A return to Bowlby: assessment, boundaries, and inner working models

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Abstract: This article provides an overview of some fundamental aspects of practice within an attachment-oriented view of therapy. The article presents a scholarly approach to understanding the mainstream contribution of the Bowlby–Ainsworth model of attachment as exemplified in the empirical literature (Ainsworth et al., 1978; Owen, 2017). The article starts with a brief conclusion on what John Bowlby argued should be the core aspects of therapy. It connects these ideas to the work of Robert Langs, arguably the one person most responsible for the idea of boundaries and guidelines in contemporary practice since the 1990s. For attachment-oriented practice, the psychodynamics of supplying and receiving care is a central dynamic in therapy. In the case of individual work, there are the countertransference and counter-resistance problems that therapists bring. On the client side of the relationship, there are the problems of what Freud called resistance, a shamefaced inhibition of speech and self-disclosure, plus transference, understood in a broad sense of making assumptions, plus misunderstanding and mis-empathising the intentions of therapists because of clients' personal histories. Bowlby identified the inner working model as explicit or implicit procedural and affective memories that are the link between the onset of an attachment process and its contemporary effects. Attachment is a developmental hypothesis about learned motivation and meaningfulness between the alleged distal causes of proximal events (Bowlby, 1973, p. 44). These topics are discussed in a wider understanding of what it means to provide good enough care.

Key words: psychodynamics, attachment, empirical research, boundary setting, inner working models, development.

This article is written with the assumption that therapy should be a "win–win" experience for therapists and clients alike. This assumption is not an idealised hope but a practical requirement. To give care involves receiving learning about what works and what does not. It also includes receiving thanks from clients whose positive reactions reward their caregivers and it wins the ethical prize of doing the right thing for the public who need care. If this were not the case, there would be no positive motivation for caregivers overall. Having an eye on the dynamics of caring, includes client and therapist perspectives, and shows that

ethically, to provide care, also achieves an ethical and compassionate aim: therapists work not only by making trusting relationships with potentially difficult clients, but also they do the right thing by them. Such a context of understanding the dynamics of helping people puts a different perspective on the emotions felt on both sides of the relationship. The negative motivation for therapists is that to want to care for traumatised and difficult to help clients, means being open to their pain and the difficulties of providing care to them. In balance, if the positive outweighs the negative across a career, then genuine satisfaction is achieved for oneself and the public. Clients should be helped to feel trust, so that they self-disclose and get the help they need. For therapists, the aim is to promote their awareness and skills so that they feel enriched by the work and enjoy client contact.

The first section starts with a return to John Bowlby to gather up the distinctions he asserted. The argument is kept close to Bowlby's texts in order to indicate the true extent of the phenomena of attachment.

Bowlby's definitions of practice

In the work of Bowlby, there are some constant themes across his writings. These are comprised of the following points, which are interconnected. The golden rule for therapists is that the primary responsibility is to make and monitor clients' usage of the relationship as a secure base (Bowlby, 1979, p. 145; 1988, pp. 138–140). Bowlby argued that therapists' primary aim is to enable a secure base to form despite the time-limited nature of the contact. Therapists facilitate client exploration of topics and emotions through asking questions and being genuinely interested. One possibility is to understand clients' relationships together (Bowlby, 1979, p. 146; 1988, p. 138). Such a direction is standard practice for all modalities. An attachment-oriented position claims the universality of attachment dynamics in all types of helping and health care because attachment is mammalian. In addition, therapists explore and correct mis-empathies of clients about themselves (Bowlby, 1979, p. 146; 1988, p. 138). This encourages being active in finding out and monitoring how clients see therapists and their efforts. Therapists make developmental understandings of client's self-images in the past and compare them with current contexts (Bowlby, 1979, p. 146; 1988, p. 139). This can be formalised in writing with clients, or by asking them to explain how they have developed, or in others ways verbally, help them create a developed narrative about their own development that includes good and bad senses about self and others.

Such a developmental perspective is one that makes falsifiable hypotheses empirically. Therapists can test hypotheses as well as provide care. They work to discriminate between old and current attachments and are free to interpret causes in the Freudian sense of suggesting a possible cause. Interpretation is not about being dogmatic, but should be done in such a way that it invites discussion, and is open to the possibility that therapists have misunderstood something, or that

something may not have been communicated to them in full. Therapists often work by finding defensively excluded information and re-supplying it to clients for their benefit (Bowlby, 1980, p. 46). The factors that create defensive exclusion originally are not the same as the factors that increase or decrease it, in the current context (Bowlby, 1980, p. 71). Across the lifespan when bids for attachment are unsuccessful, and repeated efforts have not produced the desired satisfaction, then the effort expended reduces. Bowlby called this effect deactivation and it is better known as the avoidant pattern in children or the avoidant process between adults (Bowlby, 1980, p. 42). It is defensive exclusion that makes people unable to deal with others and social contexts (Bowlby, 1980, p. 72). Bowlby recommended reliving as one way of reducing defensive exclusion and so gaining the lost information that needs to be aroused and directed to whom it concerns. This is because the feelings are about lost attachment figures (Bowlby, 1980, p. 200).

Furthermore, following the understanding of what it feels like to be temporarily or permanently separated from an attachment figure, therapists should be aware of the likely effects of separations during therapy and what it feels like to bring valued help to a close (Bowlby, 1979, p. 148). Therapeutic relationships are attachment relationships (Bowlby, 1980, p. 346). When therapists go on holiday, for instance, or are unavailable through illness or maternity leave, then clients will find it upsetting. Because of having had a training therapy and further therapies, therapists have first-hand experience of being a client and can use these experiences when they empathise. Bowlby made it clear that psycho-education on attachment is acceptable and this could be supplied by suggesting reading or watching videos (https://youtu.be/8utPZ77HepY).

In summary, the mission statement of Bowlby sets out some fundamental points about attachment-oriented therapy. Bowlby wanted to identify the motivations for what Freud would have called "finding the head of the Nile" in his psycho-analytic return to childhood (Lohser & Newton, 1996, pp. 152–155). The original reason why the current relationships of adults progress as they do is because of the accumulation of effects across childhood, where trauma and other problems around absences, repeated absences and breakdowns in caring relations, add to the complexity of the inner working models that get played out in the current moment. What Bowlby and Freud share is the belief that childhood is most influential. Furthermore, the less the number of ruptures in the secure base, the stronger will be the ability to pass on security and recover from early damage and trauma. The next section connects the idea of the secure base with that of the secure frame.

Boundaries and ground rules

Robert Langs is the person who made links between Freud's interpretation, unconscious communication and the falsification of hypotheses, following the philosopher Karl Popper (1959). Langs researched what happens in supervision during the 1970s

and forged a system that took Freud's idea of unconscious communication to be a set of commentaries on the implications of the actions of therapists, among other things. Langs devised a way of testing clients' unconscious communications that he claimed were disguised criticisms of the shortcomings and implications of the practice of their therapists. Langs' contribution highlights the need for clarity and safety, so that clients can feel properly held. The secure frame includes attending to the role of confidentiality, managing cancellations, providing ethical guidelines and gaining the support of the larger organisational context. Any setting that is unclear, unprofessional or unsafe, hinders therapeutic effects and threatens the continuance of the relationship itself (Langs, 1998).

Following this lead more broadly gives rise to the following pointers that constitute practice in a secure frame. However, for attachment-oriented practitioners, merely having a secure frame is clearly insufficient. The role of therapists in this view is much more about understanding the possible attachment processes that clients bring and pre-empting problems to prepare the way for self-disclosure.

In addition to the points already made, the role of therapists is primarily to act as a guardian of the secure frame and facilitator for the relationship, they work to make it secure, a pro-secure aim. This is done by monitoring and re-establishing secure conditions to the extent that this is possible with the full range of people who ask for help. Therapists should be well experienced at managing the starts, middles, and endings, and know how to manage absences, particularly client cancellations and how to deal with money in private practice.

The primary secure base for therapists is, of course, supervision. However, quick access to therapist colleagues is supportive. If employed or working voluntarily in an organisation, then the employer has a duty of care to their employees, and such organisational conditions should be sufficient to support a secure base also.

Being authentic, warm, relaxed, and attentive are all major aspects of what it can be like to practise. The other major aspect of any form of therapy is the degree to which it is collaborative in the sense initiated by Freud. What can be identified by a close attention to what Freud actually practised (as opposed to wrong readings that claim he was rigid, dismissive, and inflexible) was that he was a kind man, who hated rule-bound therapy and thought that strictness and a hierarchy of power in the meetings are bad practice (Lohser & Newton, 1996, p. 180). On the contrary, Freud was responsive to his clients, never had an excessive focus on boundaries and believed that therapists should not hide their humanity behind an inauthentic facade, but rather should be restrained and disciplined in how they respond (Lohser & Newton, 1996, p. 204).

Also, to specify collaboration a step further, it seems to be the case that getting mutual agreement on topics to be covered, and working through them in the order that clients feel is most important, is a way of ensuring that they get the help they have come for (Lohser & Newton, 1996, p. 209). On the part of therapists, it is also the case that specific important aspects of attending to risk and self-harm need to be dealt with before going on to other topics. The actual explanation of roles of clients

and therapists can be done in writing or verbally. It should also be clear to clients how to complain to therapists. Reviews of the work done so far are one way of getting feedback from them on how things are progressing, to pre-empt problems.

The connection between Bowlby and Langs concerns the need for therapy to feel sufficiently safe and for therapists to be approachable, particularly in cases where clients are unsure that they can be helped and are resistant in expressing confusion, lack of understanding, or other negative emotions. They may worry about the implications of how they read their therapist's intentions and manner. The connection between Bowlby and Langs concerns focusing on how clients with different attachment processes respond differently. For instance, the anxious process tries to get contact but could be critical of it when received. Alternatively, those who are avoidant are unused to asking for help, self-disclosure and emotional intimacy, and may feel repeatedly exposed after self-disclosure and find focusing on negative emotions to be stressful. A brief return to the basics of psychodynamic thinking in Freud is required to identify the commonalities between Freud and Bowlby.

The importance of resistance

Freud's observation that resistance is the slowing down or cessation of free association and self-disclosure is pertinent to any therapy, not just formal psychoanalysis and the psychodynamic approach. Freud's open listening requires the monitoring of resistance, a type of social anxiety that inhibits speech, to enable clients to attend sessions and explain their viewpoints in sufficient detail (Breuer & Freud, 1895, pp. 278–279). This is important because the route to them receiving help is by reducing their resistance and repression, so enabling them to speak and self-disclose (Breuer & Freud, 1895, p. 157). Some of the most frequent and obvious aspects of resistance are when clients are persistently late for sessions, have persistently nothing to discuss, and who persistently change an agreed topic for a session away from what was agreed. These are all resistances in Freud's sense. Freud's guidance was that this breach of the basic rule really means task-avoidance, and that therapists should work to provide help, and so uncover resistances in order to help clients reduce them (Lohser & Newton, 1996, pp. 165–168).

A second, more inarticulate resistance, is when clients' moods worsen and they do not mention it, or they develop new problems during the course of the meetings. What to be aware of are non-verbal expressions such as sullenness, anger, sharp voice tones, or flat uninterested moods, or non-verbally expressing dislike when discussing emotions. The key indicators are to be aware of what is expressed non-verbally through visual acuity and attention to voice tonality. Non-verbal communication is more important and continually expressed in comparison to the verbal content of speech, which is only spasmodic. If anything, non-verbal demeanour is worthy of interpretation in Freud's sense, which is to suggest possible causes of the non-verbal sense that clients are expressing (Lohser & Newton, 1996, p. 172). A third

inarticulate expression of resistance is when therapists do all the work because it is easier for them to be busy. Specifically, it is easy for therapists to employ their empathy and intuition and to make all the links when clients are hanging back in doing so. Such a situation is an opportunity for holding on to what therapists think and asking clients to make some links, through question-asking or some other procedure.

While a central focus of psychodynamic therapy since Freud has been on transference and countertransference, a proper understanding of Freud's original project always entailed resistance. The further identification of counter-resistance by Heinrich Racker is the observation that therapists, too, can be resistant. Counter-resistance refers to therapists' own resistance to interpretation (1958, p. 215), and by extension, to therapists who increase the difficulty in seeking care within a trusting relationship. The analysis of individual therapy by Una McCluskey and colleagues, for instance, identifies unhelpful processes that arise that are failures, mainly on the therapist side of the relationship (Heard et al., 2009, pp. 133–141). The component pieces of how therapy goes awry are stated pithily as when any person in the role of caregiver is "unavailable … present and inattentive … present and threatening (including threatening abandonment) … [or] perceived as rejecting and/or dismissive or shaming" (Heard et al., 2009, p. 134).

All the comments above so far, have been merely introductory. What follows is the main body of a focus on the importance of the assessment phase as an opportunity to find out the potential attachment dynamics with new clients. The role of thorough assessment has the purpose of securing the frame and removing hindrances, before offering on-going meetings. Of course, no one knows the future, and some occurrences cannot be predicted. Yet the assessment meetings are a good opportunity to create the conditions that will support proper expression from clients—and should enable therapists to enjoy their work and provide safe and effective care. In order to achieve these aims there appears the importance of the assessment phase and how to get an objective handle on the mental states of clients. The next section comments on assessment. The section after it discusses the use of a questionnaire to monitor risk and progress that has been used in the research of real therapy, outside of research clinics.

Assessment

The decision to accept someone as a client means providing a secure base for their distress, as agreed by Bowlby and McCluskey, and others within similar models such as Freud and Langs. To create and monitor the use of the secure base, at an emotional level, means that therapists are willing to tolerate empathising the emotional pain that clients bring. Practically, it includes pre-empting hindrances that can be expected during the assessment phase itself, before making a firm commitment to help. However, a number of problems arise in making such estimations, and whilst

at one level, it is an empirical question as to what will happen during the course of the meetings, the responsibility of providing safe and effective therapy requires recapping the basics of practice, in any setting and for any modality. Given that Crawford et al. (2016) found that approximately 95% of people are helped with therapy, there is always the possibility that the remaining 5% are not helped by therapeutic conditions to such an extent that they deteriorate long-term. The role of assessment is to be thorough in agreeing collaboratively what the focus of the work will be, and to remove potential obstacles, before making a commitment to stay with the person and keep motivating them to achieve change, about what can be changed, and to accept what cannot.

Assessment is an opportunity to explore initially the conditions around clients, and their understanding of their tendencies, at a time when there is no commitment to standing by them. Thus, the role of assessment needs to be made clear to avoid misunderstanding and disappointment. For instance, "the purpose of meeting with you today is to find out how to help you best." The least amount of help that can be offered at assessment would be to recommend a plan for grounding and preparation, to enable people to be ready for therapy later. This course of action can be offered unless people have repeatedly deteriorated in past therapies because they found it far too distressing and impairing for them: in this case, the recommendation would be to self-manage their lifestyles and practise compassionate self-care.

Three other possibilities become more likely when there is a lack of a thorough assessment. One problem would be to take on persons who later become actively suicidal, for instance. Such a danger is amplified when they have no secure base in the therapy or in their home lives: they do not turn towards anyone when they are distressed and keep their intentions and feelings of self-loathing entirely to themselves and may not call crisis services of any sort. Clearly, if someone were contemplating suicide, had made plans about how to kill themselves, or had in their mind a situation they would find intolerable, then these are clear risks that need discussion and planning.

In the case that clients are self-harming or are at risk of suicide, then a written individual crisis plan should be made with them that specifies, "when I feel suicidal I will …". This should be done with each person and the idea of merely saying "call the NHS or the Samaritans" is insufficient. If a client dies, then therapists will be requested to attend a Coroners Court where they will have to explain their actions to the family of the deceased.

Some current self-harm, even if it is regular cutting and self-injury, can be successfully treated, as can severe and enduring eating disorders and obsessive–compulsive disorder. The relational, cognitive, and affective impairments that go with excess drug and alcohol usage are treated by agreeing a focus of reducing, or being abstinent from usage, prior to beginning any other focus apart from dealing with suicide and risk. People who have fully recovered from a psychosis may be able to participate in therapy, as even to some extent will some people who have well-managed residual psychotic experiences.

Another problem is taking on people who later promote feelings of dread, overwhelm, and excessive responsibility in their therapists. The emotion of not wanting to meet clients, or not wanting to hear specific emotions, or not discuss specific topics, are all hindrances to clients receiving care. If there are dilemmas about helping someone, the dilemma should be shared with them openly and discussed in a problem-solving manner with them.

However, there may be sound reasons why the emotions that arise from seeing someone are personally overwhelming. For instance, if therapists have suffered sexual assault or sexual abuse as a child, then when meeting with persons who have the same experiences, it might be possible to resonate with what they feel. Yet to offer help is to state that one will accept the emotional pain that arises in oneself merely through being open to the pain of the people seen.

Another problem of a different sort is being too risk-sensitive, and turning down those who ask for help at assessment, through a misplaced sense of overwhelm. If the therapists' sense of overwhelm had been properly addressed, it would have required a thorough exploration and preparation. If therapists feel overwhelm at assessment, then good supervision or new supervision, should have dealt with the worry and address it, so care could be offered.

No one is above the law and all are subject to legislation and the recommendations of professional bodies on safeguarding against risk to self and others. This is particularly pertinent in helping people who self-harm, have suicidal feelings, and have problems such as anorexia, where clients could die. The other most likely problem is encountering people who have been sexually abused yet the perpetrator may still have access to children.

It is acceptable to say that it is not possible to help someone currently and explain why that is the case. In such a case, the minimum help the public can expect is for therapists to offer some recommendations, verbally or in writing, to help stabilise them prior to therapy—or to suggest community resources. It is not just eye movement desensitisation reprocessing (EMDR), cognitive behavioural therapy (CBT) or behaviour therapy that needs careful screening as to who to accept, to stave off potential problems. The exclusion criteria for therapy include some of the following points. One key question that defines assessment can be stated as "what is sufficient to make my modality work for this person?" In addition, "what is it about what is on offer that is sufficient for this person?" If there is risk, self-harm or potential harm to others, then these matters should be dealt with according to the local legal situation, the rules of one's employer and professional body. At assessment, it could be asked if clients are ready to begin to give up their self-harm (in the broadest possible sense of this term). If there is risk to self and others, including the possibility of self-harm of any sort, or other major psychological crises (extreme emotional states, dissociation, etc.), then these need to be addressed as a priority and managed. For those who work outside of psychiatric and forensic settings, this may mean not starting therapy until such matters have been safely contained and addressed.

A number of priorities shape the decision-making process overall. If the physical health of self or others is endangered through attack, self-harm or suicidal intent, then these need to be addressed as a matter of urgency. Self-harm can also be understood in a broad sense that includes the need for maintaining the bodily self and providing caring for self, as that person would care for others. If there is a current psychosis, or transient psychotic experiences, then unless specialist therapy can be offered to deal with these experiences, then the person should be referred elsewhere. For instance, therapy should not be offered when clients are seriously suicidal, particularly when their self-harm and low self-esteem are active, and if they have a complex personal history. This is because even if social support is present, therapy is likely to increase temporarily their low self-esteem, regret, and self-loathing. Such negative feeling could happen after airing their thoughts in sessions to the extent that it might weaken the relationship and elicit their strong belief in their own worthlessness.

People who do not self-disclose are easily rejected, and those who do not understand what sessions will entail, are likely to have difficulty in using the opportunities offered them. Clients can fulfil their potential by finding a social context (of family, home, friendships, play, and work) that they feel they belong to and are right for them. This latter aim is usually part of the end-phase of therapy and may feature as the last stage in providing care to people who self-harm and experience severe and enduring distress.

The following are further factors that may increase the odds against any type of therapy coming to a successful close: where "successful" means being able to increase understanding and quality of life through alterations in relating and behaviour. On the client side, the following tendencies may contribute towards a contra-indication for any therapy. Some reasons for not offering therapy include a refusal to ask for help when feeling actively suicidal. Those who are actively suicidal with no social support, and who refuse to ask for help when suicidal, ultimately could become subject to the Mental Health Act 1983 and need to be referred to emergency psychiatric services.

If people are unwilling or unable to tolerate the pressures of ordinary living without drink or drugs, they may not be psychologically available for therapy, because whenever they are distressed they will abuse their substance. If a person is using drink and drugs to keep away thoughts and feelings, then decreasing the substance usage needs to be the first priority, before working on any other matters. If clients are not willing to decrease their usage and the usage is defensive, then the possibility of change will be severely hampered to the extent that the side effects of the substance will mask their thoughts and feelings. This is why substance usage itself needs to be an early priority for therapy before other matters can be addressed.

When clients have had multiple "failed" therapies, each one needs exploring in detail to ascertain what happened. The explicit intention is not to repeat the same problems in the current meetings through having a sufficient discussion about how to proceed if such previous problematic events recur, that stopped them getting help

last time. The aim this time around is to provide some corrective experience instead of repetition, leading to an abrupt ending. The next section comments on one system of using a questionnaire to support the monitoring of risk and change and makes comments on some empirical research on therapy in the UK.

The positive use of outcome measures

The way that attachment research has progressed since 1980, and the way that research into the therapeutic process and outcome have studied the therapeutic relationship in various contexts, is to note that there are confounding aspects to practice. The focus on effectiveness, as a rivalry between modalities, obscures some more disturbing findings by William Stiles and colleagues who analysed Core 34 scores obtained in the UK (CORE System Group, 1998; Stiles et al., 2008a,b). Core 34 is a set of twelve questions about problems, twelve questions about functioning, four questions about well-being and six questions about risk. The Core system scores distress between zero and four points at maximum. The answers have been checked statistically with the UK population at large to ascertain how the higher level of distress among those who seek mental health care compares to those who are relatively distress free and do not seek help. The scoring system provides clinically useful estimations of severity of distress against nationally graded scoring for both the clinical and non-clinical parts of the population. In a sample size of 33,587 completed therapies not made within research clinics, the statistically averaged finding is that *all approaches are equally effective*.

This outcome shows that despite there being highly specific processes across different brands of therapy, they produce uniform changes. This finding is called the "equivalence paradox" (Stiles et al., 1986), and is connected to the view that there are common factors within therapy, which in turn promotes empirical research to find the core processes by which it works. In brief, Stiles and colleagues findings are as follows. Three major brand names of therapy of psychodynamic, person-centred, and eclectic practice (each of which were practised in two different forms) were found to be equally effective as measured by therapists practising in the real world, not following the randomised control trial (RCT) format in a research clinic, where research-unsuitable clients have been rejected. Individual therapists are consistently effective with the range of different clients they see who have various combinations of personality, developmental impairment, and vulnerability to current stressors. Each of the brand names has their own theory and practice yet has no pragmatic difference in effectiveness.

The Core outcome measure scores well-being and distress from zero to four points, where four is intense distress and zero is none. When the overall scores are greater than 1.19 for men and 1.29 for women, it means that distress is clinically significant and can reach as high as four in the Core system. Stiles and colleagues found that therapy was highly effective with an effect size of 1.39. This means that the average amount of change that was created by receiving therapy moved people,

on average, from 1.76 points of distress down to 0.883 points. Statistically, a change of more than 0.49 points showed reliable change. So with statistical confidence, 58% of those clients involved moved downwards more than one point of distress; and a further 21% were judged as being less than 0.49 points changed and could not be judged as being statistically significantly improved. Another finding was that 1% of the total population had deteriorated by more than 0.49 points.

The remainder of the article considers the centrality of the IWM in the psychology of attachment and discusses Bowlby's thoughts on the importance of early loss in the lifespan.

The centrality of the inner working model

First, a few words of introduction are required about the hypothesis of the inner working model (IWM). Attachment patterns in children are noted as phases of personality functioning (Bowlby, 1969, p. 4). It is clear that "patterns of interaction" are what occurs in the attachment dynamic between children and their carers (Bowlby, 1969, p. 332). The word "pattern" is used to describe the attachment phenomena as experienced by children and their adult carers; while the word "process" is used for attachment between adults (Owen, 2017). Control systems theory is the explanation for the time-variable and context-dependent ways of care-seekers asking for care from others, caregivers (Bowlby, 1969, pp. 18, 137, 140). It is important to bear in mind that all future reference to attachment assumes an on–off variation, according to the feedback control setting first acquired in childhood. The same control setting is part of one or more IWM of any emotionally intimate relationship between self and other (Bowlby, 1973, pp. 236, 418). Old inaccurate IWMs can be used to understand and act in contemporary relationships (Bowlby, 1973, p. 204; 1980, p. 231). One model of the interaction between self and other, let's call it IWM1, is formed by what parents have *told* children about a traumatic event, for instance. Another completely different model, IWM2, is formed from what children have *experienced* about the same event (Bowlby, 1980, pp. 234–236). Bowlby defined the Freudian sense of the term "dynamic unconscious" as equivalent to the idea of multiple IWMs that cause changes in relating and emotions, and can be felt on both sides of the same relationship. Bowlby did not specify what the upper limit is on the number of IWMs within the same person. For attachment phenomena to be "goal-corrected" means that the set-goal of any IWM, the sense of the cared-for self and the caregiving other, first acquired in childhood and updated and added to thereafter, is what motivates relating with contemporary attachment figures. When there are no attachment figures available immediately, the set of IWMs available is what constitutes feelings and is consulted when working out how to proceed. The IWM in operation at any current moment is what causes the automatic and involuntary eruption of emotion, memories, anticipations, and attachment-related explicit thoughts and beliefs in consciousness.

In general, good mental health can be expressed as *map-territory* accuracy between the acquired IWM and the shared history with the current other: the IWM is the map and the current relationship is the territory to be negotiated. If inaccuracy remains, attachment satisfactions are based on the acquired IWM of the interrelated senses of the care-worthy self and the caregiving other. If the IWM acquired is not secure then the anxious or avoidant pattern or process will be manifest instead (Bowlby, 1969, p. 82). At the egoic conscious level, the ego attends to emotions felt and the sense of the response from the other. At the primary unconscious level of the automatic and involuntary creation of sense of the self–other connection, the IWMs already acquired are constitutive of what is felt and anticipated to happen (Bowlby, 1969, p. 112). The unconscious is also that part of consciousness that produces and maintains defensive exclusion of painful sense, and creates the experienced conscious senses of others and situations for the ego to inspect (Bowlby, 1980, p. 229). It is important to distinguish between primary process repression and manipulation of emotions; and not confuse that with higher egoic refusal and suppression of what the ego needs to feel and contemplate when it plans its future and deals with the present. Bowlby noted that working through, in the sense of providing therapy (Bowlby, 1973, p. 239), is the process of making old IWMs more accurate with respect to current relationships through discussion in therapy. When this occurs, the map becomes an accurate picture of the current territory.

IWMs are models of self and other that are learnings and beliefs that are triggered in specific current relationship conditions. Although the observable action is current, the hypothesis is that the cause happened some time ago, and is now being re-enacted in the current version. Interestingly, there are connections between the four attachment processes that are highly similar to the intersubjective view of Diana Diamond and colleagues (1993). Diamond posits ten levels of movement towards most accurate co-empathic senses of self and other. The first three levels are very inaccurate representations. The fourth and fifth levels involve idealisation and denigration to achieve the impression of constancy, when really there is ambivalence, and reference to ambivalent senses maintains an avoidant–ambivalence. The anxious process concerns an emergent ambivalence in the place of constancy: there are two stable but shifting disparate senses of one object, either self or other. It is only the secure processes that have with them a singular pair of objects, self and other, where the unique and complex account of any important attachment figure is represented as a single person capable of including increasingly complex senses of their reciprocal and mutual responsiveness, with each other. This is superseded by the secure processes that involves the most accurate relation between self and other as co-empathic, attuned, and evolving across time, in a mature emotionally and socially literate manner. Object constitution is the technical term to describe how senses of self and other can become unified and cohesive (Bowlby, 1973, p. 361); or remain inconsistent and ambiguous, even when the senses refer to the same person. What is being referred to are the ways in which experiences about the same person do not become unified into one overall sense.

However, one occurrence of object constancy is the anticipation that an attachment figure is still alive when they are dead; or is still present in the environs, when they are physically absent (Bowlby, 1980, p. 86). This phenomenon is most easily seen in small children when their attachment figures are not present (children go looking for them) and in small children whose attachment figures have died (children cannot understand that they are in fact dead). To a lesser degree, the same is seen in adults particularly in stuck grief processes or grief after trauma. The yearning and searching for lost attachment figures continues as the hope and desire to be reunited with them; and the anger and frustration felt at not being able to find them (Bowlby, 1980, p. 87).

Within the whole of a complex control system, this following general wholistic principle applies to individuals and families: *any change to one part of the whole will create changes in the whole* (Bowlby, 1980, p. 66). However, the senses of the objects, self, and other, have multiple senses according to the behaviour that is currently occurring. The IWMs are hypothesised links between the distal and the proximal and are implicit beliefs that interpret the current situation (Bowlby, 1973, pp. 238–239).

The IWMs concern the generalised relationship between self and other, written in shorthand as "Self: Other", a notation that is intended to capture the necessity of noting the senses of self and other, and the relationship between them. As regards how the self is empathised in the views of others, when there have been negative experiences, the attachment-damaged self is valued negatively, as unlovable, unentitled to good things in life, or the self is felt to be shameful and damaged (Bowlby, 1980, p. 248). Similarly, the implicated anticipations of others with respect to the self include feeling that others are unresponsive and uninterested—which exists alongside a sense of self as requiring much attention in a negative self-absorbed way. One implication is that the self is damaged and that its distress is too large for it to be able to cope with. The good news from therapy is that self esteem, mood, and a proactive lifestyle are indeed capable of achievement. Most often, the learning from therapy is that clients ultimately find the world is safer and more trustworthy than they had previously thought. Surprisingly, other people can be kind and trustworthy. The healed self can be discovered to have sufficient within itself to manage most challenging situations and deal with uncertainty. These positive learnings fall under the heading of learning to trust the process of using new learning from therapy and gain the confidence that self is able to deal with uncertainty and the unknown.

Bowlby rated early attachment losses as important motivations for depression in adults. If the self cannot turn to a current supportive attachment figure, then hope may be lost. If the ego's picture of its own needs is intact, then it can turn to others for help or be able to soothe itself in the absence of attachment figures (Bowlby, 1980, pp. 245–246). Depression occurs when there is no current positive interchange with others, in the event of temporary or permanent loss of an attachment figure (Bowlby, 1980, p. 246). Only when mourning is complete will the person

be able to reorganise their life in the absence of the attachment figure. On the one hand, when there is loss for children, then the care they receive after loss can be protective of their ability to mourn and attach again. On the other hand, being re-housed in a neglectful family of blood relatives known to the child, and outside of it in neglectful care and fostering multiple times, will damage their ability to mourn and attach (Bowlby, 1980, p. 312).

Similarly, children who are unwanted, and had temporary or permanent loss of attachment figures, or have been neglected, violated, or in care, are similarly vulnerable (Bowlby, 1980, p. 216). Also parenting that is overly demanding creates a sense of unlovability in children and low self-esteem or shame (Bowlby, 1980, p. 221). When it comes to the long goodbye of loss through death, culturally approved mourning practices provide succour to the bereaved (Bowlby, 1980, p. 93). It is the duty for professional caregivers to provide children and their families with the truth that a child is dying in order to promote forthcoming acceptance of the death and promote trust in the caregivers (Bowlby, 1980, p. 118). If not, children will find it difficult to trust carers, and when the child dies, the death will be more shocking than it should be.

When insufficient mourning occurs, those who have not properly grieved will have difficulties in forming new attachment relationships, have difficulties in maintaining them, and will suffer negative consequences later in the lifespan (Bowlby, 1980, p. 137). If recovery to loss has not begun during the first year after it, then a poor recovery is probable, he thought (Bowlby, 1980, p. 148). Persons who are anxious, avoidant, or compulsive caregivers are those who are vulnerable to disordered mourning (Bowlby, 1980, p. 212).

Managing attachment processes, and working towards a secure process, requires being able to distinguish how attachment processes appear in adults. This requires organisational support and containment and good clinical supervision. The context around therapists in private practice or organisations needs to be sufficient for the type of work undertaken. When working with client groups, there needs to be sufficient organisational help to contain the frontline staff. Ever since Isabel Menzies Lyth (1959), it is fundamental that any type of mental health work needs to be supported by the home–work balance. When the prospect of going to work elicits feelings of overwhelm or aversion, then the unconscious has spoken in that it grumbles and groans on the way into work. Moods, emotions, and thinking in language use by the ego, are most often created by primary processes outside of egoic control and its direct influence (Bowlby, 1980, p. 49). Because there are only twenty-four hours in a day, the effects of over-work, or ordinary volumes of work that are under-supported, all mount up. They can be responded to with the type of supportive contact that restore the felt-sense of good mental health. The felt-sense of being under-supported at work concerns those emotions where the challenge is to maintain one's well-being and act collectively on the organisational problems that prevent support.

However, caring between adults is different to caring between a parent and child, in that the caring between adults should be two-way. What this leads me to

introduce is a topic I would like to call the "economy of care" as it exists in families, between partners, and in other intimate and important relationships where people matter to each other. Attachment means the accumulation of good will in those who receive care, and creates a type of debt in those who receive it. Different types of care provision create debts of care, which are paid back, sometimes with other sorts of reward.

The inner working models of a person are the containers, as it were, that exist within unique individuals. Attachment is learned through interactions between parents and children, and the family of origin in childhood. Throughout adulthood, there remains an openness to new attachment influences. However, the sense of the hypothesis of attachment is specifying that there are four identifiable adult processes, capable of distinction only through the Adult Attachment Interview (George et al., 1996) that focuses entirely on the coherence of speech.

It is an open question as to what degree heritability may have any influence on attachment (Fearon et al, 2014). If it is true that attachment processes in adults are to some degree genetically inherited, that would contest the idea that attachment is initiated entirely through parenting and childcare. Perhaps a view that hedges its bets is best to keep open to the scientific view of monozygotic research to see what evidence it suggests, and specify how such predictions can be tested. Inner working models are specific hypotheses about the strong early influence of the interaction between self and other. This template is the model for future intimacy. By the simplest mode of interpretation, what is required is the conceptual space to map the whole event between self and other: explicit memories, procedural memories and implicit emotions, beliefs and expectations that accompany the pair of senses, self and other: both the explicit and the implicit memories represent attachment. This is the material of the unconscious as it grows and develops across time, throwing out its contents of emotions automatically produced, that are added to the current moment, or those that are added to imaginings and worries, or to the observation of film or digital images.

Conclusion

The aim of psychological therapy is to improve the quality of life of clients. What Bowlby proposed is a link between a distal original cause in childhood and the triggered proximal cause in the current time (Bowlby, 1973, p. 44). While there was always some variability between what happened in the Strange Situation Procedure and the home (Ainsworth et al., 1978), it seems to me that the value of attachment is to understand it is a key developmental idea. In practice its worth concerns enabling clients to be self-determining and become motivated to find their own direction and enjoy life more, no matter what their freedoms and constraints actually are. It also concerns how therapists manage the pressures on them from any source. In conclusion, the legacy of John Bowlby is clear thinking on attachment in

childhood and adulthood. Mary Ainsworth made the empirical standards for Strange Situation and attachment was furthered by Mary Main's Adult Attachment Interview (George et al., 1996). The worth of attachment theory is that it is falsifiable in Popper's sense. Specific hypotheses can be tested with clients, face to face. The emotions that clients elicit in us, and those we have about our ability to help in our organisational contexts, are important information.

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