The title of one of Bowlby's (1988) late papers 'on knowing what you are not supposed to know, and feeling what you are not supposed to feel' captures this confusion beautifully. We know that other people have minds, the argument goes, because we ourselves have been treated as people with minds. The care-giver's view of us becomes internalized not just as our view of ourselves, but also of others. From this follows concern for the object and awareness of others' needs that is so often distorted in survivors of abuse.

Memory and abuse

A fierce debate has raged on the question of memory and abuse. From an attachment perspective, abused children are likely to have disorganized attachments and incoherent narrative styles. This means that their capacity to hold onto a personal narrative is profoundly compromised: reality and fantasy may be confused, fact and fiction conflated, and the normal capacity (which is installed early in development, around the age of 3 years) to distinguish between what is the case and imagination (which will inevitably be stimulated by real events) impaired.

For Freud, the clarity of memories, as opposed to the hazy quality of dreams and phantasy, was the method by which we decide on their veracity; thus an 'ultra-clear' phantasy (which may arise in those who have been subject to trauma generally) can easily, by perceptual 'mis-attribution', be labelled as a memory (a point originally made in the eighteenth century by Berkeley).

Recent findings from cognitive science help us to unravel some aspects of memory in relation to abuse. For example, 'infantile amnesia' (Lindsay and Read 1994) is virtually universal for the first 2 years of life. It seems likely that there is a neurological/maturational basis for such a lack of memory, and that the advent of language around 2 years is linked in some way with the beginnings of what Tulving (1985) calls 'episodic memory' – that is, the ability to recall specific events and situations. That is not to say that the experiences of the first 2 years of life have no effects, or are not in some way 'laid down' in the nervous system. Quite the contrary: Tulving differentiates the episodic memory system from what he calls 'semantic' and 'procedural' memory. Semantic memory refers to the 'grammar' of our lives: the rules of relationships that are just as ingrained as are actual happenings, which Byng-Hall (1995, after Schank 1982), calls 'event-scripts'. Procedural memory would be akin to Segal's (1991) 'memory in the body', the somatic sensations of intimacy, rejection, satiation, frustration, and so on that form a psychophysiological substrate to the sense of self (what we and the world 'feel' like), and is presumably related to parental handling in the early months of life including attachment experience.

Again, the radical distinction between memory and forgetting assumed by some authors is questionable. We now conceive of a much more fluid relationship between consciousness and the rest of the mind. We may be completely unaware, dimly aware or consciously suppress painful feelings and memories or, at times of stress and depression, feel overwhelmed by them.

The return of the repressed

Jonathan, a depressed teacher in his forties, 'knew' that his father had been an alcoholic and had died when he was 11, that his brother had died in a road accident a year later, and that his mother had had a depressive breakdown soon afterwards, but he never talked about these events to anyone, even, as he put it, 'to myself'. It was only when he began to be overwhelmed with feelings of sadness and futility around the time that his son reached the age of 11, and he was himself slightly injured in a minor road accident, that he sought help. In the setting of therapy, vivid images from the past came flooding back – the mixture of sympathy and disgust he experienced when he helped his father to walk to the off-licence.

In working therapeutically with abuse survivors, memories may take one of three forms. First, the patient may be helped to get in touch with current thoughts and phantasies of which she is dimly aware, but has failed to attend to, or to realize how much they may be influencing day-to-day moods and behaviour. Second, there may be the emergence of genuinely repressed traumatic memories, as in classical psychoanalysis. Third, and most contentiously, there are putative memories that may be inherently unrecoverable in 'semantic' form – if they date to a time before the age of 2 – but which may be inferred from the patient's history, collateral evidence and behaviour in relation to the therapist.

Changing clinical experience

Dissociation and classical hysteria are comparatively rare in contemporary clinical practice. We are just as likely to encounter patients who are overwhelmed with memories from the past which they cannot quell or cope with as we are people suffering from classical repression. As Alvarez (1992) put it, some people need to learn to forget, given the high incidence of traumatic abuse to be found in the histories of the borderline patients who seem to be the modern equivalent of Freud's hysterics (Bell 1992). They really do suffer from their reminiscences. From the perspective of attachment theory, enmeshment in past pain is just as much a manifestation of insecure attachment as are avoidance and dismissal.

What we call 'memory' is an active system (Loftus 1993), (a) which depends on the state of the organism and its relationships at the time of the

experience, (b) which is actively worked on ('processed' or assimilated) subsequently and given meaning, and therefore (c) which, in so far as it is congruent with the assumptive world or 'internal working models' by which the individual lives, will become part of a store of memories which can be used to guide action and to reinforce a sense of self, but, if not, acts as a potential source of conflict and self-division. Finally, (d) conscious memories and their meanings are continuously updated in the light of later experience (which, surely, is what makes psychotherapy possible). Unassimilated or unconscious memories are not available for such reworking.

The attachment literature suggests that 'processing' of feelings is only possible when an individual feels secure, since exploration is necessarily inhibited if the individual is in a state of tension. Each of the main types of insecure attachment produces a specific impairment of memory. The avoidant individual simply suppresses her memories and would perhaps be closest to Freud's original formulation of hysteria: memories are not available for assimilation since they have to be experienced in the present before they can become part of the past. The enmeshed individual, by contrast, is overwhelmed by painful memories from the past: her problem is not remembering but forgetting. In disorganized attachment, which is seen most frequently in relation to deprivation and abuse, there appears to be no coherent overall integrative strategy: the individual has a tendency to dissociate from painful experience, and presumably therefore memories from one another, leading to a lack of overall structure of personal meaning. The childhood origins of such patterns emphasize the interpersonal aspect of memory. Secure holding is needed if a child (or troubled adult) is to be helped to distinguish between fantasy and reality, to separate the real from the unreal. The style of an adult narrative is more likely to give clues as to the history of such holding, or its absence, than is the specific content of the story that is being told.

Janet saw hysteria in terms of dissociation, but dissociation is not in itself a pathological process. We all have multiple selves, both contemporaneously (husband, lover, friend, etc.) and across time ('Can the person who stole that half-crown be "me", the upright citizen, and which is the "real" me?'); we can act a part, dissemble, deceive others and sometimes ourselves. What seems to be different in hysteria is not dissociation itself, but the lack of awareness that one is dissociating. The crucial capacity here is self-awareness, or reflexive function, a key requirement if secure attachment (and therefore the ability to process memories) is to be achieved in the face of adversity.

To return to Tulving's (1985) classification of memory systems, it appears that episodic memory rests on a substrate of semantic and procedural memories which reflect the interpersonal context at the time of the experience. As suggested in the previous chapter, most individuals have a store of relatively few *prototypical* or *nodal memories*, which seem to encapsulate their view

of themselves and their past and are integral to personal identity and meaning. These are 'episodic' – in the sense that they appear to record actual events – but they also typify semantic and procedural elements. The work of psychotherapy often centres around these nodal memories as they are unpacked and recontextualized in the new setting of the therapeutic relationship.

A nodal memory recontextualized

Jamie, a highly avoidant and schizoid bisexual man, who had grown up in a rough working-class area in Glasgow and had left home at the earliest opportunity to go 'cruising' in the local bars, had a recurrent dream in which he was standing by the door of his mother's flat, unable to leave because she was holding his testicles. When he came into therapy he interpreted this as: 'She's got me by the balls'. Towards the end of therapy, he began to see the same image as an expression of her acknowledgement of his vulnerability, an attempt to cradle him and protect him from violence – his own and that with which he was surrounded.

Recovered memories and false memory syndrome

In the light of this discussion, I will now briefly comment on the controversy surrounding recovered memories and the so-called false memory syndrome. We now know how erroneous and simplistic was Freud's pre-1897 model of hysteria: symptoms equal repression equals abuse, therefore therapy equals remembering equals recovery. But there is still truth in these original ideas, especially in relation to childhood abuse. Memories are often kept out of awareness. When they do surface, they threaten to overwhelm the sufferer, who often develops symptoms which in the nineteenth century might have been labelled as 'hysteria': feelings of panic, nausea, dizziness, sexual difficulties, and so on. The 'recovery' of memories often arises out of a contemporaneous trigger, such as a relationship difficulty or a child reaching the age at which the sufferer was abused. Such people appear to have been deprived of the soothing and comfort associated with secure attachment and, as suggested in Chapter 2, may turn to drugs, self-harm, eating disorders, and so on as a vain attempt at self-soothing. Self-harm soothes because it distracts from mental pain, a dissociative technique that many traumatized people discover as a way of enduring the pain and humiliation of abuse. Chaotic relationships, alcohol and substance abuse, and eating disorders serve the three-fold function of distraction, possible endogenous opiate release and evoking protective behaviour in others (De Zulueta 1993).

The epidemiological evidence suggests that total amnesia for trauma and abuse is rare, although, as mentioned, amnesia for events before the age of 2 is almost universal. In one study of women known to have been abused in childhood, only 20 per cent had no recollection of it (Lindsay and Read 1994). Much more common are patterns of unassimilated memory coloured by insecure attachment patterns: facts are recalled but not feelings, or the sufferer develops trance-like states in which past and present are confused.

At worst, 'false memory' can arise out of simple errors of logic. *Post hoc, propter hoc* bedevils discussions of causality in psychotherapy generally. Even if the simple recovery of memories did lead to a cure – and there is very little evidence that it does – that in itself would not prove that the forgetting of memories was necessarily pathogenic. Childhood trauma and abuse undoubtedly comprise significant vulnerability factors for adult psychiatric disorder, but are not in themselves causative (Mullen *et al.* 1993). A simple error of logic is that of the 'undistributed middle'. Thus the argument 'bulemic women have often been sexually abused in childhood, you are bulemic, therefore you must have been sexually abused – even if you have no recall of it', is logically unsound, although apparently widely believed by therapists (Poole *et al.* 1995).

Conclusion

In conclusion, *memory is a construction* and is therefore inherently fallible. Attachment theory can help understand the different ways in which memory can fail. An important finding from the Strange Situation Test is that attachment status with one parent is uncorrelated with that for the other, at least at the age of one. It is possible for a child to develop a number of attachment patterns, each of which appears to be stored independently in the brain. This presumably has survival value, just as the symmetry of organs means that if one is damaged the individual can continue to function. Thus, despite abuse, if a person has had at least one relationship that allowed for the development of reflexive function, she may well survive without major relationship or emotional difficulties. Autobiographical competence – the ability to describe one's past, however painful, clearly and coherently without denial or being overwhelmed – is a manifestation of secure attachment and reflexive function. Freud thought that putting trauma into words was curative, but it is more likely that *secure attachment and concomitant reflexive function* underlie *both* resilience and narrative competence.

It follows that the recovery of memories will not in itself necessarily be curative. Indeed, an enmeshed and intrusive therapist–patient relationship in which trauma is endlessly rehearsed may merely reinforce ambivalent forms of insecure attchment (cf. Dozier *et al.* 1994). The therapist must create a secure base for the patient from which she can begin to recover and re-evaluate her past. As we have seen, secure attachment follows from responsiveness, attunement and the capacity for healthy protest. Intrusiveness and inconsistency are associated with ambivalent attachment; in so far as 'suggestion' is intrusive and compromising of autonomy, Freud was

correct in his eschewing of suggestion. A major aim of therapy is to enhance reflexive function, through providing the patient with an opportunity to experience, consider and master her feelings in relation to the therapist. It is this that makes Sandler and Sandler's (1994) 'present transference' as important as any recovery of memory.

The importance of present transference

Alison, mentioned in Chapter 7, a woman in her forties, felt that her whole life had been ruined by a tyrannical and abusive father. In therapy (as in the rest of her life) she was placatory and compliant, endlessly trying to guess what the therapist wanted from her, so that she could earn the approval from him which she felt had never been forthcoming from her father. On one occasion her therapist had to change the time of her session slightly and rang her at home to arrange this. In the subsequent session she described her initial reaction, which was to think 'Good, now he owes me a favour, he really *will* have to care for me this time'. When the therapist failed to offer her the praise or encouragement she craved, she became first self-pitying and then angry, and finally revealed how intruded upon and abused she had felt by the therapist's telephone call. 'Reconstructing' her father's abuse was important, but it was also familiar territory, which in itself had not alleviated her pain. 'Finding' her authentic anger in the present was a necessary step towards turning her abuse from continuous torment into a painful memory.

As our lives progress through time, we are constantly creating a past. To experience the present – joyful, neutral or painful – we have both to let go of the past and to preserve it. From her dark perspective, Melanie Klein (1986) saw life as a series of losses, and equated maturity with the depressive position in which loss and the hatred it evokes are reconciled with attachment and love. As we have described, later Kleinian writers have seen depressive position function in Oedipal terms: the ability to separate oneself from one's mother and 'allow' her to be with one's father (and siblings). This creates a 'third term', a distance, a space within which thought and words can arise (Britton *et al.* 1989). For Klein (1986), loss is bearable because, in healthy development, the lost object is 'reinstated' in the inner world. This 'reinstatement' is inseparable from memory. In Sonnet 29, Shakespeare starts in narcissistic despair: 'When in disgrace with fortune and men's eyes/I all alone beweep my outcast state' and then, suddenly, he remembers his beloved:

Yet in these thoughts myself almost despising
Haply I think on thee, – and then my state
Like to the lark at break of day arising
From sullen earth, sings hymns at heaven's gate;
For thy sweet love remembered such wealth brings
That then I scorn to change my state with kings.

This poem spontaneously came to mind while working with an utterly miserable, borderline patient who seemed to see no hope and no future. It prompted me to remind her that she had lost touch with the one good relationship in her life, which was with her father (who sadly had died when she was in her teens). This produced at least a temporary shift towards a more positive mood in the session. For Shakespeare the 'good object' was not just his beloved, but the poem itself within which she (and in the early sonnets, he) is reinstated. Similarly, it is the psychotherapist's task to help the traumatized patient to find not just good memories, but to provide the setting that can prompt the words to describe them, in such a way that they no longer distort the present as in false memory syndrome, nor are lost in an irretrievable past as in classical repression. In the next chapter, I look in more detail at the role of art in helping overcome trauma, once again using examples from Alison and Oliver's therapy.