A TAVISTOCK PROFESSIONAL BOOK

A Secure Base

Clinical applications of attachment theory

JOHN BOWLBY

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To
Mary D.S. Ainsworth
who introduced the concept of
a secure base

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Preface

In 1979, under the title of *The Making and Breaking of Affectional Bonds*, I published a small collection of lectures that I had given to a variety of audiences during the two preceding decades. In this volume I present a further selection of the lectures given since then. Each of the first five was delivered to a particular audience on a particular occasion; details of each are described in a brief preamble. The remaining three are extended versions of lectures given in extempore form to audiences made up of mental health professionals in countries of Europe and America. As in the earlier collection, I have thought it best to print each lecture in a form close to that in which it was originally published.

Since the theory of attachment provides the basis for every lecture some deletions have been necessary to avoid an excess of repetition. It is hoped that such as remains will, by presenting the same ideas in different contexts, clarify and emphasize distinctive features of the theory.

It is a little unexpected that, whereas attachment theory was formulated by a clinician for use in the diagnosis and treatment of emotionally disturbed patients and families, its usage hitherto has been mainly to promote research in developmental psychology. Whilst I welcome the findings of this research as enormously extending our understanding of personality development and psychopathology, and thus as of the greatest

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continue to be inaccessible. When there is anger, it will continue to be directed at inappropriate targets. Similarly anxiety will continue to be aroused by inappropriate situations and hostile behaviour be expected from inappropriate sources. The therapeutic task is therefore to help the patient discover what these events and experiences may have been so that the thoughts, feelings, and behaviour that the situations arouse, and that continue to be so troublesome, can be linked again to the situations that aroused them. Then the true targets of his yearning and anger and the true sources of his anxiety and fear will become plain. Not only will such discoveries show that his modes of cognition, feeling, and behaviour are far more intelligible, given the circumstances in which they originated, than they had seemed before but, once the patient has grasped how and why he is responding as he is, he will be in a position to reappraise his responses and, should he wish, to undertake their radical restructuring. Since such reappraisal and restructuring can be achieved only by the patient himself, the emphasis in this formulation of the therapist's task is on helping the patient first to discover *for himself* what the relevant scenes and experiences probably were and secondly to spend time pondering on how they have continued to influence him. Only then will he be in a position to undertake the reorganization of his modes of construing the world, thinking about it, and acting in it which are called for.

The concepts of therapeutic process outlined here are similar to those described in much greater detail by others. Examples are publications by Peterfreund (1983) and by Guidano and Liotti (1983). Although the authors of these two books started their therapeutic work from radically different positions, namely traditional versions of psychoanalysis and of behaviour therapy respectively, the principles that now guide their work show a striking convergence. Similarly current forms of bereavement therapy, which focus on distressing events in the comparatively recent past, are found to be based on the very same principles, even when developed within equally different traditions (Raphael 1977; Melges and DeMaso 1980). However divergent tactics may still appear, strategic thinking is on a convergent course.

LECTURE 7

The role of attachment in personality development

Evidence regarding the role of attachment in personality development has been accumulating apace during the nineteen-eighties. Earlier findings have been replicated on samples of diverse origin; methods of observation have been refined and new methods introduced; and the role of easy two-way communication between parent and child in making for healthy emotional development has been emphasized. Since I believe this new work to have far-reaching clinical implications, my aim in this lecture has been to present a review of these findings in a form suited to those working as psychotherapists in the mental health field.

For the convenience of the reader I begin by restating in summary form some of the features most distinctive of attachment theory.

Some distinctive features of attachment theory

It will be remembered that attachment theory was formulated to explain certain patterns of behaviour, characteristic not only of infants and young children but also adolescents and adults, that were formerly conceptualized in terms of dependency and overdependency. In its original formulation observations of how young children respond when placed in a strange place with strange people, and the effects such experiences have on a child's subsequent relations with his parents, were especially influential. In all subsequent work theory has continued to be

tied closely to detailed observations and interview data of how individuals respond in particular situations. Historically the theory was developed out of the object-relations tradition in psychoanalysis; but it has drawn also on concepts from evolution theory, ethology, control theory, and cognitive psychology. One result is the reformulation of psychoanalytic metapsychology in ways compatible with modern biology and psychology and in conformity with the commonly accepted criteria of natural science (see Lecture 4).

Attachment theory emphasizes:

(a) the primary status and biological function of intimate emotional bonds between individuals, the making and maintaining of which are postulated to be controlled by a cybernetic system situated within the central nervous system, utilizing working models of self and attachment figure in relationship with each other.*

(b) the powerful influence on a child's development of the ways he is treated by his parents, especially his mother-figure, and

(c) that present knowledge of infant and child development requires that a theory of developmental pathways should replace theories that invoke specific phases of development in which it is held a person may become fixated and/or to which he may regress.

The primacy of intimate emotional bonds

Attachment theory regards the propensity to make intimate emotional bonds to particular individuals as a basic component

* In earlier publications I have sometimes used the term 'representational model' as a synonym for 'working model' because representation has been the more familiar concept in clinical literature. In a dynamic psychology, however, working model is the more appropriate term, and it is also the term that is now coming into use among cognitive psychologists (e.g. Johnson-Laird 1983). Within the attachment framework the concept of working model of an attachment figure is in many respects equivalent to, and replaces, the traditional psychoanalytic concept of internal object.

of human nature, already present in germinal form in the neonate and continuing through adult life into old age. During infancy and childhood bonds are with parents (or parent substitutes) who are looked to for protection, comfort, and support. During healthy adolescence and adult life these bonds persist, but are complemented by new bonds, commonly of a heterosexual nature. Although food and sex sometimes play important roles in attachment relationships, the relationship exists in its own right and has a key survival function of its own, namely protection. Initially the only means of communication between infant and mother is through emotional expression and its accompanying behaviour. Although supplemented later by speech, emotionally mediated communication nonetheless persists as a principal feature of intimate relationships throughout life.

Within the attachment framework therefore intimate emotional bonds are seen as neither subordinate to nor derivative from food and sex. Nor is the urgent desire for comfort and support in adversity regarded as childish, as dependency theory implies. Instead the capacity to make intimate emotional bonds with other individuals, sometimes in the careseeking role and sometimes in the caregiving one, is regarded as a principal feature of effective personality functioning and mental health.

As a rule careseeking is shown by a weaker and less experienced individual towards someone regarded as stronger and/or wiser. A child, or older person in the careseeking role, keeps within range of the caregiver, the degree of closeness or of ready accessibility depending on circumstances: hence the concept of attachment behaviour.

Caregiving, the major role of parents and complementary to attachment behaviour, is regarded in the same light as careseeking, namely as a basic component of human nature (see Lecture 1).

Exploring the environment, including play and varied activities with peers, is seen as a third basic component and one antithetic to attachment behaviour. When an individual (of any age) is feeling secure he is likely to explore away from his attachment figure. When alarmed, anxious, tired, or unwell he feels an urge towards proximity. Thus we see the typical pattern of inter-

action between child and parent known as exploration from a secure base, first described by Ainsworth (1967). Provided the parent is known to be accessible and will be responsive when called upon, a healthy child feels secure enough to explore. At first these explorations are limited both in time and space. Around the middle of the third year, however, a secure child begins to become confident enough to increase time and distance away – first to half-days and later to whole days. As he grows into adolescence, his excursions are extended to weeks or months, but a secure home base remains indispensable nonetheless for optimal functioning and mental health. Note that the concept of secure base is a central feature of the theory of psychotherapy proposed.

During the early months of life an infant shows many of the component responses of what will later become attachment behaviour, but the organized pattern does not develop until the second half of the first year. From birth onwards he shows a germinal capacity to engage in social interaction and pleasure in doing so (Stern 1985): thus there is no autistic or narcissistic phase. Within days, moreover, he is able to distinguish between his mother-figure and others by means of her smell and by hearing her voice, and also by the way she holds him. Visual discrimination is not reliable until the second quarter. Initially crying is the only means available to him for signalling his need for care, and contentment the only means for signalling that he has been satisfied. During the second month, however, his social smile acts strongly to encourage his mother in her ministrations and his repertoire of emotional communications rapidly extends (Izard 1982; Emde 1983).

The development of attachment behaviour as an organized system, having as its goal the keeping of proximity or of accessibility to a discriminated mother-figure, requires that the child should have developed the cognitive capacity to keep his mother in mind when she is not present: this capacity develops during the second six months of life. Thus from nine months onwards the great majority of infants respond to being left with a strange person by protest and crying, and also by more or less prolonged fretting and rejection of the stranger. These observations demonstrate that during these months an infant is becoming

capable of representation and that his working model of his mother is becoming available to him for purposes of comparison during her absence and for recognition after her return. Complementary to his model of his mother, he develops a working model of himself in interaction with her; likewise for father.

A major feature of attachment theory is the hypothesis that attachment behaviour is organized by means of a control system within the central nervous system, analogous to the physiological control systems that maintain physiological measures such as blood pressure and body temperature within set limits. Thus the theory proposes that, in a way analogous to physiological homeostasis, the attachment control system maintains a person's relation to his attachment figure between certain limits of distance and accessibility, using increasingly sophisticated methods of communication for doing so. As such, the effects of its operation can be regarded as an example of what can usefully be termed environmental homeostasis (Bowlby 1969, 1982). By postulating a control system of this sort (with analogous systems controlling other forms of behaviour) attachment theory contains within itself a theory of motivation that can replace traditional theories which invoke a postulated build-up of energy or drive. Among several advantages of control theory are that it gives as much attention to the conditions terminating a behavioural sequence as to those initiating it and is proving a fruitful framework for empirical research.

The presence of an attachment control system and its linkage to the working models of self and attachment figure(s) that are built in the mind during childhood are held to be central features of personality functioning throughout life.

Patterns of attachment and conditions determining their development

The second area to which attachment theory pays special attention is the role of a child's parents in determining how he develops. There is today impressive and mounting evidence that the pattern of attachment that an individual develops during the years of immaturity – infancy, childhood, and

adolescence – is profoundly influenced by the way his parents (or other parent figures) treat him. This evidence derives from a number of systematic research studies, the most impressive being prospective studies of socio-emotional development during the first five years undertaken by developmental psychologists who are also clinically sophisticated. Pioneered by Ainsworth (Ainsworth, Blehar, Waters, and Wall 1978; Ainsworth 1985) and expanded, notably by Main (Main, Kaplan, and Cassidy 1985) and Sroufe (1983, 1985) in the United States and by Grossmann (Grossmann, Grossmann, and Schwan 1986) in Germany, these studies are now multiplying fast. Their findings are remarkably consistent and have the clearest of clinical significance.

Three principal patterns of attachment, first described by Ainsworth and her colleagues in 1971, are now reliably identified, together with the family conditions that promote them. These are first the pattern of secure attachment in which the individual is confident that his parent (or parent figure) will be available, responsive, and helpful should he encounter adverse or frightening situations. With this assurance, he feels bold in his explorations of the world. This pattern is promoted by a parent, in the early years especially by mother, being readily available, sensitive to her child's signals, and lovingly responsive when he seeks protection and/or comfort.

A second pattern is that of anxious resistant attachment in which the individual is uncertain whether his parent will be available or responsive or helpful when called upon. Because of this uncertainty he is always prone to separation anxiety, tends to be clinging, and is anxious about exploring the world. This pattern, in which conflict is evident, is promoted by a parent being available and helpful on some occasions but not on others, and by separations and, as clinical findings show, by threats of abandonment used as a means of control.

A third pattern is that of anxious avoidant attachment in which the individual has no confidence that, when he seeks care, he will be responded to helpfully but, on the contrary, expects to be rebuffed. When in marked degree such an individual attempts to live his life without the love and support of others, he tries to become emotionally self-sufficient and may later be diagnosed as narcissistic or as having a false self of the type

described by Winnicott (1960). This pattern, in which conflict is more hidden, is the result of the individual's mother constantly rebuffing him when he approaches her for comfort or protection. The most extreme cases result from repeated rejections.

Although in most cases the pattern observed conforms fairly closely to one or another of the three well-recognized types, there have been puzzling exceptions. During the assessment procedure used in these studies (the Ainsworth Strange Situation), in which infant and mother are observed in interaction during a series of brief episodes, certain infants have appeared to be disoriented and/or disorganized. One infant appears dazed; another freezes immobile; a third engages in some stereotypy; a fourth starts a movement, then stops unaccountably. After much study Main and her colleagues have concluded that these peculiar forms of behaviour occur in infants who are exhibiting a disorganized version of one of the three typical patterns, more often than not the anxious resistant one (Main and Weston 1981; Main and Solomon in press). Some instances are seen in infants known to have been physically abused and/or grossly neglected by the parent (Crittenden 1985). Others occur in dyads in which the mother is suffering from a severe form of bipolar affective illness and who treats her child in an erratic and unpredictable way (Radke-Yarrow *et al.* 1985). Yet others are shown by the infants of mothers who are still preoccupied with mourning a parental figure lost during the mother's childhood and by those of mothers who themselves suffered physical or sexual abuse as children (Main and Hesse, in press). Cases showing these deviant patterns are clearly of great clinical concern, and much attention is now being given to them.

Knowledge of the origins of these deviant patterns confirms in the clearest possible way the influence on a child's pattern of attachment of the parent's way of treating his or her child. Yet further confirmatory evidence comes from detailed observations of the way different mothers treat their children during a laboratory session arranged when the child is 2½ years old (Matas, Arend, and Sroufe 1978). In this study the child is given a small but difficult task for the solution of which he requires a little assistance, and his mother is free to interact with him. In this situation, it is found, the way she treats him correlates closely

with the pattern of attachment her child showed towards her eighteen months earlier. Thus the mother of a child earlier assessed as securely attached is found to be attentive and sensitive to his performance and to respond to his successes and difficulties in a way that is helpful and encouraging. Conversely the mother of a child earlier assessed as insecure is found to be less attentive and/or less sensitive. In some cases her responses are ill-timed and unhelpful; in others she may take little notice of what he is doing or how he is feeling; in yet others she may actively discourage or reject his bids for help and encouragement. Note that the pattern of interaction adopted by the mother of a secure infant provides an excellent model for the pattern of therapeutic intervention advocated here.

In thus underlining the very great influence that a child's mother has on his development, it is necessary also to consider what has led a mother to adopt the style of mothering she does. One major influence on this is the amount of emotional support, or lack of it, she herself is receiving at the time. Another is the form of mothering that she herself received when a child. Once these factors are recognized, as they have been by many analytically oriented clinicians long since, the idea of blaming parents evaporates and is replaced by a therapeutic approach. Since the emotional problems of parents stemming from the past and their effects on children has now become a field for systematic research, a brief description of current work is given at the end of Lecture 8.

Persistence of patterns

If we return now to the patterns of attachment observed in one-year-olds, prospective studies show that each pattern of attachment, once developed, tends to persist. One reason for this is that the way a parent treats a child, whether for better or for worse, tends to continue unchanged. Another is that each pattern tends to be self-perpetuating. Thus a secure child is a happier and more rewarding child to care for and also is less demanding than an anxious one. An anxious ambivalent child is apt to be whiny and clinging; whilst an anxious avoidant child

keeps his distance and is prone to bully other children. In both of these last cases the child's behaviour is likely to elicit an unfavourable response from the parent so that vicious circles develop.

Although for these reasons patterns, once formed, are apt to persist, this is by no means necessarily so. Evidence shows that during the first two or three years the pattern of attachment is a property of the relationship, for example, child to mother or child to father, and that if the parent treats the child differently the pattern will change accordingly. These changes are amongst much evidence reviewed by Sroufe (1985) that stability of pattern, when it occurs, cannot be attributed to the child's inborn temperament as has sometimes been claimed. Nevertheless, as a child grows older, the pattern becomes increasingly a property of the child himself, which means that he tends to impose it, or some derivative of it, upon new relationships such as with a teacher, a foster-mother, or a therapist.

The results of this process of internalization are evident in a prospective study which shows that the pattern of attachment characteristic of a mother–child pair, as assessed when the child is aged 12 months, is highly predictive of how that child will behave in a nursery group (with mother absent) three and a half years later. Thus children who showed a secure pattern with mother at 12 months are likely to be described by nursery staff as co-operative, popular with other children, resilient, and resourceful. Those who showed an anxious avoidant pattern are likely to be described as emotionally insulated, hostile or antisocial and, paradoxically, as unduly seeking of attention. Those who showed an anxious resistant pattern are likely to be described as also unduly seeking of attention and as either tense, impulsive, and easily frustrated or else as passive and helpless (Sroufe 1983). In view of these findings it is hardly surprising that in two other prospective studies, a pioneering one in California (Main and Cassidy, in press) and a replicative one in Germany (Wärtner 1986), the pattern of attachment assessed at 12 months is found to be highly predictive also of patterns of interaction with mother five years later.

Although the repertoire of a 6-year-old's behaviour towards a parent is vastly greater than that of a one-year-old, the earlier

patterns of attachment are nonetheless readily discernible to an educated eye at the older age. Thus children who are classified as being securely attached at 6 years are those who treat their parents in a relaxed and friendly way, who enter into easy, and often subtle, intimacies with them, and who engage in free-flowing conversation. Children classified as anxious resistant show a mixture of insecurity, including sadness and fear, and of intimacy alternating with hostility, which is sometimes subtle and at others overt. In some of these cases the child's behaviour strikes an observer as self-conscious, even artificial. As though they were always anticipating a negative response from the parent, they try to ingratiate themselves by showing off, perhaps by being cute or especially charming (Main and Cassidy, in press; Main, personal communication).

Children aged 6 years classified as anxious avoidant tend quietly to keep the parent at a distance. Such greetings as they give are formal and brief; topics of conversation stay impersonal. He or she keeps busy with toys or some other activity and ignores or is even dismissive of a parent's initiatives.

Children who at 12 months appeared to be disorganized and/or disoriented are found five years later to be conspicuous for their tendency to control or dominate a parent. One form of this is to treat the parent in a humiliating and/or rejecting way; another is to be solicitous and protective. These are clear examples of what clinicians have labelled as an inversion, or reversal, of the child and parent roles. Conversations between them are fragmented, sentences begun but left unfinished, topics broached but changed abruptly.

In considering the persistence of a 6-year-old's patterns of interaction with parents and with other parental figures, a critical question arises: to what extent are the patterns at this age ingrained within the child's personality and to what extent are they a reflection of the way the parents still treat him or her? The answer, to which clinical experience points, is that by this age both these influences are at work so that the most effective interventions are those that take both into account, e.g. by means either of family therapy or else by giving help in parallel to parents and child.

As yet too little is known about how the influence on

personality development of interactions with the mother compares with the influence of those with the father. It would hardly be surprising were different facets of personality, manifest in different situations, to be influenced differently. In addition, their respective influences on males may be expected to differ from their respective influences on females. It is clearly a complex area that will require much research. Meanwhile it seems likely that, at least during the early years of an individual's life, the model of self interacting with mother is the more influential of the two. This would hardly be surprising since in every culture known the huge majority of infants and young children interact far more with the mother than with the father.

It must be recognized that, so far, prospective studies of the relative persistence of patterns of attachment, and of the features of personality characteristic of each, have not yet been carried beyond the sixth year. Even so, two cross-sectional studies of young adults show that the features of personality characteristic of each pattern during the early years are also to be found in young adults (Kobak and Sceery 1988; Cassidy and Kobak, in press; Hazan and Shaver 1987); and it is more than likely that, except in cases where family relations have changed substantially in the interval, they have been present continuously. All our clinical experience strongly supports that view.

A theory of internalization

In order to account for the tendency for patterns of attachment increasingly to become a property of the child himself, attachment theory invokes the concept of working models of self and of parents already described. The working models a child builds of his mother and her ways of communicating and behaving towards him, and a comparable model of his father, together with the complementary models of himself in interaction with each, are being built by a child during the first few years of his life and, it is postulated, soon become established as influential cognitive structures (Main, Kaplan, and Cassidy 1985). The forms they take, the evidence reviewed strongly suggests, are based on the child's real-life experience of day-to-day interactions

with his parents. Subsequently the model of himself that he builds reflects also the images that his parents have of him, images that are communicated not only by how each treats him but by what each *says* to him. These models then govern how he feels towards each parent and about himself, how he expects each of them to treat him, and how he plans his own behaviour towards them. They govern too both the fears and the wishes expressed in his day dreams.

Once built, evidence suggests, these models of a parent and self in interaction tend to persist and are so taken for granted that they come to operate at an unconscious level. As a securely attached child grows older and his parents treat him differently, a gradual up-dating of models occurs. This means that, though there is always a time-lag, his currently operative models continue to be reasonably good simulations of himself and his parents in interaction. In the case of the anxiously attached child, by contrast, this gradual up-dating of models is in some degree obstructed through defensive exclusion of discrepant experience and information. This means that the patterns of interaction to which the models lead, having become habitual, generalized, and largely unconscious, persist in a more or less uncorrected and unchanged state even when the individual in later life is dealing with persons who treat him in ways entirely unlike those that his parents adopted when he was a child.

The clue to an understanding of these differences in the degree to which models are up-dated is to be found in the profound differences in the freedom of communication between mother and child that characterize pairs of the two types. This is a variable to which Bretherton (1987) has drawn especial attention.

It will be noticed that in Main's longitudinal study described above the pattern of communication between a 6-year-old child and his mother, as observed in a pair that, five years earlier, had shown a secure pattern of attachment, is very different from that observed in a pair who had earlier shown an insecure pattern. Whereas the secure pairs engaged in free-flowing conversation laced with expressions of feeling, and touching on a variety of topics including personal ones, the insecure pairs did not. In some, conversation was fragmented and topics abruptly changed.

In others, notably the avoidant pairs, conversation was limited, topics kept impersonal, and all reference to feeling omitted. These striking differences in the degree to which communication is either free or restricted are postulated to be of great relevance for understanding why one child develops healthily and another becomes disturbed. Moreover it will not have escaped notice that this same variable, the degree to which communication between two individuals is restricted or relatively free, has for long been recognized as one of central concern in the practice of analytic psychotherapy.

For a relationship between any two individuals to proceed harmoniously each must be aware of the other's point-of-view, his goals, feelings, and intentions, and each must so adjust his own behaviour that some alignment of goals is negotiated. This requires that each should have reasonably accurate models of self and other which are regularly up-dated by free communication between them. It is here that the mothers of the securely attached children excel and those of the insecure are markedly deficient.

Once we focus on the degree to which communication between a parent–child pair is free-flowing or not, it quickly becomes apparent that, from the earliest days of life, the degree of freedom of communication in the pairs destined to develop a secure pattern of attachment is far greater than it is in those who do not (Ainsworth, Bell, and Stayton 1971; Blehar, Lieberman, and Ainsworth 1977). Thus it is characteristic of a mother whose infant will develop securely that she is continuously monitoring her infant's state and, as and when he signals wanting attention, she registers his signals and acts accordingly. By contrast, the mother of an infant later found to be anxiously attached is likely to monitor her infant's state only sporadically and, when she does notice his signals, to respond tardily and/or inappropriately. By the time an infant has reached his first birthday, moreover, these differences in freedom of communication have been found to be clearly evident during the Ainsworth Strange Situation procedure (Grossmann, Grossmann, and Schwan 1986). Even in the introductory episode, when infant and mother are alone together, more of the secure pairs were observed to engage in direct communication, by eye contact,

facial expression, vocalization, and showing or giving toys, than did the insecure pairs. As the stress on the child increases, so do the differences between the pairs. Thus in the reunion episode after the second separation all but one of sixteen secure pairs communicated in direct fashion in contrast to a minority of the insecure ones. There was one other very striking difference moreover. Whereas every infant classified as secure was seen to be in direct communication with his mother, not only when he was content but also when he was distressed, the infants classified as avoidant, when they did engage in direct communication, did so only when they were content.

Thus already by the age of 12 months there are children who no longer express to their mothers one of their deepest emotions or the equally deep-seated desire for comfort and reassurance that accompanies it. It is not difficult to see what a very serious breakdown of communication between child and mother this represents. Not only that but, because a child's self-model is profoundly influenced by how his mother sees and treats him, whatever she fails to recognize in him he is likely to fail to recognize in himself. In this way, it is postulated, major parts of a child's developing personality can become split off from, that is, out of communication with, those parts of his personality that his mother recognizes and responds to, which in some cases include features of personality that she is attributing to him wrongly.

The upshot of this analysis is that obstruction to communication between different parts of, or systems within, a personality, which from the earliest days Freud saw as the crucial problem to be solved, is now seen as a reflection of the differential responses and communications of a mother to her child. When a mother responds favourably only to certain of her child's emotional communications and turns a blind eye or actively discourages others, a pattern is set for the child to identify with the favoured responses and to disown the others.

It is along these lines that attachment theory explains the differential development of resilient and mentally healthy personalities, and also of personalities prone to anxiety and depression, or to developing a false self or some other form of vulnerability to mental ill-health. Perhaps it is no coincidence

that some of those who approach problems of personality development and psychopathology from a cognitive standpoint, but who also give weight to the power of emotion, e.g. Epstein (1980, 1986) and Liotti (1986, 1987), have been formulating theories that are essentially compatible with this one.

Variations in a mother's way of recalling her childhood experience

The conclusion so far reached about the role of free communication, emotional as well as cognitive, in determining mental health is strongly supported by an important recent finding from Main's longitudinal study. As a result of interviewing the mothers of the children in the study, Main found a strong correlation between how a mother describes her relationships with her parents during her childhood and the pattern of attachment her child now has with her (Main, Kaplan, and Cassidy 1985; see also Morris 1981 and Ricks 1985). Whereas the mother of a secure infant is able to talk freely and with feeling about her childhood, the mother of an insecure infant is not.

In this part of the study an interviewer asks the mother for a description of her early relationships and attachment-related events and for her sense of the way these relationships and events affected her personality. In considering results, as much or more attention is paid to the way a mother tells her story and deals with probing questions about it as to the historical material she describes. At the simplest level, it was found that a mother of a secure infant is likely to report having had a reasonably happy childhood and to show herself able to talk about it readily and in detail, giving due place to such unhappy events as may have occurred as well as to the happy ones. By contrast, a mother of an insecure infant is likely to respond to the enquiry in one of two different ways. One, shown by mothers of anxious resistant children, is to describe a difficult unhappy relationship with her own mother about which she is still clearly disturbed and in which she is still entangled mentally, and, should her mother be still alive, it is evident that she is entangled with her in reality as well. The other, shown by mothers of anxious

avoidant children, is to claim in a generalized matter-of-fact way that she had a happy childhood, but not only is she unable to give any supporting detail but may refer to episodes pointing in an opposite direction. Frequently such a mother will insist that she can remember nothing about her childhood nor how she was treated. Thus the strong impression of clinicians, that a mother who had a happy childhood is likely to have a child who shows a secure attachment to her, and that an unhappy childhood, more or less cloaked by an inability to recall, makes for difficulties, is clearly supported.

Nevertheless a second finding, no less interesting and one of especial relevance here, arises from a study of the exceptions to the general rule. These are the mothers who describe having had a very unhappy childhood but who nonetheless have children showing secure attachment to them. A characteristic of each of these mothers, which distinguishes them from mothers of insecure infants, is that, despite describing much rejection and unhappiness during childhood, and perhaps tearful whilst doing so, each is able to tell her story in a fluent and coherent way, in which such positive aspects of her experiences as there were are given a due place and appear to have been integrated with all the negative ones. In their capacity for balance they resemble the other mothers of secure infants. It seemed to the interviewers and those assessing the transcripts that these exceptional mothers had thought much about their unhappy earlier experiences and how it had affected them in the long term, and also about why their parents might have treated them as they had. In fact, they seemed to have come to terms with their experience.

By contrast, the mothers of children whose pattern of attachment to them was insecure and who also described an unhappy childhood did so with neither fluency nor coherence: contradictions abounded and went unnoticed. Moreover, it was a mother who claimed an inability to recall her childhood and who did so both repeatedly and strongly who was a mother whose child was insecure in his relation to her.*

* In further examination of the data it has been found that all these correlations also hold true for fathers (Main, personal communication).

In the light of these findings Main and her colleagues conclude that free access to, and the coherent organization of information relevant to attachment play a determining role in the development of a secure personality in adult life. For someone who had a happy childhood no obstacles are likely to prevent free access to both the emotional and the cognitive aspects of such information. For someone who suffered much unhappiness or whose parents forbade him or her to notice or to remember adverse events, access is painful and difficult, and without help may indeed be impossible. Nevertheless, however she may accomplish it, when a woman manages either to retain or to regain access to such unhappy memories and reprocess them in such a way that she can come to terms with them, she is found to be no less able to respond to her child's attachment behaviour so that he develops a secure attachment to her than a woman whose childhood was a happy one. This is a finding to give great encouragement to the many therapists who for long have sought to help mothers in just this kind of way. Further reference to techniques for helping disturbed mothers is made at the end of Lecture 8.

Pathways to personality development

There is one further way in which attachment theory differs from traditional types of psychoanalytic theory, namely its rejection of the model of development in which an individual is held to pass through a series of stages in any one of which he may become fixated or to which he may regress, and its replacement by a model in which an individual is seen as progressing along one or another of an array of potential developmental pathways. Some of these pathways are compatible with healthy development; others deviate in one or another direction in ways incompatible with health.

All variants of the traditional model invoking phases of development are based on the assumption that, at some phase of normal development, a child shows psychological features that, in an older individual, would be regarded as signs of pathology. Thus a chronically anxious and clinging adult might

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be regarded as being fixated in or having regressed to a postulated phase of orality or of symbiosis; whilst a deeply withdrawn individual might be regarded as having regressed to a postulated phase of autism or of narcissism. Systematic and sensitive studies of human infants, such as those reported by Stern (1985), have now rendered this model untenable. Observations show that infants are socially responsive from birth onwards. Healthily developing toddlers do not show anxious clinging except when they are frightened or distressed; at other times they explore with confidence.

The model of developmental pathways regards an infant at birth as having an array of pathways potentially open to him, the one along which he will in fact proceed being determined at every moment by the interaction of the individual as he now is with the environment in which he happens then to be. Each infant is held to have his own individual array of potential pathways for personality development which, except for infants born with certain types of neurological damage, include many that are compatible with mental health and also many that are incompatible. Which particular pathway he proceeds along is determined by the environment he meets with, especially the way his parents (or parent substitutes) treat him, and how he responds to them. Children who have parents who are sensitive and responsive are enabled to develop along a healthy pathway. Those who have insensitive, unresponsive, neglectful, or rejecting parents are likely to develop along a deviant pathway which is in some degree incompatible with mental health and which renders them vulnerable to breakdown, should they meet with seriously adverse events. Even so, since the course of subsequent development is not fixed, changes in the way a child is treated can shift his pathway in either a more favourable direction or a less favourable one. Although the capacity for developmental change diminishes with age, change continues throughout the life cycle so that changes for better or for worse are always possible. It is this continuing potential for change that means that at no time of life is a person invulnerable to every possible adversity and also that at no time of life is a person impermeable to favourable influence. It is this persisting potential for change that gives opportunity for effective therapy.

LECTURE 8

Attachment, communication, and the therapeutic process

In the second part of my 1976 Maudsley Lecture, 'The making and breaking of affectional bonds' (1977), I described some of my ideas on the therapeutic implications of attachment theory. Much that has been learned since then has strengthened my confidence in the approach. The present account therefore should be regarded as an amplification of the earlier one. In it I give more detailed attention to the ways a patient's earlier experiences affect the transference relationship and discuss further the therapist's aim as being that of enabling his patient to reconstruct his working models of himself and his attachment figure(s) so that he becomes less under the spell of forgotten miseries and better able to recognize companions in the present for what they are.

a thing which has not been understood
inevitably reappears; like an unlaid ghost,
it cannot rest until the mystery has been
resolved and the spell broken.

Sigmund Freud 1909

Those who cannot remember the past are
condemned to repeat it.

George Santayana 1905

Five therapeutic tasks

The theory of personality development and psychopathology outlined above can be used as a framework to guide each one of the three principal forms of analytic psychotherapy in use today – individual therapy, family therapy, and group therapy. Here I deal only with the first.

A therapist applying attachment theory sees his role as being one of providing the conditions in which his patient can explore his representational models of himself and his attachment figures with a view to reappraising and restructuring them in the light of the new understanding he acquires and the new experiences he has in the therapeutic relationship. In helping his patient towards this end the therapist's role can be described under five main heads.

The first is to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds it difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance.

A second is to assist the patient in his explorations by encouraging him to consider the ways in which he engages in relationships with significant figures in his current life, what his expectations are for his own feelings and behaviour and for those of other people, what unconscious biases he may be bringing when he selects a person with whom he hopes to make an intimate relationship and when he creates situations that go badly for him.

A particular relationship that the therapist encourages the patient to examine, and that constitutes the third task, is the relationship between the two of them. Into this the patient will import all those perceptions, constructions, and expectations of how an attachment figure is likely to feel and behave towards him that his working models of parents and self dictate.

A fourth task is to encourage the patient to consider how his current perceptions and expectations and the feelings and actions to which they give rise may be the product either of the events and situations he encountered during his childhood and

adolescence, especially those with his parents, or else as the products of what he may repeatedly have been told by them. This is often a painful and difficult process and not infrequently requires that the therapist sanction his patient to consider as possibilities ideas and feelings about his parents that he has hitherto regarded as unimaginable and unthinkable. In doing so a patient may find himself moved by strong emotions and urges to action, some directed towards his parents and some towards the therapist, and many of which he finds frightening and/or alien and unacceptable.

The therapist's fifth task is to enable his patient to recognize that his images (models) of himself and of others, derived either from past painful experiences or from misleading messages emanating from a parent, but all too often in the literature mislabelled as 'fantasies', may or may not be appropriate to his present and future; or, indeed, may never have been justified. Once he has grasped the nature of his governing images (models) and has traced their origins, he may begin to understand what has led him to see the world and himself as he does and so to feel, to think, and to act in the ways he does. He is then in a position to reflect on the accuracy and adequacy of those images (models), and on the ideas and actions to which they lead, in the light of his current experiences of emotionally significant people, including the therapist as well as his parents, and of himself in relationship to each. Once the process has started he begins to see the old images (models) for what they are, the not unreasonable products of his past experiences or of what he has repeatedly been told, and thus to feel free to imagine alternatives better fitted to his current life. By these means the therapist hopes to enable his patient to cease being a slave to old and unconscious stereotypes and to feel, to think, and to act in new ways.

Readers will be aware that the principles set out have a great deal in common with the principles described by other analytically trained psychotherapists who regard conflicts arising within interpersonal relationships as the key to an understanding of their patient's problems, who focus on the transference and who also give some weight, albeit of varying degree, to a patient's earlier experience with his parents.

Among the many well-known names that could be mentioned in this context are those of Fairbairn, Winnicott, and Guntrip in Britain, and Sullivan, Fromm-Reichmann, Gill, and Kohut in the United States. Among recently published works that contain many of the ideas prescribed here are those by Peterfreund (1983), Casement (1985), Pine (1985), and Strupp and Binder (1984), and also those of Malan (1973) and Horowitz *et al.* (1984) in the field of brief psychotherapy. In particular, I wish to draw attention to the ideas of Horowitz and his colleagues who, in their description of the treatment of patients suffering from an acute stress syndrome, employ a conceptual framework closely similar to that presented here. Although their technique is aimed to help patients recover from the effects of a recent severely stressful event, I believe the principles informing their work are equally applicable to helping patients recover from the effects of a chronic disturbance resulting from stressful events of many years ago, including those that occurred during their earliest years.

Although in this exposition it is convenient to list the therapist's five tasks in a logical way, so interrelated are they that in practice a productive session is likely to involve first one task, then another. Nevertheless, unless a therapist can enable his patient to feel some measure of security, therapy cannot even begin. Thus we start with the role of the therapist in providing his patient with a secure base. This is a role very similar to that described by Winnicott as 'holding' and by Bion as 'containing'.

In providing his patient with a secure base from which to explore and express his thoughts and feelings the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world. The therapist strives to be reliable, attentive, and sympathetically responsive to his patient's explorations and, so far as he can, to see and feel the world through his patient's eyes, namely to be empathic. At the same time he is aware that, because of his patient's adverse experiences in the past, the patient may not believe that the therapist is to be trusted to behave kindly or to understand his predicament. Alternatively the unexpectedly attentive and sympathetic responses the patient receives may lead him to

suppose that the therapist will provide him with all the care and affection which he has always yearned for but never had. In the one case therefore the therapist is seen in an unduly critical and hostile light, in the other as ready to provide more than is at all realistic. Since, it is held, both types of misunderstanding and misconstruction, and the emotions and behaviour to which they give rise, are central features of the patient's troubles, a therapist needs to have the widest possible knowledge of the many forms these misconstructions can take and also of the many types of earlier experience from which they are likely to have sprung. Without such knowledge a therapist is poorly placed to see and feel the world as his patient is doing.

Even so, a patient's way of construing his relationship with his therapist is not determined solely by the patient's history: it is determined no less by the way the therapist treats him. Thus the therapist must strive always to be aware of the nature of his own contribution to the relationship which, amongst other influences, is likely to reflect in one way or another what he experienced himself during his own childhood. This aspect of therapy, the counter-transference, is a big issue of its own and the subject of a large literature. Since it is not possible to deal with it further here, I want to emphasize not only the importance of the counter-transference but also that the focus of therapy must always be on the interactions of patient and therapist in the here and now, and that the only reason for encouraging the patient at times to explore his past is for the light it throws on his current ways of feeling and dealing with life.

With that proviso firmly in mind, let us consider some of the commoner forms that a patient's misconstructions can take and how they are likely to have originated. This is the aspect of therapy in which the work of a therapist who adopts attachment theory is likely to differ most from one who adopts certain of the traditional theories of personality development and psychopathology. Thus, for example, a therapist who views his patient's misperceptions and misunderstandings as the not unreasonable products of what the patient has actually experienced in the past, or has repeatedly been told, differs sharply from one who sees these same misperceptions and

misunderstandings as the irrational offspring of autonomous and unconscious fantasy.

In what follows I am drawing on several distinct sources of information: studies by epidemiologists; the studies by developmental psychologists already referred to; observations made during the course of family therapy; and not least what I have learned from patients whom I have treated myself and from those whose therapy I have supervised.

Influence of earlier experiences on the transference relationship

It not infrequently happens that a patient is acutely apprehensive lest his therapist reject, criticize, or humiliate him. Since we know that all too many children are treated in this way by one or other, or both, of their parents, we can be reasonably confident that that has been our patient's experience. Should it seem likely that the patient is aware of how he is feeling and how he expects the therapist to treat him, the therapist will indicate that he also is aware of the problem. How soon the therapist can link these expectations to the patient's experiences of his parents, in the present perhaps as well as the past, turns on how willing the patient is to consider that possibility, or whether, by contrast, he insists that his parents' treatment of him is above criticism. Where the latter situation obtains, there is the prior problem of trying to understand why the patient should insist on retaining this favourable picture when such evidence as is available points to its being mistaken.

It happens in some families that one or other parent insists that he or she is an admirable parent who has always done everything possible for the child and that, in so far as friction is present, the fault lies exclusively with the child. This attitude of the parent all too often cloaks behaviour that, by ordinary standards, has been far from perfect. Yet, since the parent insists that he or she has given the child constant affection and that the child must have been born bad and ungrateful, the child has little option but to accept the picture, despite being aware somewhere in his mind that the picture is hardly fair.

An added complication arises when a patient has, as a child, been subjected to the strongest of instructions from a parent on no account to tell anyone of certain happenings within the family. These are usually quarrels in which the parent is aware that his or her behaviour is open to criticism; for example, quarrels between the parents, or between a parent and a child, during which dreadful things have been said or done. The more insistent a therapist is that his patient tell everything, the more distressing the dilemma is for his patient. Injunctions to silence are not uncommon in families and have been much neglected as sources of what has traditionally been called resistance. It is often useful for a therapist to enquire of a patient whether he may have been subjected to such pressures and, if so, to help him resolve the dilemma.

So far we have been considering cases in which a patient is in some degree aware of his expectations of being rejected, criticized, or humiliated. Not infrequently, however, a patient seems wholly unaware of any such feelings despite his attitude to the therapist exuding distrust and evasion. Evidence shows that these states of mind occur especially in those who, having developed an anxiously avoidant pattern of attachment during early years, have striven ever since to be emotionally self-contained and insulated against intimate contacts with other people. These patients, who are often described as being narcissistic or as having a false self, avoid therapy as long as they can and, should they undertake it, keep the therapist at arm's length. If allowed to, some will talk incessantly about anything and everything except emotionally charged relationships, past or present. Others will explain that they have nothing to talk about. One young woman, whose every move indicated deep distrust of me, spent the time boasting of her delinquent exploits, many of them fictitious I suspected, and pouring contempt on what she insisted was my dull and narrow life. To treat such deeply distrustful people was compared many years ago by Adrian Stephen (1934) with trying to make friends with a shy or frightened pony: both situations require a prolonged, quiet, and friendly patience. Only when the therapist is aware of the constant rebuffs the patient is likely to have been subjected to as a child whenever he sought comfort or help, and

of his terror of being subjected to something similar from the therapist, can the latter see the situation between them as his patient is seeing it.

Another and quite different cause of wariness of any close contact with a therapist for the patient is dread lest the therapist trap him into a relationship aimed to serve the therapist's interests rather than his own. A common origin of such fear is a childhood in which a parent, almost always mother, has sought to make the child her own attachment figure and caregiver, that is, has inverted the relationship. Very often this is done unconsciously and using techniques that, to an uninformed eye, may appear to be overindulgence but that are really bribes to retain the child in a caregiving role.

Not infrequently a patient shifts during the therapy from treating his therapist as though he was one or other of his parents to behaving towards him in the way one of his parents had treated him. For example, a patient who has been subjected to hostile threats as a child may use hostile threats to his therapist. Experiences of scornful contempt from a parent may be re-enacted as scornful contempt of the therapist. Sexual advances from a parent may reappear as sexual advances to the therapist. Such behaviour may be understood in the following way. During his childhood a person learns two principal forms of behaviour and builds in his mind two principal types of model. One form of behaviour is, of course, that of a child, namely himself, interacting with a parent, his mother or his father. The corresponding working models he builds are those of himself as a child in interaction with each parent. The other form of behaviour is that of a parent, namely his mother or his father, interacting with a child, himself. The corresponding models he builds are those of each parent in interaction with himself. Therefore, whenever a therapist is puzzled by, or resentful of, the way he is being treated by a patient, he is always wise to enquire when and from whom the patient may have learned that way of treating other people. More often than not it is from one of his parents.*

* Within traditional theory this shift of role by a patient is likely to be termed a case of identification with the aggressor.

With some patients the therapeutic relationship is one in which anxiety, distrust, and criticism, and sometimes also anger and contempt, are overt and predominate, and the therapist seen in dark colours. Such sentiments as gratitude for the therapist's efforts or respect for his competence are conspicuous by their absence. The task then is to help the patient grasp that much of his present resentment stems from past mistreatment at the hands of others and that, however understandable his anger may be as a result, to continue fighting old battles is unproductive. To accept that an unhappy past cannot be changed is usually a bitter pill.

With other patients the situation is reversed: the transference relationship becomes one in which overt gratitude, admiration, and affection are readily expressed, and the therapist seen in a glow of rosy perfection. Dissatisfaction and criticism are notably absent, and anger at the therapist's shortcomings, especially absences, unimaginable. Such idealization of the therapist springs, I believe, partly from unrealistic hopes and expectations of what the therapist is able and willing to provide, and partly from a childhood in which criticism of a parent is forbidden and compliance enforced, either by some guilt-inducing technique or else by sanctions such as threats not to love, or even to abandon, the child. With this type of childhood experience, the patient's unconscious assumption is that the therapist will expect the same degree of obedience as his parents had expected and will enforce it by techniques or by threats similar to the ones they used.

Unfortunately there has been a tendency in some quarters to confuse the theory advanced here, which regards the way certain parents treat their children as being a major cause of mental ill-health, with an attitude of mind that simply blames parents. No one who works in the fields of child psychiatry and family therapy is likely to make this mistake. On the contrary, as already remarked, it has long been recognized that the misguided behaviour of parents is more often than not the product of their own difficult and unhappy childhood. As a result much skilled time has always been devoted to helping parents escape from the adverse influences of their own childhoods.

Furthermore, during the treatment of an individual (of any age) who has suffered at the hands of his parents, the therapist, whilst accepting the patient's account, avoids moral judgement. On the contrary, whenever opportunity offers, he will encourage his patient to consider how and why the parent under discussion may have behaved as he or she has done. In raising these questions, it is always useful for the therapist to enquire of the patient what he knows of the childhood experiences that the parent in question may have had. Not infrequently this leads the patient to gain some understanding of how things had developed and, from understanding, often to move on to a measure of forgiveness and reconciliation. In family sessions it can be especially valuable if a parent can be encouraged to give an account of his or her childhood. This enables all those present – the parent him- or herself, the spouse, the children, and the therapist – to gain some insight into how and why family life has developed as it has and how each can best help improve it. As already mentioned (p. 133), this strong tendency for attachment problems to be transmitted across generations, through the influence on parenting behaviour of relationship problems stemming from the parent's own childhood, is at last receiving the research attention it deserves.

Some pathogenic situations and events of childhood

A therapist, I believe, cannot be too well informed about the disguised and distorted relationships that can occur in some families, and the terrible things that can happen in others, for it is only if he is so informed that he can have a reasonably clear idea of what probably lies behind his patient's defences, or of the origins of his anxiety, anger, and guilt. Once he is adequately informed, he is well placed not only to appreciate the truth of what his patient may be describing as having happened to him but also to broach, more or less tentatively, some of the kinds of situation to which the patient may well have been exposed but to which he may be either unable or unwilling to refer. In listing the following situations I am doing no more than indicating

some that are both common and have, until recently, been neglected in the psychotherapeutic literature.*

Threats not to love a child used as a means of control

It is easy for a mother to say to a child that she will not love him if he behaves in such and such a way. What this means is that the mother is threatening not to provide affection or comfort at times when her child is upset, frightened, or distressed, and not to provide help or encouragement at other times. If such threats are used systematically by either parent, or both, the child inevitably grows up intensely anxious to please and guilt-prone.

Threats to abandon a child

Threats to abandon are a degree more frightening to a child than threats no longer to love him. This is especially so if the parent enacts a threat, perhaps by disappearing herself for a few hours or by packing her child's suitcase and walking him up the street, allegedly to the home for bad boys. Since threats to abandon often take a highly idiosyncratic form, a patient may deny that he was ever subjected to them. In such cases the truth may emerge with its accompanying emotion only when the special way in which the threat was phrased is recollected. One example is a mother who had concocted the story that a yellow van would draw up and take her son away. Another is a father whose story was that his daughter would be sent to a school on a remote rock surrounded by sharks (Marrone 1984). Thus, in the first case, all the mother had to say was 'Well the yellow van will come', and, in the second, for the father to say 'Then it will be the rock school', for the child instantly to desist from whatever he or she was doing. In a third case, the code word was 'margarine', the mother having coupled her threat to send her son away to a children's home with an insistence that he would have to eat margarine there. For these patients a general phrase

* Since in previous publications I have given much attention to the ill effects on personality development of bereavements and prolonged separations, these themes are omitted from what follows.

like 'threat to abandon' had failed to ring a bell. Only when the code word was unearthed was the original terror experienced afresh and the source of the separation anxiety located.

Threats to commit suicide

Sometimes a distraught parent threatens to commit suicide if some distressing situation continues. This may occur during quarrels between parents, which the child overhears, or may be directed at the child himself. In either case such threats strike terror. One lesson to be learned from these cases is that, whenever a patient refers to his parents as having quarrelled, the therapist should always enquire 'What did they *say* to each other?' Not infrequently a patient blocks at this. In a fit of temper quarrelling parents may say appalling things to each other. This is bad enough. What makes it far worse is when, after cooling down, they disclaim having said any such thing.

Disclaimers and disconfirmations

Examples of disclaimers by a parent of what he or she has said or done, and persistent efforts to disconfirm what a child has seen or heard, are given in some detail in Lecture 6 and the adverse effects on personality development of such pressures emphasized. During therapy these effects emerge as great uncertainty in a patient as to whether some family episode did or did not occur and guilt about adumbrating it. Here, as so often, a key role for the therapist is to sanction the patient's exploration of all the various possibilities, both those favourable to his parents and those unfavourable to them, and to encourage him to weigh the evidence available, whilst he (the therapist) remains resolutely open-minded as to where the truth may lie.

Thus far in this exposition I have not considered the critical issue of how far we can and should rely on the validity of our patients' reports. Memories are certainly fallible, and there are various occasions when an experienced therapist will rightly question the truth of what his patient is saying. What then are the criteria by which we should judge?

First, broad generalizations about the kind of parent the mother or father was and about the kind of parenting received are never to be given credence unless and until they are supported by detailed examples of how each treated the patient as a child in particular situations. For example, the glowing account of a wonderful mother may well go unsupported when detail becomes available. Valid accounts of affectionate parenting not only give plenty of favourable details but are likely also to be interlaced with occasional criticism, so that the parent can be seen in the round. Similarly, disparaging accounts of parents in uniformly adverse terms need close examination. Invalid accounts of either sort tend to be sweeping and extreme, to be either white or black. Detail is either lacking or, should it be given, is at variance with the portrait presented. By contrast, whenever plenty of consistent detail is given and the picture that emerges conforms to what we know, from other sources, does happen in other families, and also to the known antecedents of the types of problem besetting the patient, it is absurd to doubt its overall validity, even if some points remain in question.

The origin of these extremes is not infrequently external pressure. For example, one parent has insisted that the child take sides with him or her against the other parent who is represented as being all bad. Or else a parent who has many shortcomings insists that he or she is above criticism.

Another occasion when a therapist is right to doubt the patient's story is when there is reason to suspect that the patient is a pathological liar. Such cases are comparatively rare and, if only for that reason, may go undetected for a time. Sooner or later, however, mounting inconsistencies and improbabilities, as well as the way the patient tells his story, engender first doubt and, later, certainty that the patient is not to be believed.

Apart from these exceptions I believe patients' accounts are sufficiently trustworthy that a therapist should accept them as being reasonable approximations to the truth;* and furthermore that it is anti-therapeutic not to do so. Constantly to query the

* For research purposes, however, criteria for accepting retrospective information as valid must be much stricter.

validity of the patient's story, even if only by implication, and insistence on the distorting role of imagination or fantasy, is the reverse of empathic. It conveys to the patient that the therapist does not understand him and may indeed convince him that the therapist is behaving exactly as his parent had predicted. Thus some parents, having insisted that their child not tell of something the parent is ashamed of, may then add that, in any case, were he to do so no one would believe him.

Among the large range of adverse events and situations not so far mentioned in this lecture that a therapist should have in his mind as likely to have occurred in the life of one patient or another are the following:

a child may never have been wanted by one or both parents;

a child may be of the wrong sex in a family in which parents had set their hearts on a boy or a girl;

a child may have been made the family scapegoat, sometimes as a result of a family tragedy that, with greater or less plausibility, has always been attributed to him;

a parent may have used guilt-inducing techniques to control a child, for example, frequent claims that the child's behaviour makes mother ill;

a parent may have sought to make one of her children her attachment figure by discouraging him from exploring the world away from her and from believing that he will ever be able to make his way on his own;

a child's unusual role in a family may be the result of his mother having had an extra-marital affair during her marriage so that the child's putative father is not his real father;

another cause of a child's unusual role is when one or other parent identifies one child with a relative, often one of the child's grandparents, with whom he or she has had a difficult relationship, and who then re-enacts that relationship with the child;

a child may have been the target of more or less serious physical abuse from a parent or step-parent;

a child may have been involved in sexual abuse from a parent, step-parent, or older sibling for short or long periods of time.

For those unaware of the commoner effects on personality development of exposure to situations of these kinds, a number of references are given in an Appendix (pp. 173–4).

Inevitably the influential events of an individual's first two or three years will either never have been registered in his memory or else cannot now be recalled. Here, of course, the best a therapist can do is to infer, on the basis of the transference situation and of such information as the patient has gleaned about his early years, combined with such wider knowledge of personality development as the therapist has acquired, what the nature of those events may have been. In other words, he resorts to reconstruction; but in doing so he can in future draw on a much wider and more reliable knowledge of family influences on personality development than has traditionally been available to analytically trained psychotherapists.

The therapist's stance

In this account of therapeutic principles, therapists will recognize much that has long been familiar, though often under a different name. The therapeutic alliance appears as a secure base, an internal object as a working, or representational, model of an attachment figure, reconstruction as exploring memories of the past, resistance (sometimes) as deep reluctance to disobey the past orders of parents not to tell or not to remember. Among points of difference is the emphasis placed on the therapist's role as a companion for his patient in the latter's exploration of himself and his experiences, and less on the therapist interpreting things to the patient. Whilst some traditional therapists might be described as adopting the stance 'I know; I'll tell you', the stance I advocate is one of 'You know, you tell me'. Thus the patient is encouraged to believe that, with support and

occasional guidance, he can discover for himself the true nature of the models that underlie his thoughts, feelings, and actions and that, by examining the nature of his earlier experiences with his parents, or parent substitutes, he will understand what has led him to build the models now active within him and thus be free to restructure them. Fortunately the human psyche, like human bones, is strongly inclined towards self-healing. The psychotherapist's job, like that of the orthopaedic surgeon's, is to provide the conditions in which self-healing can best take place.

Amongst those who have recently given detailed accounts of the special value of adopting a modest and tentative approach are Peterfreund (1983) and Casement (1985).

In the foregoing description the therapist's role has been likened to that of a mother who provides her child with a secure base from which to explore. This means, first and foremost, that he accepts and respects his patient, warts and all, as a fellow human being in trouble and that his over-riding concern is to promote his patient's welfare by all means at his disposal. To this end the therapist strives to be reliable, attentive, empathic, and sympathetically responsive, and also to encourage his patient to explore the world of his thoughts, feelings, and actions not only in the present but also in the past. Whilst always encouraging his patient to take the initiative, the therapist is in no sense passive. On the one hand he tries to be attentive and sensitively responsive. On the other, he recognizes that there are times when he himself should take the initiative. For example, when a patient wastes time talking about everything and anything except his thoughts and feelings about people, it will be necessary to draw his attention to his avoidance of the area, and perhaps also to his deep distrust of the therapist's efforts to be helpful or of his capacity to keep confidences. With another patient, who perhaps is very willing to explore memories of childhood, there will be many occasions when a therapist can usefully ask for more detail or raise questions about situations of childhood that the patient has so far not referred to directly, but which seem plausible possibilities in the light of what he has been describing, and in the light also of the particular problems from which the patient is suffering. In doing

so, moreover, the therapist must never forget that his patient may still be strongly influenced by his parents' injunctions not to know about events he is not supposed to know about and not to experience feelings he is not supposed to experience.

An interruption to therapy probably always generates some reaction in a patient; sometimes it is conscious, at others unconscious, but nonetheless evident. When conscious, it may take the form of overt complaint or angry protest; when unconscious it may manifest itself by the patient disparaging therapy or missing a session or two before the break. How a therapist evaluates these reactions and responds to them will reflect his theoretical position. Someone who adopts attachment theory will respect his patient's distress or anger about the separation and will regard them as the natural responses of someone who has become attached to another – a respect that will be implicit in anything he says or does. At the same time he will give attention to the form his patient's reaction takes. If openly expressed, he will be sympathetic and may be able to ease the patient's distress by giving him information about how he could communicate during the break. In addition, the therapist will consider how the patient is construing the interruption and, should there be evidence of misconstruction, will attempt to discover how it may have originated. If, for example, the patient is apprehensive that the therapist will not return, the possibility of the patient having been exposed to threats by a parent to abandon him might be explored. In cases where the interruption is due to the therapist being unwell, he will be alert to the possibility that the patient may be apprehensive lest something he (the patient) has done or said is responsible. Were that to be so, the therapist would explore whether one of the patient's parents had sought to control him by claiming that the way he behaved was making mother or father ill.

Similarly, should a patient react to an interruption by disparaging therapy or missing a session, a therapist who adopts attachment theory would ask himself why his patient is afraid to express his feelings openly and what his childhood experiences may have been to account for his distrust.

It is not unlikely that the description just given of a therapist's mode of responding to his patient's reactions to an interruption

will contrast with that of a therapist who adopts and applies one or another of the traditional psychoanalytic theories. For example, one such therapist might regard his patient's reactions as being rather childish, even infantile, and as indicating that the patient was fixated in an oral or a symbiotic phase. What the therapist then might say, and especially the way he might say it, could well be experienced by the patient as lacking in respect for his (the patient's) current feelings of attachment, distress, or anger. Here again there would be danger that the therapist might appear to be responding in a cold unsympathetic way and all too like one or other of the patient's parents. Were that so the exchange would be anti-therapeutic.

How far a therapist can wisely go in meeting a patient's desire to keep in communication during breaks, e.g. by telephone, and for comforting when distressed during a session, turns on many personal factors in their relationship. On the one hand, there is danger of the therapist's appearing to lack sympathy for the patient's distress or even to seem rejecting. On the other is the risk of his appearing to offer more than he is prepared to give. There are occasions when it would be inhuman not to allow a distressed patient to make some form of physical contact: the roles are then explicitly comforter and comforted. Yet there is always danger that physical contact can elicit sexual feelings, especially when sexes are different. Depending on the situation each therapist must make his own decisions and draw his own lines. The more alive to such issues a therapist is the better will he be able to avoid the pitfalls.

Emotional communications and the restructuring of working models

When a therapist utilizes the kind of technique advocated here, it can sometimes happen that therapy gets into a rut in which the patient persists endlessly in describing what a terrible time he had as a child and how badly his parents treated him, without any progress being made. One cause of such perseveration, I suspect, is that the patient is convinced that his therapist does not accept the truth of what he is saying: hence his endless

repetition of it. This may be due to the patient having always been scoffed at by those to whom he has told the story in the past or, and perhaps more commonly, to the therapist himself having indicated scepticism or disbelief. This can be done in a myriad of ways, by tone of voice, by querying the details, by failing to attach any particular weight to what the patient describes.

Evidently when the problem lies in the therapist's incredulity the way out is for him to make it plain that he knows all too well that such things do happen to children and has no reason to doubt the patient's account. Even so the impasse may continue: the story is told and retold in a flat cynical way with no show of feeling whatever.

This situation has been discussed by Selma Fraiberg who, with colleagues, set out to help vulnerable mothers at risk of either neglecting or abusing their infants (Fraiberg, Adelson, and Shapiro 1975). They describe making visits to the homes of two such mothers and listening to the distressing tales these women had to tell. Each told a story of gross cruelty during childhood – being subjected to violent beatings, being locked out in the cold, often deserted by mother, being shunted from one place to another, and of having no one to go to for help or comfort. Neither gave a hint of how they might have *felt* nor what they may have felt like *doing*. One, a girl of sixteen who avoided touching or holding her baby (who screamed hopelessly), insisted: 'But what's the use of talking? I always kept things to myself. I want to forget. I don't want to think.' This was the point at which the therapist intervened – by herself expressing all the feelings that any and every child would be expected to have in the situations described: how frightened, how angry, how hopeless one would feel, and also how one *would long to go to someone* who would understand and provide comfort and protection. In doing so the therapist not only showed an understanding of how the patient must have felt, but communicated in her manner that the expression of such feeling and desire would be met with a sympathetic and comforting response. Only then was it possible for the young mother to express all the grief, the tears, 'and the unspeakable anguish for herself as a cast-off child' that she had always felt but had never dared express.

In this account of Fraiberg's methods of helping a patient express the emotions she dares not show I have deliberately emphasized the link between emotion and action. Failure to express emotion is due very largely to unconscious fear lest the action of which the emotion is a part will lead to a dreaded outcome. In many families anger with an adult leads to punishment which can sometimes be severe. Moreover a tearful appeal for comfort and help can lead to rejection and humiliation. It is perhaps too often forgotten by clinicians that many children, when they become distressed and weepy and are looking for comfort, are shooed off as intolerable little cry-babies. Instead of the comforting provided by an understanding and affectionate parent, these children meet with an unsympathetic and critical rebuff. No wonder therefore if, should this pattern prevail during childhood, the child learns never to show distress or seek comfort and, should he undertake therapy, assumes that his therapist will be as intolerant of anger and tears as his parents always were.

Every therapist who adopts a psychoanalytic perspective has long recognized that, to be effective, therapy requires that a patient not only talks about his memories, his ideas and dreams, his hopes and desires, but also expresses his feelings. The discussion of Fraiberg's technique for helping a cynical and frozen young woman to discover the depth of her feelings and to express them freely to her therapist is therefore a fitting note on which to end.

In writing this lecture I have throughout been aware that, by using terms such as 'information', 'communication', and 'working models', it would be easy for an unwary reader to suppose that these terms belong within a psychology concerned only with cognition and one bereft of feeling and action. Although for many years it was all too common for cognitive psychologists to omit reference to emotion, it is now recognized that to do so is artificial and unfruitful (Hinde, Perret-Clermont, and Stevenson-Hinde 1985). There are, in fact, no more important communications between one human being and another than those expressed emotionally, and no information more vital for constructing and reconstructing working models of self and

other than information about how each feels towards the other. During the earliest years of our lives, indeed, emotional expression and its reception are the only means of communication we have, so that the foundations of our working models of self and attachment figure are perforce laid using information from that source alone. Small wonder therefore, if, in reviewing his attachment relationships during the course of psychotherapy and restructuring his working models, it is the emotional communications between a patient and his therapist that play the crucial part.

Bowlby, J. (1951) *Maternal care and mental health*, Geneva: World Health Organisation; London: Her Majesty's Stationery Office; New York: Columbia University Press; abridged version: *Child Care and the Growth of Love* (second edn, 1965) Harmondsworth: Penguin.

Bowlby, J. (1958) The nature of the child's tie to his mother, *International Journal of Psycho-Analysis, 39*: 350–73.

Bowlby, J. (1960) 'Grief and mourning in infancy and early childhood', *The Psychoanalytic Study of the Child*, 15: 9–52.

Bowlby, J. (1961) 'Processes of mourning', *International Journal of Psycho-Analysis*, 42: 317–40.

Bowlby, J. (1969) *Attachment*, vol. 1 of *Attachment and loss* (2nd edition 1982), London: Hogarth Press; New York: Basic Books; Harmondsworth: Penguin (1971).

Bowlby, J. (1973) *Separation: anxiety and anger*, vol. 2 of *Attachment and loss*, London: Hogarth Press; New York: Basic Books; Harmondsworth: Penguin (1975).

Bowlby, J. (1977) 'The making and breaking of affectional bonds', *British Journal of Psychiatry*, 130: 201–10 and 421–31; reprinted 1979, New York: Methuen Inc.; London: Tavistock.

Bowlby, J. (1980) *Loss: sadness and depression*, vol. 3 of *Attachment and loss*, London: Hogarth Press; New York: Basic Books; Harmondsworth: Penguin (1981).

Bowlby, J. (1981) 'Psychoanalysis as a natural science', *International Review of Psycho-Analysis*, 8: 243–56.

Bowlby, J. (1982) *Attachment*, 2nd edition of vol. 1 of *Attachment and loss* London: Hogarth Press.

Brazelton, T.B., Koslowski, B., and Main, M. (1974) 'The origins of reciprocity in mother–infant interaction' in M. Lewis and L.A. Rosenblum (eds) *The Effect of the Infant on its Caregiver*, 49–76, New York; Wiley-Interscience.

Bretherton, I. (1987) 'New perspectives on attachment relations in infancy: security, communication and internal working models' in J.D. Osofsky, (ed.) *Handbook of infant development* (2nd edition), 1061–100, New York: Wiley.

Brown, G.W. and Harris, T. (1978) *The social origins of depression*, London: Tavistock.

Burlingham, D. and Freud, A. (1942) *Young children in war-time London*, London: Allen & Unwin.

Burlingham, D. and Freud, A. (1944) *Infants without families*, London: Allen & Unwin.

Burnham, D.L. (1965) 'Separation anxiety', *Archives of General Psychiatry*, 13: 346–58.

Cain, A.C. and Fast, I. (1972) 'Children's disturbed reactions to parent suicide' in A.C. Cain (ed.) *Survivors of suicide*, Springfield, Illinois: C.C. Thomas.

Casement, P. (1985) *On learning from the patient*, London: Tavistock.

Cassidy, J. and Kobak, R. (in press) 'Avoidance and its relation to other defensive processes' in J. Belsky and T. Nezworski (eds.) *Clinical Implications of Attachment*, Hillsdale, NJ: Lawrence Erlbaum.

Cater, J.I. and Easton, P.M. (1980) 'Separation and other stress in child abuse', *Lancet*, 1 (3 May 1980): 972.

Clarke-Stewart, K.A. (1978) 'And daddy makes three: the father's impact on mother and young child', *Child Development*, 49: 466–78.

Collis, G.M. and Schaffer, H.R. (1975) 'Synchronization of visual attention in mother–infant pairs', *Journal of Child Psychology and Psychiatry*, 16: 315–20.

Crittenden, P. (1985) 'Maltreated infants: vulnerability and resilience', *Journal of Child Psychology and Psychiatry*, 26: 85–96.

DeLozier, P.P. (1982) 'Attachment theory and child abuse' in C.M. Parkes and J. Stevenson-Hinde *The place of attachment in human behavior*, 95–117, New York: Basic Books; London: Tavistock.

Deutsch, H. (1937) 'Absence of grief', *Psychoanalytic Quarterly*, 6: 12–22.

Dixon, N.F. (1971) *Subliminal perception: the nature of a controversy*, London: McGraw-Hill.

Dixon, N.F. (1981) *Preconscious processing*, Chichester and New York: Wiley.

Efron, A. (1977) 'Freud's self-analysis and the nature of psycho-analytic criticism', *International Review of Psycho-analysis*, 4: 253–80.

Emde, R.N. (1983) 'The prerepresentational self and its affective core', *The Psychoanalytic Study of the Child*, 38: 165–92.

Epstein, S. (1980) 'The self-concept: a review of the proposal of an integrated theory of personality' in E. Staub (ed.) *Personality: basic issues and current research*, Englewood Cliffs, NJ: Prentice Hall.

Epstein, S. (1986) 'Implications of cognitive self-theory for psychopathology and psychotherapy' in N. Cheshire and H. Thoma (eds) *Self-esteem and Psychotherapy*, New York: Wiley.

Erdelyi, M.H. (1974) 'A new look at the New Look: perceptual defense and vigilance', *Psychological Review*, 81: 1–25.

Fairbairn, W.R.D. (1940) 'Schizoid factors in the personality' in *Psychoanalytic studies of the Personality*, 3–27, London: Tavistock (1952); New York: Basic Books (1952).

Farrington, D.P. (1978) 'The family backgrounds of aggressive youths'

References

Adams-Tucker, C. (1982) 'Proximate effects of sexual abuse in childhood: a report on 28 children', *American Journal of Psychiatry*, 139: 1252–6.

Ainsworth, M.D. (1962) 'The effects of maternal deprivation: a review of findings and controversy in the context of research strategy' in: *Deprivation of maternal care: a reassessment of its effects*, Public Health Papers no. 14, Geneva: World Health Organisation.

Ainsworth, M.D. (1963) 'The development of infant–mother interaction among the Ganda' in B. M. Foss (ed.) *Determinants of infant behaviour*, vol. 2, London: Methuen; New York: Wiley.

Ainsworth, M.D.S. (1967) *Infancy in Uganda: infant care and the growth of attachment* Baltimore: Johns Hopkins University Press.

Ainsworth, M.D.S. (1969) 'Object relations, dependency and attachment: a theoretical review of the infant-mother relationship', *Child Development*, 40: 969–1025.

Ainsworth, M.D.S. (1977) 'Social development in the first year of life: maternal influences on infant–mother attachment' in J. M. Tanner (ed.) *Developments in psychiatric research*, London: Tavistock.

Ainsworth, M.D.S. (1982) 'Attachment: retrospect and prospect' in C.M. Parkes and J. Stevenson-Hinde (eds) *The place of attachment in human behavior*, 3–30, New York: Basic Books; London: Tavistock.

Ainsworth, M.D.S. (1985) 'I Patterns of infant-mother attachment: antecedents and effects on development' and 'II Attachments across the life-span', *Bulletin of New York Academy of Medicine*, 61: 771–91 and 791–812.

Ainsworth, M.D.S. and Wittig, B.A. (1969) 'Attachment and exploratory behaviour of one-year-olds in a strange situation' in B.M. Foss (ed.) *Determinants of infant behaviour*, vol. 4, London: Methuen; New York: Barnes & Noble.

Ainsworth, M.D.S., Bell, S.M., and Stayton, D.J. (1971) 'Individual differences in strange situation behavior of one-year-olds' in H.R. Schaffer (ed.) *The origins of human social relations*, 17–57, London: Academic Press.

Ainsworth, M.D., Blehar, M.C., Waters, E., and Wall, S. (1978) *Patterns of attachment: assessed in the strange situation and at home*, Hillsdale, NJ: Lawrence Erlbaum.

Anderson, J.W. (1972) 'Attachment behaviour out of doors' in N. Blurton Jones (ed). *Ethological studies of child behaviour*, Cambridge: Cambridge University Press.

Arend, R., Gove, F.L., and Sroufe, L.A. (1979) 'Continuity of individual adaptation from infancy to kindergarten: a predictive study of ego-resiliency and curiosity in preschoolers', *Child Development*, 50: 950–9.

Baldwin, J. (1977) 'Child abuse: epidemiology and prevention' in *Epidemiological approaches in child psychiatry*, 55–106, London: Academic Press.

Ballou, J. (1978) 'The significance of reconciliative themes in the psychology of pregnancy', *Bulletin of the Menninger Clinic*, 42: 383–413.

Bender, L. (1947) 'Psychopathic behaviour disorders in children' in R.M. Lindner and R.V. Seliger (eds) *Handbook of correctional psychology*, New York: Philosophical Library.

Bender, L. and Yarnell, H. (1941) 'An observation nursery', *American Journal of Psychiatry*, 97: 1158–74.

Blehar, M.C., Lieberman, A.F., and Ainsworth, M.D.S. (1977) 'Early face-to-face interaction and its relations to later infant–mother attachment', *Child Development*, 48: 182–94.

Blight, J.G. (1981) 'Must psychoanalysis retreat to hermeneutics?', *Psychoanalysis and Contemporary Thought*, 4: 147–205.

Bliss, E.L. (1980) 'Multiple personalities: report of 14 cases with implications for schizophrenia and hysteria', *Archives of General Psychiatry*, 37: 1388–97.

Bliss, E.L. (1986) *Multiple personality, allied disorders and hypnosis*, Oxford: Oxford University Press.

Bloch, D. (1978) *'So the witch won't eat me'*, Boston: Houghton Mifflin.

Bowlby, J. (1940) 'The influence of early environment in the development of neurosis and neurotic character', *International Journal of Psycho-Analysis*, 21: 154–78.

Bowlby, J. (1944) 'Forty-four juvenile thieves: their characters and home life', *International Journal of Psycho-Analysis*, 25: 19–52 and 107–27.

Harlow, H.F. and Zimmermann, R.R. (1959) 'Affectional responses in the infant monkey', *Science*, 130: 421.
Harris, T.O. (in press) 'Psycho-social vulnerability to depression: the biographical perspective of the Bedford College studies' in S. Henderson (ed.) *Textbook of Social Psychiatry*, Amsterdam: Elsevier.
Harrison, M. (1981) 'Home-start: a voluntary home-visiting scheme for young families', *Child Abuse and Neglect*, 5: 441–7.
Hazan, C. and Shaver, P. (1987) 'Romantic love conceptualised as an attachment process', *Journal of Personality and Social Psychology*, 52: 511–24.
Heinicke, C. (1956) 'Some effects of separating two-year-old children from their parents: a comparative study', *Human Relations*, 9: 105–76.
Heinicke, C. and Westheimer, I. (1966) *Brief separations*, New York: International Universities Press; London: Longman.
Helfer, R.E. and Kempe, C.H. (eds) (1976) *Child abuse and neglect: the family and the community*, Cambridge, Mass.: Ballinger.
Hinde, R.A. (1974) *Biological bases of human social behaviour*, New York and London: McGraw-Hill.
Hinde, R.A., and Spencer-Booth, Y. (1971) 'Effects of brief separation from mother on rhesus monkeys', *Science*, 173: 111–18.
Hinde, R.A., Perret-Clermont, A.–N., and Stevenson-Hinde J. (eds) (1985) *Social relationships and cognitive development*, Oxford: Clarendon Press.
Holt, R.R. (1981) 'The death and transfiguration of metapsychology', *International Review of Psycho-Analysis*, 8: 129–43.
Home, H.J. (1966) 'The concept of mind', *International Journal of Psycho-Analysis*, 47: 43–9.
Hopkins, J. (1984) 'The probable role of trauma in a case of foot and shoe fetishism: aspects of the psychotherapy of a six-year-old girl', *International Review of Psycho-analysis*, 11: 79–91.
Horney, K. (1951) *Neurosis and human growth*, London: Routledge & Kegan Paul.
Horowitz, M., Marmar, C., Krupnick, J., Wilner, N., Kaltreider N., and Wallerstein, R. (1984) *Personality styles and brief psychotherapy*, New York: Basic Books.
Izard, C.E. (ed.) (1982) *Measuring emotions in infants and children*, Cambridge: Cambridge University Press.
Johnson-Laird, P.N. (1983) *Mental models*, Cambridge: Cambridge University Press.
Jones, E. (1957) *Sigmund Freud: life and work*, vol. 3, London: Hogarth Press, New York: Basic Books.
Kaye, H. (1977) 'Infant sucking behaviour and its modification' in L.P. Lipsitt and C.C. Spiker (eds) *Advances in child development and behaviour*, vol. 3, 2–52, London and New York: Academic Press.
Kennell, J.H., Jerrauld, R., Wolfe, H., Chesler, D., Kreger, N.C., McAlpine, W., Steffa, M., and Klaus, M.H. (1974) 'Maternal behaviour one year after early and extended post-partum contact', *Developmental Medicine and Child Neurology*, 16: 172–9.
Kernberg, O. (1975) *Borderline conditions and pathological narcissism*, New York: Jason Aronson.
Kernberg, O. (1980) *Internal world and external reality: object relations theory applied*, New York: Jason Aronson.
Klaus, M.H. and Kennell, J.H. (1982) *Maternal–infant bonding* (2nd edition), St Louis: C.V. Mosby.
Klaus, M.H., Trause, M.A., and Kennell, J.H. (1975) 'Does human maternal behaviour after delivery show a characteristic pattern?' in *Parent-infant interaction, Ciba Foundation Symposium 33 (new series)*: 69–78, Amsterdam: Elsevier.
Klaus, M.H., Kennell, J.H., Robertson, S.S., and Sosa, R. (1986) 'Effects of social support during parturition on maternal and infant morbidity', *British Medical Journal*, 283: 585–7.
Klein, G.S. (1976) *Psychoanalytic theory: an exploration of essentials*, New York: International Universities Press.
Klein, M. (1940) 'Mourning and its relation to manic-depressive states' in *Love, guilt and reparation and other papers, 1921–1946*, 311–38, London: Hogarth (1947); Boston: Seymour Lawrence/Delacorte.
Klein, Milton (1981) 'On Mahler's autistic and symbiotic phases: an exposition and evaluation', *Psychoanalysis and Contemporary Thought*, 4: 69–105.
Kliman, G. (1965) *Psychological emergencies of childhood*, New York: Grune & Stratton.
Kluft, R.P. (ed.) (1985) *Childhood antecedents of multiple personality*, Washington D.C.: American Psychiatric Press.
Kobak, R.R. and Sceery, A. (1988) 'Attachment in late adolescence; working models, affect regulation and representations of self and others'. *Child Development*, 59.
Kohut, H. (1971) *The analysis of the self*, New York: International Universities Press.
Kohut, H. (1977) *The restoration of the self*, New York: International Universities Press.
Kuhn, T.S. (1962) *The structure of scientific revolutions* (2nd edition 1970) Chicago: University of Chicago Press.
Kuhn, T.S. (1974) 'Second thoughts on paradigms' in F. Suppe (ed.) *The structure of scientific theory*, 459–99, Urbana, Illinois: University of Illinois Press.

in L. Hersov and M. Berger (eds) *Aggression and anti-social behaviour in children and adolescents*, 73–93, Oxford and New York: Pergamon Press.

Feinstein, H.M., Paul, N., and Pettison, E. (1964) 'Group therapy for mothers with infanticidal impulses', *American Journal of Psychiatry*, 120: 882–6.

Fraiberg, S., Adelson, E., and Shapiro, V. (1975) 'Ghosts in the nursery: a psychoanalytic approach to the problems of impaired infant–mother relationships', *Journal of the American Academy of Child Psychiatry*, 14: 387–421.

Freud, S. (1909) 'Analysis of a phobia in a five-year-old boy', *Standard Edition 10*, 5–149, London: Hogarth Press.

Freud, S. (1914) 'Remembering, repeating and working through', *SE* 12, 147–56, London: Hogarth Press.

Freud, S. (1917) *Introductory lectures on psycho-analysis Part III*, *SE* 16, 243–476, London: Hogarth Press.

Freud, S. (1918) 'From the history of an infantile neurosis', *SE* 17, 7–122, London: Hogarth Press.

Freud, S. (1925) 'An autobiographical study', *SE* 20, 7–70, London: Hogarth Press.

Freud, S. (1926) *Inhibitions, symptoms and anxiety*, *SE* 20, 87–174, London: Hogarth Press.

Freud, S. (1937) 'Constructions in analysis', *SE* 23, 257–69, London: Hogarth Press.

Freud, S. (1939) 'Moses and monotheism', *SE* 23, 7–137, London: Hogarth Press.

Freud, S. (1940) 'An outline of psycho-analysis', *SE* 23, 144–207, London: Hogarth Press.

Freud, S. (1950) 'Project for a scientific psychology', *SE1*, 295–397, London: Hogarth Press.

Frodi, A.M. and Lamb, M.E. (1980) 'Child abusers' responses to infant smiles and cries', *Child Development*, 51: 238–41.

Frommer, E.A. and O'Shea, G. (1973) 'Antenatal identification of women liable to have problems in managing their infants', *British Journal of Psychiatry*, 123, 149–56.

Furman, E. (1974) *A child's parent dies*, New Haven and London: Yale University Press.

Gaensbauer, T.J. and Sands, K. (1979) 'Distorted affective communications in abused/neglected infants and their potential impact on caretakers', *Journal of the American Academy of Child Psychiatry*, 18: 236–50.

Gayford, J.J. (1975) 'Wife-battering; a preliminary survey of 100 cases',

British Medical Journal, vol. 1, 194–7, no. 5951.

Gedo, J.E. (1979) *Beyond interpretation: toward a revised theory for psychoanalysis*, New York: International Universities Press.

George, C. and Main, M. (1979) 'Social interactions of young abused children: approach, avoidance and aggression', *Child Development*, 50: 306–18.

Gill, H.S. (1970) 'Parental influences in a child's capacity to perceive sexual themes', *Family Process* 9: 41–50; reprinted in R. Gosling (ed.) *Support, innovation and autonomy*, 113–24, London: Tavistock (1973).

Goldfarb, W. (1943a) 'Infant rearing and problem behaviour', *American Journal of Orthopsychiatry*, 13: 249–65.

Goldfarb, W. (1943b) 'The effect of early institutional care on adolescent personality', *Child Development*, 14: 213–23.

Goldfarb, W. (1943c) 'The effects of early institutional care on adolescent personality', *Journal of Experimental Education*, 12: 106–29.

Goldfarb, W. (1955) 'Emotional and intellectual consequences of psychologic deprivation in infancy: a revaluation' in P.H. Hoch and J. Zubin (eds) *Psychopathology of Childhood*, New York: Grune & Stratton.

Green, A.H., Gaines, R.W., and Sandgrun, A. (1974) 'Child abuse: pathological syndrome of family interaction', *American Journal of Psychiatry*, 131, 882–6.

Grinker, R.R. (1962) '"Mentally healthy" young males (homoclites)', *Archives of General Psychiatry*, 6: 405–53.

Grossmann, K.E., Grossmann, K., and Schwan, A. (1986) 'Capturing the wider view of attachment: a reanalysis of Ainsworth's strange situation' in C.E. Izard and P.B. Read (eds.) *Measuring emotions in infants and children*, vol. 2, New York: Cambridge University Press.

Guidano, V.F. and Liotti, G. (1983) *Cognitive processes and emotional disorders*, New York: Guilford Press.

Guntrip, H. (1975) 'My experience of analysis with Fairbairn and Winnicott', *International Review of Psycho-Analysis*, 2: 145–56.

Hall, F., Pawlby, S.J. and Wolkind, S. (1979) 'Early life experiences and later mothering behaviour: a study of mothers and their 20-week old babies' in D. Shaffer and J. Dunn (eds) *The first year of life*, 153–74, Chichester and New York: Wiley.

Hansburg, H.G. (1972) *Adolescent separation anxiety: a method for the study of adolescent separation problems*, Springfield, Illinois: C.C. Thomas.

Harlow, H.F. and Harlow, M.K. (1965) 'The affectional systems' in A.M. Schrier, H.F. Harlow, and F. Stollnitz (eds) *Behaviour of non-human primates*, vol, 2, New York and London: Academic Press.

Matas, L., Arend, R.A., and Sroufe, L.A. (1978) 'Continuity of adaptation in the second year: the relationship between quality of attachment and later competence', *Child Development*, 49: 547–56.

Mattinson, J. and Sinclair, I. (1979) *Mate and stalemate*, Oxford: Blackwell.

Meiselman, K.C. (1978) *Incest – a psychological study of causes and effects with treatment recommendations*, San Francisco: Jossey-Bass.

Melges, F.T. and DeMaso, D.R. (1980) 'Grief resolution therapy: reliving, revising, and revisiting', *American Journal of Psychotherapy*, 34: 51–61.

Miller, A. (1979, English translation 1983) *The drama of the gifted child and the search for the true self*, London: Faber and Faber.

Mintz, T. (1976) 'Contribution to panel report on effects on adults of object loss in the first five years', reported by M. Wolfenstein, *Journal of the American Psychoanalytic Association*, 24, 662–5.

Mitchell, M.C. (in preparation) 'Physical child abuse in a Mexican-American population' in K.E. Pottharst (ed.) *Research explorations in adult attachment*.

Morris, D. (1981) 'Attachment and intimacy' in G. Stricker (ed.) *Intimacy*, New York: Plenum.

Morris, M.G. and Gould, R.W. (1963) 'Role reversal: a necessary concept in dealing with the "Battered child syndrome"', *American Journal of Orthopsychiatry*, 32: 298–9.

Newson, J. (1977) 'An intersubjective approach to the systematic description of mother–infant interaction', in H.R. Schaffer (ed.) *Studies in mother–infant interaction*, New York: Academic Press.

Niederland, W.G. (1959a) 'The "miracled-up" world of Schreber's childhood', *The Psychoanalytic Study of the Child*, 14: 383–413.

Niederland, W.G. (1959b) 'Schreber: father and son', *Psycho–Analytic Quarterly*, 28: 151–69.

Norman, D.A. (1976) *Memory and attention: introduction to human information processing* (2nd edition), New York: Wiley.

Offer, D. (1969) *The psychological world of the teenager: a study of normal adolescent boys*, New York: Basic Books.

Palgi, P. (1973) 'The socio-cultural expressions and implications of death, mourning and bereavement arising out of the war situation in Israel' *Israel Annals of Psychiatry*, 11: 301–29.

Parke, R.D. (1979) 'Perspectives on father–infant interaction' in J.D. Osofsky (ed.) *Handbook of infant development*, New York: Wiley.

Parke, R.D. and Collmer, C.W. (1975) 'Child abuse: an interdisciplinary analysis' in E.M. Hetherington (ed.) *Review of Child Development Research*, vol. 5, Chicago: University of Chicago Press.

Parkes, C.M. (1972) *Bereavement: studies of grief in adult life*, London: Tavistock; New York: International Universities Press.

Parkes, C.M. and Stevenson-Hinde, J. (eds) (1982) *The place of attachment in human behavior*, New York: Basic Books; London: Tavistock.

Pedder, J. (1976) 'Attachment and new beginning', *International Review of Psycho-analysis*, 3: 491–7.

Peterfreund, E. (1971) *Information, systems, and psychoanalysis*, Psychological Issues, vol.VII. Monograph 25/26, New York: International Universities Press.

Peterfreund, E. (1978) 'Some critical comments on psychoanalytic conceptualizations of infancy', *International Journal of Psycho-Analysis*, 59: 427–41.

Peterfreund, E. (1983) *The process of psychoanalytic therapy: modes and strategies*, New York: Analytic Press.

Peterson, G.H. and Mehl, L.E. (1978) 'Some determinants of maternal attachment', *American Journal of Psychiatry*, 135: 1168–73.

Pine, F. (1985) *Developmental theory and clinical process*, New Haven: Yale University Press.

Popper, K.R. (1972) *Objective knowledge: an evolutionary approach*, Oxford: Clarendon Press.

Pound, A. (1982) 'Attachment and maternal depression' in C.M. Parkes and J. Stevenson-Hinde (eds.) *The place of attachment in human behavior*, 118–130, New York: Basic Books; London: Tavistock.

Pound, A. and Mills, M. (1985) 'A pilot evaluation of Newpin, a home visiting and befriending scheme in South London', *Newsletter of Association for Child Psychology and Psychiatry*, 7, no 4: 13–15.

Provence, S. and Lipton, R.C. (1962) *Infants in institutions*, New York: International Universities Press.

Radford, M. (1983) 'Psychoanalysis and the science of problem-solving man: an application of Popper's philosophy and a response to Will (1980)', *British Journal of Medical Psychology*, 56: 9–26.

Radke-Yarrow, M., Cummings, E.M., Kuczynski, L., and Chapman, M. (1985) 'Patterns of attachment in two- and three-year olds in normal families and families with parental depression', *Child Development*, 56: 884–93.

Rajecki, D.W., Lamb, M.E., and Obmascher, P. (1978) 'Towards a general theory of infantile attachment: a comparative review of aspects of the social bond', *The Behavioral and Brain Sciences*, 3: 417–64.

Raphael, B. (1977) 'Preventive intervention with the recently bereaved', *Archives of General Psychiatry*, 34: 1450–4.

Lamb, M.E. (1977) 'The development of mother–infant and father–infant attachment in the second year of life', *Developmental Psychology*, 13: 637–48.

Latakos, I. (1974) 'Falsification and the methodology of scientific research programmes' in I. Latakos and A. Musgrave (eds) *Criticism and the growth of knowledge*, London: Cambridge University Press.

Levy, D. (1937) 'Primary affect hunger', *American Journal of Psychiatry*, 94: 643–52.

Lind, E. (1973) 'From false-self to true-self functioning: a case in brief psychotherapy', *British Journal of Medical Psychology*, 46: 381–9.

Liotti, G. (1986) 'Structural cognitive therapy' in W. Dryden and W. Golden (eds.) *Cognitive-behavioural approaches to psychotherapy*, 92–128, New York: Harper & Row.

Liotti, G. (1987) 'The resistance to change of cognitive structures: a counterproposal to psychoanalytic metapsychology', *Journal of Cognitive Psychotherapy*, 1: 87–104.

Lorenz, K.Z. (1935) 'Der Kumpan in der Umvelt des Vogels', *J. Orn. Berl.*, 83, English translation in C.H. Schiller (ed.) *Instinctive behaviour*, New York: International Universities Press (1957).

Lynch, M. (1975) 'Ill-health and child abuse', *The Lancet*, 16 August 1975.

Lynch, M.A. and Roberts, J. (1982) *Consequences of child abuse*, London: Academic Press.

Mackey, W.C. (1979) 'Parameters of the adult–male–child bond', *Ethology and Sociobiology*, 1: 59–76.

Mahler, M.S. (1971) 'A study of the separation–individuation process and its possible application to borderline phenomena in the psychoanalytic situation', *The psychoanalytic study of the child*, 26: 403–24.

Mahler, M.S., Pine, F., and Bergman, A. (1975) *The psychological birth of the human infant*, New York: Basic Books.

Main, M.B. (1977) 'Analysis of a peculiar form of reunion behaviour in some day-care children: its history and sequelae in children who are home-reared', in R. Webb (ed.) *Social development in childhood: day-care programs and research*, Baltimore: Johns Hopkins University Press.

Main, M. (in press) 'Parental aversion to physical contact with the infant: stability, consequences and reasons' in T.B. Brazelton and K. Barnard (eds) *Touch*, New York: International Universities Press.

Main, M. and Cassidy, J. (in press) 'Categories of response with the parent at age six: predicted from infant attachment classifications and stable over a one month period', *Developmental Psychology*.

Main, M. and George, C. (1985) 'Responses of abused and disadvantaged toddlers to distress in age-mates: a study in the day-care setting', *Developmental Psychology*, 21, 407–12.

Main, M. and Hesse, E. (in press) 'Lack of resolution of mourning in adulthood and its relationship to infant organization: some speculations regarding causal mechanisms', in M. Greenberg, D. Cicchetti and M. Cummings (eds) *Attachment in the preschool years*, Chicago: University of Chicago Press.

Main, M. and Solomon, J. (1987) 'Procedure for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation' in M. Greenberg, D. Cicchetti, and M. Cummings (eds), *Attachment in the preschool years*, Chicago: University of Chicago Press.

Main, M. and Weston, D. (1981) 'Quality of attachment to mother and to father: related to conflict behaviour and the readiness for establishing new relationships', *Child Development*, 52: 932–940.

Main, M., Kaplan, N., and Cassidy, J. (1985) 'Security in infancy, childhood and adulthood: a move to the level of representation' in I. Bretherton and E. Waters (eds) *Growing points in attachment: theory and research*, Monographs of the Society for Research in Child Development Serial 209: 66–104, Chicago: University of Chicago Press.

Malan, D.M. (1973) 'Therapeutic factors in analytically-oriented brief psychotherapy' in: R.H. Gosling (ed.) *Support, Innovation and Autonomy*, 187–209, London: Tavistock.

Malone, C.A. (1966) 'Safety first: comments on the influence of external danger in the lives of children of disorganized families', *American Journal of Orthopsychiatry*, 36: 6–12.

Manning, M., Heron, J., and Marshall, T. (1978) 'Styles of hostility and social interactions at nursery, at school and at home: an extended study of children' in L. Hersov and M. Berger (eds) *Aggression and antisocial behaviour in childhood and adolescence*, 29–58, Oxford and New York: Pergamon.

Marris, P. (1958) *Widows and their families*, London: Routledge & Kegan Paul.

Marrone, M. (1984) 'Aspects of transference in group analysis', *Group Analysis*, 17: 179–90.

Marsden, D. and Owens, D. (1975) 'The Jekyll and Hyde marriages', *New Society*, 32: 333–5.

Martin, H.P. and Rodeheffer, M.A. (1980) 'The psychological impact of abuse in children' in G.J. Williams and J. Money (eds.) *Traumatic abuse and neglect of children at home*, Baltimore, Maryland: Johns Hopkins University Press.

Spiegel, R. (1981) 'Review of *Loss: Sadness and Depression* by John Bowlby', *American Journal of Psychotherapy*, 35: 598–600.
Spinetta, J.J. and Rigler, D. (1972) 'The child-abusing parent: a psychological review', *Psychological Bulletin*, 77: 296–304.
Spitz, R.A. (1945) 'Hospitalism: an enquiry into the genesis of psychiatric conditions in early childhood', *The Psychoanalytic Study of the Child*, 1: 53–74.
Spitz, R.A. (1946) 'Anaclitic depression', *The Psychoanalytic Study of the Child*, 2: 313–42.
Spitz, R.A. (1947) *Grief: a peril in infancy* (film), New York: New York University Film Library.
Spitz, R.A. (1957) *No and yes*, New York: International Universities Press.
Sroufe, L.A. (1983) 'Infant–caregiver attachment and patterns of adaptation in pre-school: the roots of maladaptation and competence', in M. Perlmutter (ed.) *Minnesota Symposium in Child Psychology, vol. 16*, 41–81, Minneapolis: University of Minnesota Press.
Sroufe, L.A. (1985) 'Attachment-classification from the perspective of infant–caregiver relationships and infant temperament', *Child Development*, 56: 1–14.
Sroufe, L.A. (1986) 'Bowlby's contribution to psychoanalytic theory and developmental psychology', *Journal of Child Psychology and Psychiatry*, 27: 841–9.
Steele, B.F. and Pollock, C.B. (1968) 'A psychiatric study of parents who abuse infants and small children' in R.E. Helfer and C.H. Kempe (eds) *The battered child*, 103–45, Chicago: University of Chicago Press.
Stephen, A. (1934) 'On defining psychoanalysis', *British Journal of Medical Psychology*, 11: 101–16.
Stern, D.N. (1977) *The first relationship: infant and mother*, London: Fontana, Open Books.
Stern, D.N. (1985) *The interpersonal world of the infant*, New York: Basic Books.
Strachey, J. (1959), Editor's introduction to the *Standard Edition* of Freud's *Inhibitions, Symptoms and Anxiety, SE* 20, 77–86, London: Hogarth Press.
Stroh, G. (1974) 'Psychotic children' in P. Barker (ed.) *The residential psychiatric treatment of children*, 175–90, London: Crosby.
Strupp, H.H. and Binder, J.L. (1984) *Psychotherapy in a new key: a guide to time-limited dynamic psychotherapy*, New York: Basic Books.
Sulloway, F. (1979) *Freud, biologist of the mind*, New York: Basic Books.
Svejda, M.J., Campos, J.J., and Emde, R.N. (1980) 'Mother–infant bonding: failure to generalize', *Child Development*, 51: 775–9.
Trevarthen, C. (1979) 'Instincts for human understanding and for cultural co-operation: their development in infancy', in M. von Cranach, K. Foppa, W. Lepenies, and D. Ploog (eds) *Human Ethology*, 539–71, Cambridge: Cambridge University Press.
van der Eyken, W. (1982) *Home-start: a four-year evaluation*, Leicester: Home-Start Consultancy (140 New Walk, Leicester LE1 7JL).
Waddington, C.H. (1957) *The strategy of the genes*, London: Allen & Unwin.
Wärtner, U.G. (1986) 'Attachment in infancy and at age six, and children's self-concept: a follow-up of a German longitudinal study', doctoral dissertation, University of Virginia.
Weisskopf, V.F. (1981) 'The frontiers and limits of physical sciences' *Bulletin of the American Academy of Arts and Sciences*, 34.
Wenner, N.K. (1966) 'Dependency patterns in pregnancy', in J.H. Masserman (ed.) *Sexuality of women*, 94–104, New York: Grune & Stratton.
Winnicott, C. (1980) 'Fear of breakdown: a clinical example', *International Journal of Psycho-Analysis*, 61: 351–7.
Winnicott, D.W. (1957) 'Primary maternal preoccupation', in *Collected papers: through paediatrics to psychoanalysis*, 300–5, London: Tavistock.
Winnicott, D.W. (1960) 'Ego distortion in terms of true and false self', reprinted in D.W. Winnicott (1965) *The maturational process and the facilitating environment*, 140–52, London: Hogarth; New York: International Universities Press.
Winnicott, D. (1974) 'Fear of breakdown', *International Review of Psychoanalysis*, 1: 103–7.
Wolkind, S., Hall, F., and Pawlby, S. (1977) 'Individual differences in mothering behaviour: a combined epidemiological and observational approach' in P.J. Graham (ed.) *Epidemiological approaches in child psychiatry*, 107–23, New York: Academic Press.
Zahn-Waxler, C., Radke-Yarrow, M., and King, R.A. (1979) 'Child-rearing and children's prosocial initiations toward victims of distress', *Child Development*, 50: 319–30.

Raphael, B. (1982) 'The young child and the death of a parent' in C.M. Parkes and J. Stevenson-Hinde (eds) *The place of attachment in human behaviour*, 131–50, New York: Basic Books; London: Tavistock.

Raphael, D. (1966) 'The lactation-suckling process within a matrix of supportive behaviour', dissertation for the degree of PhD submitted to Columbia University.

Ricks, M.H. (1985) 'The social transmission of parental behaviour: attachment across generations' in I. Bretherton and E. Waters (eds) *Growing points in attachment theory and research*, Monograph of the Society for Research in Child Development Serial no. 209, 211–27.

Ricoeur, P. (1970) *Freud and philosophy: an essay in interpretation* (trans: D. Savage), New Haven: Yale University Press.

Ringler, N., Kennell, J.H., Jarvella, R., Navajosky, R.J., and Klaus, M.H. (1975) 'Mother to child speech at two years: the effects of increased postnatal contact', *Journal of Pediatrics*, 86, 141–4.

Robertson, J. (1952) *A two year-old goes to hospital* (film), Ipswich: Concord Films Council; New York: New York University Film Library.

Robertson, J. (1953) 'Some responses of young children to loss of maternal care', *Nursing Times*, 49: 382–6.

Robertson, J. (1958) *Going to hospital with mother* (film) Ipswich: Concord Films Council; New York: New York University Film Library.

Robertson, J. (1970) *Young children in hospital* (2nd edition) London: Tavistock.

Robertson, J. and Bowlby, J. (1952) 'Responses of young children to separation from their mothers', *Courrier Centre Internationale Enfance*, 2: 131–42.

Robson, K.M. and Kumar, R. (1980) 'Delayed onset of maternal affection after childbirth', *British Journal of Psychiatry*, 136: 347–53.

Rosen, V.H. (1955) 'The reconstruction of a traumatic childhood event in a case of derealization', *Journal of the American Psychoanalytic Association*, 3: 211–21; reprinted in A.C. Cain (ed.) (1972) *Survivors of suicide*, Springfield, Illinois: C.C. Thomas.

Rosenblatt, A.D. and Thickstun, J.T. (1977) *Modern psychoanalytic concepts in a general psychology*, parts 1 and 2, Psychological Issues Monograph 42/43, New York: International Universities Press.

Rosenfeld, S. (1975) 'Some reflections arising from the treatment of a traumatized child' in *Hampstead Clinic Studies in Child Psychoanalysis*, 47–64, New Haven, Conn.: Yale University Press.

Rubinstein, B.B. (1967) 'Explanation and mere description: a metascientific examination of certain aspects of the psychoanalytic theory of motivation' in R.R. Holt (ed.) *Motives and thought: psychoanalytic essays in honor of David Rapaport*, 20–7, Psychological Issues Monograph 18/19, New York: International Universities Press.

Rutter, M. (1979) 'Maternal deprivation, 1972–1978: new findings, new concepts, new approaches', *Child Development*, 50: 283–305; reprinted in *Maternal Deprivation Reassessed* (2nd edition), Harmondsworth: Penguin, 1981.

Rutter, M. (ed.) (1980) *Scientific foundation of developmental psychiatry*, London: Heinemann Medical Books.

Sameroff, A.J. and Chandler, M.A. (1975) 'Reproductive risk and the continuance of caretaking casualty' in F.D. Horowitz, *et al.* (eds) *Review of Child Development Research*, vol.4, 187–244, Chicago: University of Chicago Press.

Sander, L.W. (1964) 'Adaptive relationships in early mother–child interaction', *Journal of the American Academy of Child Psychiatry*, 3: 231–64.

Sander, L.W. (1977) 'The regulation of exchange in the infant-caregiver system and some aspects of the context–content relationships' in M. Lewis and L. Rosenblum (eds) *Interaction, conversation and the development of language*, 133–56, New York and London: Wiley.

Sander, L. (reporter) (1980) 'New knowledge about the infant from current research: implications for psychoanalysis', Report of panel held at the Annual Meeting of the American Psychoanalytic Association, Atlanta, May 1978, *Journal of the American Psychoanalytic Association*, 28: 181–98.

Santayana, G. (1905) *The life of reason*, vol.1, New York: Scribner.

Schafer, R. (1976) *A new language for psychoanalysis*, New Haven: Yale University Press.

Schaffer, H.R. (ed.) (1977) *Studies in mother–infant interaction*, London: Academic Press.

Schaffer, H.R. (1979) 'Acquiring the concept of the dialogue' in H.M. Bornstein and W. Kessen (eds) *Psychological development from infancy: image to intention*, 279–305, Hillsdale, New Jersey: Lawrence Erlbaum.

Schaffer, H.R. and Crook, C.K. (1979) 'The role of the mother in early social development' in B. McGurk (ed.) *Issues in childhood social development*, 55–78, London: Methuen.

Schaffer, H.R., Collis, G.M., and Parsons, G. (1977) 'Vocal interchange and visual regard in verbal and preverbal children', in H.R. Schaffer (ed.) *Studies in mother–infant interaction*, 291–324, London: Academic Press.

Sosa, R., Kennell, J., Klaus, M., Robertson, S., and Urrutia, J. (1980) 'The effect of a supportive companion on length of labour, mother–infant interaction and perinatal problems', *New England Journal of Medicine*, 303: 597–600.

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