fatal and non-fatal overdoses. This, in our opinion, suggests that, for barbiturates, the toxicity of the drug plays an important role in the outcome of an overdose while this is much less the case in overdoses with other psychotropic drugs, including tricyclic antidepressants. However, our results also indicate that there are no truly 'safe' drugs when taken in overdose and in our opinion it is necessary to correct the misconception about the safety of benzodiazepines.

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Attachment theory

SIR: Holmes' engaging review of the history of attachment theory and its relation to biology through ethology (*BJP*, October 1993, **163,** 430–438) could have pointed to several other biological markers of interest to those 'brain scientists' who have kidnapped the term biological psychiatry.

Kraemer (1992) has presented details about the effects of different rearing patterns and attachment behaviour on brain amines and developing brain structure. He integrates the results in such a way that it is easy to conceptualise further bridges between the development of insecure-ambivalent attachment, depressive positions and treatment with antidepressants which have common biological pathways at brain systems level (here it is necessary to conceptualise the balance between the differing brain amines in systems terms).

Some of the tenets of evolutionary biology need to be considered in more detail in relation to 'secure attachment'. There is a danger that 'secure', will be equated with 'good/right'. Yet it is uncertain whether such attachment patterns will prepare children for their adult environments.

Similarly, it is essential to remember the qualitative marker of 'good enough' in this evolutionary perspective. Holmes presents an uncritical view of the maternal/psychotherapist attribute of attunement. As Winnicott (1971) pointed out, if the mother knows too well what the child is wanting, feeling or thinking, this is magic and has no place in the development of a therapeutic relationship.

Holmes could usefully have introduced readers in his review to the ways in which biological aspects of memory influence choice of therapeutic strategies within the attachment paradigm. With a greater awareness of these issues some of the 'equivalence paradox' to which he refers could be explored. Crittenden (1992*a*,*b*) has begun to do this in a way which colleagues in adult psychiatry may find useful for their practice. She highlights the usefulness of applying Tulving's three memory forms – the procedural, the semantic and the episodic (Tulving, 1985) – to understanding the ways in which life experiences will modify attachment behaviour on differing bases. The procedural memory form is preconscious, based on the ways in which children have been handled in the initial months. It is reflected in posture and bodily signs. It is at this level that it is particularly difficult to improve the lot of our patients with treatments which are not primarily behavioural or somatic in focus. It is particularly difficult to alter the behaviour of borderline personality through a primary focus on increasing reflexive self-awareness. One strategy is to influence the child's working model of his caregiver directly through short-term work with the mother, as shown by Murray & Cooper (1993), referred to by Holmes.

In the first few years the child learns a way of accounting for his state, based on the way in which his condition is attributed to things happening around him. His semantic memory, based on the words applied by others, predominates. These biographical stories are retained and enlivened throughout childhood by the caregivers, but they do not necessarily coincide with the experiences which children subsequently have, and can reflect on themselves, stored in their episodic memory. Crittenden's suggestion is that cognitive–behavioural techniques are best suited to addressing problems associated with dissonance between semantic memory and episodic memory, whereas psychodynamic approaches are best suited to traumatic confusions in episodic memory. Clearly the degree to which distortions are present between the three memory types will present varying problems for producing a coherent, truly autobiographical account, in contrast to borrowed autobiographical accounts. Therefore, it is to be expected that therapy will have to address all memory levels. Kraemer's summary suggests how integration of the different therapy forms could also benefit from an understanding of brain amine changes and potential advantages of integrating physical treatments, such as with antidepressants, with the psychological.

My purpose in highlighting these additional points concerning the biology of attachment are to

encourage readers to go even further then Holmes in searching for an integrated and coherent developmental psychobiosocial approach relevant to their daily clinical practice. The biological elements emphasise the need to step away from phase-based models of development, be they Piagetian, Kleinian or Eriksonian, and wholeheartedly adopt the developmental pathways approach followed by Bowlby. In that lies a revolution for our field which I hope that readers will ponder over and perhaps espouse.

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SIR: Dr Jeremy Holmes' article was very welcome at a time when the psychotherapies are being questioned and are questioning their place in the treatment of mental disorders.

I would argue that attachment theory does have the potential to form the basis of a 'Bowlbian', thoroughly interpersonal 'school' of psychotherapy developing naturally out of current thinking on object relations theory and out of recent developments in attachment theory.

The idea of an 'attachment dynamic' (Heard & Lake, *BJP*, October 1986, **149**, 430–438) broadens the concept of attachment as a primary, goal-directed instinct in the human search for well-being. The supportive aspect of attachment (caregiving and protection in childhood, and a haven from threats and life stresses in adulthood) is matched by and is dynamic with a developmental aspect derived from 'playful interaction' in childhood between parent and offspring, and from 'companionable interaction' in adulthood. Stern (1985) emphasises the importance of the latter in infancy for the development of the self. Ego strength and self-esteem are diminished by a failure in the attachment process.

Psychotherapy can be identified by its aims and by its techniques (both infused by its theoretical basis). A Bowlbian therapy might have the aim of providing an experience of secure attachment with its two strands of support and emotional development. The therapist's task would then be to get to know his/her patients, their individual needs and their individual responses to difficulties, to respond appropriately to their different pleasures and woes, and to remain in emotional contact with them through the range of different feeling states. The therapist would thus be aiming to provide a model for intimacy, and to help the patient to give up maladaptive attachment patterns, both overly clingy or overly independent.

Technique would entail the reframing of 'resistance' and the emotionality of 'transference' in terms of insecure attachment (resistance equating with avoidant attachment, and transferance with ambivalent attachment), and would emphasise to patients the naturalness of some expression of separation and of reunion phenomena. It would address the way fear about unreliable and abusive attachment can cause people to focus on specific aspects of a relationship while ignoring other aspects. Using Daniel Stern's terminology, the therapist would work to modulate affect within the relationship by 'attuning' to low and high levels of affect, and by 'purposefully misattuning' to emotions and behaviour in order to broaden the individual's range of emotional responses and develop mastery and understanding of different feeling states. Both experiential and cognitive techniques have an important place in this process.

The emphasis would be on real difficulties in developing a confiding relationship, the disappointment that occurs when the therapist inadvertently makes mistakes, and the way mutual misunderstandings are handled in the therapy. In this way the power relationship of therapy might be minimised and an empowering partnership achieved. The aim of promoting secure and healthy attachment patterns clarifies the need to interpret resistance or defence in the arena of the therapy relationship. Internal object relations in the light of attachment theory refers to past unsuccessful attachment relationships (internal working models) and also to the attempt to repress the attachment instinct or need by calling it bad, shameful, or too exciting or terrifying, or by denying its existence, so creating a false autonomy.

Attachment theory suggests that research into the outcome of dynamic psychotherapy should concentrate more on changes in the nature of attachment in work and in partnerships following therapy. Process research might include the study of the changing attachment between patient and therapist from