

Developmental Attachment Psychotherapy with Fostered and Adopted Children

David Howe

School of Social Work and Psychosocial Sciences, Elizabeth Fry Building, University of East Anglia, Norwich, NR4 7TJ, UK.
E-mail: d.howe@uea.ac.uk

Developmental attachment theory and research is now beginning to inform practice, particularly in the field of foster care and adoption. A brief outline of attachment theory and the four main patterns of attachment is followed by a review of attachment-based support services and psychotherapies with fostered and adopted children, including infants, preschoolers, school age children, and caregivers. Particular attention is given to the behaviour, defensive strategies and developmental needs of fostered and adopted children with pre-placement histories of abuse and neglect.

Keywords: attachment; psychotherapy; foster children; adopted children

Introduction

The goal of the attachment system is protection at times of danger. Attachment is one of a number of proximity seeking behavioural control systems, which also include affiliation, sexuality and caregiving. Attachment behaviours are triggered whenever the highly vulnerable human infant experiences anxiety, fear, confusion, or feelings of abandonment. Distress signals, such as crying, either bring the sensitive carer to the child, or if the child has locomotion, get the child to the carer. In this sense, the primary caregiver, destined to become the child's selective attachment figure, acts as a secure base, a haven of safety.

As the young child seeks proximity with her attachment figure, she is likely to be in an emotionally dysregulated state. Thus, as well as acting as a secure base, sensitive caregivers also help their child regulate and manage arousal and distress. There is a strong view that attachment is primarily a regulator of emotional experience, including physiological arousal (Schore, 2001a). Within the affective exchanges between parents and infants, children begin to build up an understanding of how their own and other people's minds work at the emotional, intentional and behavioural level, and how these mental states affect social interaction and relationships.

The more open, reflective, undefended, curious, fascinated, emotionally attuned and communicative the carer is about her child's mental state, the more the child feels understood. The more understood the child feels, the more understanding she has of her own and other people's psychological make-up. Therefore, carers who see and acknowledge the child's mind at work help their child develop mindful qualities. Following Fonagy and colleagues (2002), the parent's capacity to observe the child's mind seems to facilitate the child's general understanding of minds, and hence her self-organisation through the medium of a secure attachment. Indeed, Schore (2001a) puts it even more forcefully

explaining that 'young minds form in the context of close relationships'. Thus, as carers help children make sense of their own and other people's behaviour by recognising that lying behind actions and behaviour are minds, mental states and intentions, a whole train of psychosocial benefits accrue, including emotional attunement, reflective function, social cognition, emotional intelligence and interpersonal competence. It is these developmental and relational insights that underpin and inform most attachment-based therapies.

Children whose carers are responsive and available at times of need and who are sensitive and emotionally attuned are likely to be classified as securely attached. With maturation, these children develop mental representations (internal working models) of themselves as loved and worthy of that love, and a complementary model of others as available and loving, understanding and interested, particularly at times of need. Children who experience secure attachments therefore are likely to enjoy healthy psychosocial development, improved social cognition, and raised levels of resilience based on high self esteem, self-efficacy and coping capacity.

However, in the case of insecure children, the availability, sensitivity and responsiveness of carers at times of need is not so straightforward (Howe et al., 1999). Avoidant and ambivalent children defensively have to organise their attachment behaviour to increase the availability of their carer at times of need and distress. These adaptive strategies involve downplaying or excluding some types of psychological information from conscious processing. This affects the individual's ability to cope in a fully rounded and reflective way with the normal range of stresses met in social relationships.

Avoidant (defended) children (whose carers become anxious and rejecting whenever others place emotional demands on them) cope and adapt by excluding attachment-based feelings and behaviours from conscious processing. Displays of need, weakness, dependency, and vulnerability in the self or others, make them anxious and avoidant. In order to

be acceptable and increase the other's availability, they become emotionally self-contained but astute observers of other people's feelings and behaviour. More extreme avoidant strategies are used by children who suffer rejection, abuse and psychological maltreatment. For example, physically and emotionally abused children typically do not seek comfort or safety when upset, ill, vulnerable, or frightened. They have learned that care and protection are not unconditionally available, and that being in a state of need only seems to make matters worse and might even make the carer more dangerous. Trust in the availability, care and interest of others is largely absent. This means that any relationship in which there are attachment-related issues will trigger feelings of anxiety, distress and aggression. Children who experience extreme tension, stress and rejection in the parent-child relationship can even suffer growth failure and poor physiological health. For children classified as avoidant, the therapeutic aim is to help children access, admit, acknowledge, explore and reflect on their own feelings, especially those involving need and vulnerability.

Ambivalent (resistant, dependent) children (whose carers are inconsistent and poor at recognising other people's needs and attachment signals) cope and adapt by maximising their distress and attachment behaviour to increase their chances of getting noticed. Their greatest anxiety is being ignored, abandoned and left alone with needs unmet and arousal unregulated. They live in an unpredictable world, in which there seems no guarantee that others will be there or respond at times of need and distress. They have little confidence in their own abilities to bring about change and get the things they need. This results in a passive and fatalistic attitude to events; an anxious preoccupation with other people's inconsistent emotional availability; and an angry, demanding, dissatisfied, needy, pleading, and provocative approach to relationships. There is little monitoring of one's own behaviour or emotional condition. More pronounced versions of this attachment strategy are met in some types of chaotic neglect. Under stress, children feel helpless. Their immaturity, impatience and impulsivity mean that they repeatedly 'go too far'. Underpinning all their behaviour is the drive to be noticed, valued, acknowledged, and recognised. They act as if always in a crisis (Crittenden, 1999). This produces children who are demanding and yet never satisfied or reassured. The therapeutic aim is to help children stop and reflect, structure their thoughts, feel valued and worthwhile, and think through the causes and consequences of their feelings and behaviour. Children also need to learn to trust that new carers will be sensitively available at times of vulnerability and dependence; that they will not be overwhelmed by emotional need.

The group that finds it most difficult to organise an attachment strategy is children whose carers are the direct cause of their distress and fear. Attachment figures who frighten; menacingly threaten, physically and sexually abuse, and abandon their children; or behave in a helpless and dysregulated way when faced with their children's attachment needs, these parents are both the source of fear and the supposed solution to that fear. Within such caregiving environments, children find it difficult to organise an attachment strategy

to increase the carer's availability, hence the classification of *disorganised* attachment (Main & Solomon, 1990).

Developmentally, abused and neglected children with disorganised attachments suffer more complex and profound impairments as they experience the worst elements of both avoidant and ambivalent caregiving environments. In effect, they experience unpredictable danger *and* abandonment over which, as infants, they have little control and can develop no attachment strategy. Emotional arousal and the attachment system remain acutely and chronically activated. Much mental time and energy is spent on issues of safety, security and monitoring, leaving less time for exploration and pleasurable interaction with their caregiver. Being the cause of their children's distress, and being caught up in their own anxiety and dysregulation, these parents fail to perceive and emotionally attune with their children's distressed mental states at the very time the children most need to feel safe, recognised, understood, contained and regulated. Children therefore fail to develop coherent models and mental representations of their own or other people's psychological make-up, and so find it difficult to regulate their own arousal or deal reflectively with their own needs. It is this group of children who are most at risk of developing behavioural problems (including aggression), psychopathology, and being placed in foster or adoptive care (Howe, 2005).

With maturation, disorganised children do manage to develop fragile and more coherent representations of themselves as less helpless or at the mercy of others. With carers who are unavailable and frightening, children begin to take control of their own safety and needs. This results in various *controlling* strategies, including compulsive compliance, compulsive caregiving, compulsive self-reliance, and coercion as the child outmanoeuvres the parent and controls their availability by switching between threatening/aggressive and disarming/helpless behaviours (Crittenden, 1995, 1997). These are very partial, incomplete and brittle strategies that quickly break down under stress leaving the child once more frightened, angry, sad and highly dysregulated. The therapeutic aim for these children (and their parents) is to help them feel safe enough to recognise, acknowledge and process their emotions, both at the psychological and physiological level. They only feel safe when they are in anxious control, but this strategy denies them experiences designed to help them look at, understand, and handle their own and other people's minds.

Interventions with foster carers and adoptive parents

Post-placement support

The provision of substitute parents in itself represents the most radical, comprehensive and potent therapeutic change in a child's psychosocial prospects. The most effective therapeutic focus, particularly with younger children, is to work with and through the new carers. Therefore, the first level of intervention needs to ensure that carers are sufficiently stress free and reflectively open in order to be psychologically available, attuned

and responsive to the placed child's developmental needs. Adoption and foster care research repeatedly reports that good social support, whether from family or the community, correlates with better placement outcomes. More recent practices suggest that other foster and adoptive parents can provide effective emotional support, information, and the wisdom of their experience. Both individual telephone contact and group support have been found to be effective.

Educational support and training

Adoptive and foster carers benefit from training and education about both normal and abnormal child development. Particularly helpful are programmes which increase parents' knowledge about how adversity affects children's development, behaviour and mental health. For example, work by Dozier and colleagues illustrates how children bring to their new placements the insecure attachment strategies that have helped them cope with and, to an extent, survive parental abuse and neglect (Dozier et al., 2002a, b; Dozier, Lindhiem, & Ackerman, 2005; also see Schofield & Beek, 2006). Many maltreated children find it difficult to elicit sensitive and responsive care and protection. Children's previous experiences and adaptations to hostile and helpless caregiving environments not only affect their behaviour, but also affect new carers and their caregiving. Therefore, attachment strategies that are adaptive in one caregiving situation may become maladaptive in another. Teaching carers (typically in supportive groups) about the adaptive strategies, defensive manoeuvres, and attachment behaviours employed by abused and neglected children provides them with a conceptual framework, not only better to understand their children, but also to interact with them more sensitively and creatively (Marvin et al., 2002; Schofield & Beek, 2006; Golding, 2003; Golding & Picken, 2004; Allen & Vostanis, 2005; Adoption UK, 2005).

Behavioural guidance

Successful therapy with placed children who have suffered neglect or maltreatment needs to introduce them to many of the skills and behaviours shown by sensitive carers whose children are classified as secure. The regulation of emotional arousal is key to success, and therefore affect regulation is a primary target of all interventions. Attachment-based therapies aim to support and develop further new parents' capacity for empathy, mind-mindedness and reflective function. Fostered and adopted children with histories of loss, neglect and abuse need help to get in touch with their feelings, to recognise them, consider their impact on self and others, and begin to process them in a more reflective, conscious, regulated way. Even so, some emotions are difficult to bear and it may take some time and trust before they can be examined. In effect, parents or therapists co-construct with children the key features of a secure attachment in order to help them recognise and regulate affect. Carers have to amplify what they feel and perceive in the child, in the manner of the secure parent-child relationship, to ensure that as much emotional and psychological information is conveyed to the child who is not used to receiving so much interest and feedback in the context of a safe

relationship. This empathic match or affect synchrony operates both inside and outside language; eyes, facial expression, voice, and body language are particularly important channels of communication for children who have been maltreated and tend not to hear or process words (Schore, 2001b).

The sensitive caregiving behaviours are potentially 'mind-engaging'. They provoke in the child self-reflection and thoughts about the other. However, children who have suffered loss or been maltreated can be anxious and fearful of direct mind-to-mind communication. They have learned to stay safe by not letting other people impose and intrude their demands on them (too dangerous), and by not exploring other people's minds and perspectives (too frightening, too hurtful). Maltreated children will avoid emotional contact and robust psychological exchange until the relationship feels safe. Practitioners and therapists therefore have to proceed very gently, backing off if the closeness, the movement, the psychological intimacy seems to be too frightening. Fear will trigger defensive manoeuvres, including dissociation, aggression, withdrawal and other compulsively self-reliant controlling strategies.

When people begin to feel safe, memories and emotions can enter consciousness and be accessed, acknowledged and processed more readily. We can put words to feelings. The more safe, contained and trusting children feel, the more they are able to allow painful and difficult emotions to be contemplated. Interventions are therefore designed to increase young children's security of attachment by improving parental sensitivity, mind-mindedness, responsiveness, and involvement. This might be achieved either by changing parental *behaviour* as they interact with their child or by shifting the carers' own *mental representations of attachment* towards greater security and autonomy. Either way, treatment is directed at modifying the way in which parents process attachment-related information in relationship with their children.

Behaviourally based attachment interventions seek to improve parental sensitivity and the affect-communicating capacities of mother-infant interactions. They guide parents as they interact with their children. Treatments are designed to help carers see, understand and respond to their child's signals, particularly their distress signals. This is true even when children send out the signal that they do not want nurturing even at times of distress. In these cases, there is the real risk that the new carer will de-activate his or her caregiving. Dozier and colleagues have developed interventions that help carers 'provide a nurturing relationship by over-riding the natural propensity to respond in a complementary fashion to a child's behavioral signals' (Dozier et al., 2002b; Dozier, 2003, p.256; Dozier & Sepulveda, 2004). For example, 'if the child appears angry when the caregiver attempts to soothe him or her, the caregiver is encouraged to see the behavior as resulting from the child's frustration with caregivers not being dependable in the past' (Dozier et al., 2002b, p.547). Therapists can facilitate reflective function by commenting on interactions between parent and child that seem mis-cued, confusing or distressing by 'asking the parent to stop and reflect on the thoughts and feelings that accompanied the negative interaction'

(Kobak & Esposito, 2004, p. 162). Through repeated use of this 'stop-the-action' technique, parents are helped to get better at monitoring, reappraising and repairing their communications with an insecure child.

Videotaped parent-infant interactions are used to help carers recognise their own positive responses and interactions. By recognising their positive impact on the placed child, parental competence and confidence is built up. As well as being helped to recognise, understand and communicate their child's perceived affective state, new carers are also helped to follow their child's lead (in play, in conversation), in short to become more responsive social partners and improve the child's sense of 'agency' (Dozier et al., 2005).

A study by Juffer et al. (1997) evaluated an early intervention programme. The intervention aimed to support parental sensitivity by promoting secure attachments in a group of 90 mothers who had adopted a young child from another country. The mothers were divided into three equal size groups. One received a personal book programme on how to practise sensitive parenting, playful parenting, and holding and comforting their child. The mothers' observational skills were enhanced by inviting them to describe and note down what their infants were doing. A second group was also given the book and advice about sensitive and responsive parents, but in addition mothers received three sessions of video-feedback. Each mother was shown a short video of her interaction with her infant. Sensitive responses were noted and reinforced with positive comments, including those that seemed to have a particularly beneficial effect on the child. The practitioner also verbalised the infant's signals and expressions to give a sense of what the child might be thinking, feeling and doing. There was also a control group who were given just a brochure about adoption. Twelve months later, both the mothers who received the book-based programme and those who also had the video-feedback showed higher levels of sensitivity and had more securely attached children than the control group.

Dozier and colleagues (2002b; 2005) have developed an intervention that targets foster carers ('Attachment and Biobehavioral Catch-up', currently under investigation in a randomised control trial). The 10 therapeutic sessions are administered in the parents' homes and involve the caregiver and child interacting. Sessions are videotaped. The first two sessions help carers re-interpret children's behavioural signals in terms of attachment and the need to feel protected and cared for at times of distress. The third session encourages foster carers to improve children's sense of agency by helping them follow their child's lead during interactions. Later sessions give parents the opportunity to recognise and reflect on both their own and their child's displays and experiences of attachment influenced behaviour and emotional states, particularly in terms of how past attachment-related experiences are played out in the present.

Changing the parent's mental representation/ working model of attachment

Representational models of therapy aim to bring about more positive internal working models that generally lead to more sensitive, autonomous caregiving. In the light of our relationship history, mental representations

lay down expectations about how others will respond at times of need, and about how effective we feel in securing what we need from relationships. These organised mental representations of the self and others (as either positive or negative) are carried forward by individuals and used to guide behaviour in subsequent relationships. Internal working models (states of mind) organise appraisal processes, thought, memory, and feelings with regard to attachment saturated situations, including relationships with our children.

New carers who have insecure states of mind with respect to attachment, and more particularly those who have unresolved states of mind, are likely to find that the placed child's attachment needs and behaviour activate old anxieties, defences, unresolved losses and traumas. This undermines their sensitivity and ability to attune affectively with the child (Hughes, 2002). Maltreated children placed with unresolved carers are likely to continue using their controlling/disorganised attachment behaviours, with the increased risk that the placement will break down (e.g. Dozier et al., 2001; Steele et al., 2003). Required in these cases are interventions that aim to change the carer's representations of attachment. Therapy aims to alter these distorted representations by inviting parents to reflect on their past and present attachment and experiences. This is achieved by asking parents to explore what they bring from their own relationship with their parents to the relationship they have with their own child. Group work with other parents might also be used to support and strengthen reflective function (e.g. Marvin et al., 2002). Juffer, Bakersman-Kranenburg, & van IJzendoorn (2003) also note that the practitioner is required to act as a secure base during this exploratory and reflective process.

Joint interventions with carers and placed children

Many of the original attachment-based therapies were developed by practitioners who believed that the predominant attachment behavioural pattern for fostered and adopted children with histories of maltreatment was a 'controlling/disorganised' one, including for the most severely maltreated children the likelihood that they would sometimes show dissociative behaviours. Children would continue to use these attachment strategies in their new placement. In effect, this meant that children continued to hold mental representations of carers as potentially hostile or helpless, and therefore unavailable as sources of protection or regulation. Placed children had learned to survive by not letting carers be in a position of care or control. And so, ironically, the more new carers behaved like carers, that is the more they sought to comfort and get close to children at times of upset and need, the more distressed, defensive and controlling children became, thus denying them experience of the very thing that would help them feel safe, understood and regulated.

The therapeutic task, therefore, was to help children feel safe and trust their new carers. The aim was to help children let go of their 'controlling' defensive behaviours so that they could access the sensitive, affectively attuned caregiving being offered by their new carers. One early interpretation of this task by some therapists

was to argue that defensively controlling children needed intense exposure to the safety and value of sensitive caregiving (a kind of flooding technique). In some hands, this led to the practice of 'holding therapy', which has been heavily criticised by most attachment theorists who suggest that such a treatment is incompatible with attachment theory (e.g. O'Connor & Zeanah, 2003; Boris, 2003). Instead, what is recommended is continuous and prolonged exposure to consistent, sensitive, affectively attuned caregiving. Over time, children's experience of safe, empathic, reliable parenting allows them to disconfirm their old mental representations of carers as dangerous and/or helpless replacing them with more secure, available models of caregiving at times of need. In practice, this approach has produced three linked interventions.

Sensory integration techniques and other developmentally-based treatments

Many abused and neglected children have suffered sensory deprivation in the context of non-sensitive caregiving. They display a range of physical, sensory and emotional impairments. Balance can be affected (making children very accident prone). Perception and processing of sight, sound, touch, taste, smell, and the relationship between emotional experience at the somatic and psychological level can be upset. For example, an intense and unexpected physical stimulus can act as a reminder of past abuse causing the child to become extremely distressed. Using sensory integration techniques (based on the provision of multi-sensory and stimulating environments), children begin to develop a more integrated understanding of how their bodies and senses work (e.g. Ayers, 1989). Until children have learned to organise sensation, they find it difficult to move to the next stage of emotional development. Elements of Fisher and Chamberlain's (2000) Early Intervention Foster Care project also help children regulate their bodies as well as their minds.

The provision of sensitive, emotionally attuned caregiving

Many attachment-oriented clinicians believe that new parents have to understand that in order to 'connect' with their defended child, they may have to interact at the developmental age of the child and not the chronological age, particularly at times of distress and high arousal (Schore, 2001b; Holmes, 2001; Howe & Fearnley, 2003; Levy & Orlans, 1998; van Gulden & Bartels-Rabb, 1995). This requires a heightened degree of sensitivity, accurate, exaggerated and repeated feedback about the child's emotional condition (as you would with a baby or toddler). There is emotional congruence and co-regulation of affect. All this is conducted in the context of a structured, warm, predictable, contingent caregiving environment that is particularly responsive to the child's signals (Perry, 1999; Dozier et al., 2002b; Fisher et al., 2000). This promotes children's ability to self-regulate.

Most attachment therapists therefore recognise that treatment somehow has to replicate the developmental characteristics of secure caregiving, but with a child who deeply mistrusts being looked after, cared for and protected by his or her 'attachment figures'. Hughes

(1997, 1998, 2003, 2004), for example, has fashioned a treatment model (Dyadic Developmental Psychotherapy) based on reciprocal experiences between parent and child that are 'affectively and cognitively matched to the developmental, age-appropriate needs of the child' (Hughes, 2002). The treatment and parenting model includes teaching carers the importance of attuned and sensitive eye contact, voice tone, touch (including nurturing-holding) and gestures that communicate safety, acceptance, curiosity, playfulness, and empathy (Hughes, 2004). Older children are also helped to make sense of their history and how this plays out in their current behavioural and emotional functioning.

Similar to secure parent-infant interactions, therapy involves helping parents react contingently, collaboratively and with sensitivity as children experience affect-laden material. They track and react to the child's emotional state. Fonagy et al. (2002) describe this as 'mentalised affectivity', something rather like 'affect mirroring' which takes place between mothers and babies. When employed therapeutically, the child's emotional, mental and somatic states are recognised, named and mirrored back verbally, facially, in gesture and body posture. Mentalised affectivity is present in children when they begin to recognise the way their own and other people's affective states affect both parties' feelings, thoughts and behaviour. 'In successful therapy, the client gradually comes to accept that feelings can safely be felt and ideas may be safely thought about' (Fonagy, 1998 cited in Allen, 2001, p. 310). Mentalised affectivity therefore feeds the incoherent, unintegrated mind with powerful and valuable information about its own state.

Helping children to feel safe when they relinquish their 'controlling' behaviours

The third therapeutic strand helps 'controlling/disorganised' children lower their defences so that they can access and engage with their carer's mind. Parents are taught a range of techniques that help children feel safe even when the parent is in charge. Essentially, children are given 'choices' and some sense of control, although these choices are determined by parents. It is lack of control, predictability and structure that makes traumatised children feel that situations are getting dangerous (Perry, 1999). Children who have been neglected and abused should be provided with clear and full information about present and future events, repeated as often as necessary. Uncertainty distresses children with a history of maltreatment. Dozier and colleagues have also developed techniques that help carers generate situations that children can experience as controllable by teaching parents to follow their child's lead (Dozier & Sepulveda, 2004).

Conclusion

Attachment theory and research have run ahead of practice. Evidence-based interventions are most developed in the case of infant and young child placements (for example, see Berlin et al, 2005). Good quality descriptive clinical experience is available for therapeutic work with older placed children but this is only now

being subjected to trialled evaluation. Underpinning most attachment-based interventions for fostered and adopted children is the recognition that sensitive and emotionally attuned care is best provided by the new parents. However, the adaptive strategies and defences developed by children in insensitive, abusive or neglectful pre-placement environments often mean that they do not trust or cannot easily access good quality caregiving. Support and therapeutic efforts therefore have to help parents not only understand and emotionally 'stay with' these children but also develop a range of responses that can distinguish between children's behaviour in terms of their chronological and socio-emotional age. Taking this perspective also allows attachment-based therapists to draw on a range of other techniques, such as social learning theory (e.g. Scott, 2003), that recognise the importance of helping children to develop their social cognitive abilities.

References

- Adoption UK (2005). *It's a piece of cake? Parenting hurt children*. Training programme. http://www.adoptionuk.com/training_cake.asp
- Allen, J. (2001). *Traumatic relationships and serious mental disorders*. Chichester: John Wiley.
- Allen, J., & Vostanis, P. (2005). The impact of abuse and trauma on the developing child: An evaluation of a training programme for foster carers and supervising social workers. *Adoption and Fostering*, 29(3): 68–81.
- Ayers, R. (1989). *Sensory integration and praxis tests*. Los Angeles: Western Psychological Press.
- Berlin, L., Ziv, Y., Jackson, L. and Greenberg, M. (2005) (Eds.) *Enhancing early attachments: Theory, research, intervention and policy*. New York: Guilford Press.
- Boris, N. (2003). Attachment, aggression and holding: A cautionary tale. *Attachment and Human Development*, 5(3): 245–248.
- Crittenden, P. (1995). Attachment and psychopathology. In S. Goldberg, R. Muir & J. Kerr (Eds.), *Attachment theory: Social, developmental and clinical perspectives* (pp. 367–406). Hillsdale, NJ: Analytic Press.
- Crittenden, P. (1997). Patterns of attachment and sexual behaviour: Risk of dysfunction versus opportunity for creative integration. In L. Atkinson & K. Zucker (Eds.), *Attachment and psychopathology* (pp. 47–93). New York: The Guilford Press.
- Crittenden, P. (1999). Child neglect: Causes and contributors. In H. Dubowitz (Ed.), *Neglected children: Research, practice and policy* (pp. 47–68). Thousand Oaks: Sage.
- Dozier, M. (2003). Attachment-based treatment for vulnerable children. *Attachment and Human Development*, 5, 253–258.
- Dozier, M., Albus, K., Fisher, P., & Sepulveda, S. (2002a). Interventions for foster parents: Implications for developmental theory. *Development and Psychopathology*, 14, 843–860.
- Dozier, M., Higley, E., Albus, K., & Nutter, A. (2002b). Intervening with foster infants' caregivers: targeting three critical needs. *Infant Mental Health Journal*, 23, 541–554.
- Dozier, M., Lindhiem, O., & Ackerman, J. (2005). Attachment and biobehavioral catch-up: An intervention targeting empirically identified needs of foster infants. In L. Berlin, Y. Ziv, L. Jackson and M. Greenberg (Eds.) *Enhancing Early Attachments*. New York: Guilford Press.
- Dozier, M., & Sepulveda, S. (2004). Foster mother state of mind and treatment: Different challenges for different people. *Infant Mental Health Journal*, 25, 368–378.
- Dozier, M., Stovall, K.C., Albus, K., & Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development*, 72, 1467–1477.
- Fisher, P., & Chamberlain, P. (2000). Multidimensional treatment foster care: A program for intensive parenting, family support, and skill building. *Journal of Emotional and Behavioral Disorders*, 8, 155–164.
- Fisher, P., Gunnar, M., Chamberlain, P., & Reid, J. (2000). Preventive intervention for maltreated preschoolers: Impact on children's behaviour, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 1356–1364.
- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization and the development of the self*. New York: Other Press.
- Golding, K. (2003). Helping foster carers, helping children: Using attachment theory to guide practice. *Adoption and Fostering*, 27, 64–73.
- Golding, K., & Picken, W. (2004). Group work for foster carers caring for children with complex problems. *Adoption and Fostering*, 28, 25–37.
- Holmes, J. (2001). *The search for the secure base: Attachment theory and psychotherapy*. London: Bruner/Routledge.
- Howe, D. (2005). *Child abuse and neglect: Attachment, development and intervention*. London: Palgrave Macmillan.
- Howe, D., Brandon, M., Hinings, D., & Schofield, G. (1999). *Attachment theory, Child maltreatment and family support*. London: Palgrave Macmillan.
- Howe, D., & Fearnley, S. (2003). Disorder of attachment in adopted and fostered children: Recognition and treatment. *Clinical Child Psychology and Psychiatry*, 8, 369–387.
- Hughes, D. (1997). *Facilitating developmental attachment*. New Jersey: Jason Aronson.
- Hughes, D. (1998). *Building the bonds of attachment*. New Jersey: Jason Aronson.
- Hughes, D. (2002). *The psychological treatment of children with PTSD and attachment disorganization: Dyadic Developmental Psychotherapy*. <http://danielhughes.homestead.co./Model.html>
- Hughes, D. (2003). Psychological interventions for the spectrum of attachment disorders and intrafamilial trauma. *Attachment and Human Development*, 5, 271–277.
- Hughes, D. (2004). An attachment-based treatment of maltreated children and young people. *Attachment and Human Development*, 6, 263–278.
- Juffer, F., Hoksbergen, R., Riksen-Walraven, J., & Kohnstamm, G. (1997). Early intervention in adoptive families: Supporting maternal sensitive responsiveness, infant-mother attachment, and infant competence. *Journal of Child Psychology and Psychiatry*, 38, 1039–1050.
- Juffer, F., Bakersman-Kranenburg, M., & van IJzendoorn, M. (2003). Enhancing children's socio-emotional development: A review of intervention studies. In D. Teti (Ed.), *Handbook of research methods in developmental psychology*. Oxford: Blackwell.
- Kobak, R., & Esposito, A. (2004). Levels of processing in parent-child relationships: Implications for clinical assessment and treatment. In L. Atkinson & S. Goldberg (Eds.), *Attachment issues in psychopathology and interventions* (pp. 139–166). Mahwah, NJ: Lawrence Erlbaum Associates.
- Levy, T., & Orlans, M. (1998). *Attachment, trauma and healing: Understanding and treating attachment disorder in children and families*. Washington, DC: CWLA.
- Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M.T. Greenberg, d. Cicchetti & E.M. Cummings (Eds.), *Attachment in the pre-school years* (pp. 121–160). Chicago: University of Chicago Press.
- Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment and Human Development*, 4, 107–124.

- O'Connor, T., & Zeanah, C. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment and Human Development, 5*, 223–244.
- Perry, B. (1999). <http://www.bcm.tmc.edu/civitas/principles>
- Schofield, G., & Beek, M. (2006). *Attachment handbook for foster care and adoption*. London: BAAF.
- Schore, A. (2001a). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 7–66.
- Schore, A. (2001b). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 201–269.
- Scott, S. (2003). Integrating attachment theory with other approaches to developmental psychopathology. *Attachment and Human Development, 5*, 307–312.
- Steele, M., Hodges, J., Kaniuk, J., Hillman, S., & Henderson, K. (2003). Attachment representations and adoption: Associations between maternal states of mind and emotion narratives in previously maltreated children. *Journal of Child Psychotherapy, 29*(2), 187–205.
- van Gulden, H., & Bartels-Rabb, L. (1995). *Real parents, real children: Parenting the adopted child*. New York: Crossroad.

Look out for the following papers in the August and September issues of *Journal of Child Psychology and Psychiatry*:

Psychosocial outcomes at 15 years of children with a preschool history of speech-language impairment

Margaret Snowling, Dorothy Bishop, Susan Stothard, Barry Chipchase and Carole Kaplan

Teenage mothers' anger over twelve years: partner conflict, partner transitions and children's anger

Jennifer Jenkins, Jennifer Shapka and Ann Sorenson

Practitioner Review: Psychopharmacology in children and adolescents with mental retardation

Benjamin Handen and Richard Gilchrist

The Croydon Assessment of Learning Study: prevalence and educational identification of mild mental retardation

Emily Simonoff et al.

Copyright of *Child & Adolescent Mental Health* is the property of Blackwell Publishing Limited and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.