



Faculty for
Children &
Young People



The
British
Psychological
Society

Division of Clinical Psychology

Briefing Paper No. 26
Attachment theory into practice

February 2007

Briefing Paper: *Attachment theory into practice* is published by The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.

© The British Psychological Society 2007

ISBN: 978 1 85433 450 3.

Copies of this briefing paper are available from the Leicester office.

Cost £3.75 (DCP members); £5 (non-members).

This document was edited by:

Kim S. Golding on behalf of the Faculty committee.

Contents

Introduction	2
About the contributors	5
SECTION 1 ATTACHMENT THEORY INTO PRACTICE: AN OVERVIEW	
Passionate about attachments <i>Richard Bowlby</i>	9
Attachment Theory, debate, controversy and hope A clinician's perspective <i>Kim S. Golding</i>	13
SECTION 2 PROVIDING A SECURE BASE FOR INFANTS AND TODDLERS	
Making a difference: Clinical psychology in primary prevention <i>P.O. Svanberg</i>	31
Clinical application of Attachment Theory: The Circle of Security approach <i>Glen Cooper, Kent Hoffman, Bob Marvin & Bert Powell</i>	38
Attachment and biobehavioral catch-up: An intervention for foster parents. <i>Mary Dozier, Michelle Knights & Elizabeth Peloso</i>	44
SECTION 3 PROVIDING THE FAMILY AS A SECURE BASE FOR THERAPY WITH CHILDREN AND ADOLESCENTS	
Intervening beyond the child: The intertwining nature of attachment and trauma <i>Margaret E. Blaustein & Kristine M. Kinniburgh</i>	48
An attachment-focused treatment for foster and adoptive families. <i>Daniel A. Hughes</i>	54
Family attachment narrative therapy <i>Joanne C. May and Todd Nichols</i>	59
Emotionally Focused Family Therapy <i>Gail Palmer</i>	65
SECTION 4 PROVIDING A GROUP AS A SECURE BASE FOR CARERS AND PARENTS TO EXPLORE PARENTING	
Developing specialised parenting interventions for foster carers and adoptive parents <i>Kim S. Golding</i>	71
Fostering attachments. A parenting training group for foster carers and adoptive parents <i>Kim S. Golding</i>	75
Attachment for foster care and adoption: A training programme <i>Mary Beek and Gillian Schofield</i>	80

1. Introduction

Attachment theory suggests that infants are biologically predisposed to form attachment relationships from which they can experience security and comfort (e.g. Bowlby, 1969; Bowlby, 1988). The attachment figure provides a secure base for the child. The child seeks this security when feeling threatened and uses the base as a platform for exploring and learning when the threat is reduced. Bowlby further suggested that this early experience leads to the development of a cognitive model (internal working model) of these relationships which influences and is modified by later relationships. The earliest relationships in a child's life are the foundation for the child's later development. Secure attachments allow children to develop trust in others and self-reliance in themselves. Securely attached children with positive expectations of self and others approach life with confidence.

If we, as practitioners, are going to support children, young people and their families then an understanding of Attachment Theory and its application to interventions will be helpful. Early intervention and prevention services can draw upon attachment theory to guide parents and carers in the early care of their children. Additionally it is a clinician's hope that later adjustment for children is not just dependent upon their early experiences. As Clarke and Clarke (2000) remind us, 'early experience represents no more than a first (and important) step on a long and complex path through life'. We might be working with parents, carers and children at many stages on this life path. Interventions aimed at helping children recover from difficult early attachment experience also need to be part of our 'toolbox'.

The development of interventions derived from Attachment Theory has been a slow process. Bowlby's primary interest was in promoting change in child-rearing practices. He wrote little about applications to clinical practice until relatively late in his career (Lieberman & Zeanah, 1999). One of his later books did consider the implications for adult therapy (Bowlby, 1988), but he has left it to others to develop interventions for child and family work. This development has taken on renewed urgency as the needs of looked after and adopted children are becoming better understood. These children have experienced early adversity, separation and loss, and therefore their early attachment relationships will have been compromised. The poor outcomes of these groups of children has led to an urgent search for interventions that can improve the early care of these children or can aid recovery from poor early experience when living with alternative families. This has led, in recent years, to a range of interventions with a focus on improving the security of attachment of the children to their parents or carers; either as an end in itself or as a means to achieve broader improvements for the child. It has also led to renewed

controversy as the efficacy and ethics of these interventions are debated (see O'Connor & Zeanah, 2003; Prior & Glaser, 2006).

This briefing paper has been developed as a guide for clinicians interested in the development of interventions based on an understanding of Attachment Theory. We have commissioned a series of articles from leading clinicians in the field. There are many unanswered questions about the use of such attachment-focused interventions. Is there sufficient evidence-base to guide these interventions? What is the advantage of these over more traditional and well-researched interventions? This paper cannot answer these questions given the current state of knowledge. This paper does provide an overview of recent developments in this field. The range of interventions being developed is explored together with discussion of the theoretical, practice and evidence base for these interventions.

Interventions with infants and their parents have a strong research base. The interventions aimed at helping older children are less researched and have become overshadowed by the criticisms and concerns about holding therapy (see Prior & Glaser, 2006). This is useful in focusing attention onto the importance of interventions being properly derived from Attachment Theory, but has appeared to have divided researchers and practitioners. The researchers are helping us to understand more about infant attachment and how to intervene to improve the sensitivity and responsiveness of parents. This has led to successful intervention programmes; although it is an irony that successful and evidence-based programmes are left without funding (see Svanberg, this paper). Practitioners are developing beyond this base to also consider ways of intervening with older children and their families. These interventions have been developed guided by an understanding of Attachment Theory combined with a knowledge of the impact on development of child abuse and/or neglect; and for some children the experience of separation from birth family and the experience of foster and adoptive care. These children can be highly troubled, not just demonstrating insecure and often disorganised attachments, but also a range of difficulties extending to social relationships more generally and impacting on behaviour, learning and emotional state (Prior & Glaser, 2006). The quality of intersubjective experience early in life (Hughes, this paper) and the extent of developmental trauma experienced (van der Kolk, 2005) need to be considered alongside current difficulties within the attachment relationship when developing intervention packages. Current critiques of the development of interventions with older children, young people and their families pay little attention to the variety of developments in this field, pointing to the lack of evidence-base and the dangerousness of the extremes of practice in this area. These provide little

guidance for the practitioner beyond advising fairly minimal cognitive-behavioural work (Prior & Glaser, 2006). For the clinician, with the troubled family in front of them, practice sometimes needs to precede research. The practitioner needs to draw upon the best of the practice base as well as the evidence base in order to provide immediate help and support.

This briefing paper provides a practice-based guide exploring the way clinicians are thinking about Attachment Theory and difficulties in attachment when developing interventions with children, young people and their families. Contributors have been invited to submit articles where there is evidence of thoughtfulness about the application of an understanding of Attachment Theory wholly or as part of the theoretical basis for the intervention. For some of these contributors there is the beginnings of an evidence base, for others evaluation is more nascent.

Clinicians have always been creative and eclectic when working with individual children, young people and their families. It is our hope that this briefing paper can provide a guide to best practice in this area whilst also stimulating further research and evaluation in the future.

References

- Bowlby, J. (1982). *Attachment and loss: Vol 1. Attachment*. New York: Basic Books. (Original work published 1969)
- Bowlby, J. (1998). *A secure base. Clinical applications of attachment theory*. London: Routledge. (Original work published 1988)
- Clarke, A. & Clarke, A. (2000). *Early experience and the life path*. London: Jessica Kingsley Publishers.
- Lieberman, A.F. & Zeanah, C.H. (1999). Contributions of attachment theory to infant-parent psychotherapy and other interventions with infants and young children. In J. Cassidy & P.R. Shaver (Eds.) *Handbook of Attachment. Theory, Research and Clinical Application*. pp.555–574. New York/London: The Guilford Press.
- O'Connor, T. & Zeanah, C. (2003). Attachment disorders: assessment strategies and treatment approaches. *Attachment and Human Development*, 5(3), 223–244
- Prior, V. & Glaser, D. (2006). *Understanding attachment and attachment disorders. Theory, evidence and practice*. London: Jessica Kingsley Publishers.
- van der Kolk, B. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401–408.

About the contributors

Editor/Contributor

Kim S. Golding is a clinical psychologist and clinical lead within the Integrated Service for Looked After Children in Worcestershire. She has been a member of the Faculty for Children and Young People Committee for the last four years. She is currently the editor of *Service & Practice Update* for the Faculty. Contact: kim.golding@tiscali.co.uk

Contributors

Mary Beek is Team Manager (Family placement, recruitment and assessment) Norfolk Children's Services and has more than 20 years' experience in adoption and fostering. She worked with Gillian Schofield as a Senior Research Associate at the University of East Anglia from 1997–2005.

Gillian Schofield is Professor of Child and Family Social Work and Co-Director of the Centre for Research on the Child and Family at the University of East Anglia. An experienced social worker and Guardian *ad Litem*, she has research interests in attachment and family placement, and particularly in long-term foster care as a route to permanence.

Richard Bowlby retired in 1999 from medical photography producing illustrations for research communications. He now lectures to health care professionals using video material and personal insights to promote a much broader understanding of his father's work on Attachment Theory. He supports a range of organisations that address challenging attachment issues, and is seeking ways to help the general public benefit from a better understanding of attachment relationships.

Margaret E. Blaustein, PhD, is Director of Training and Education at The Trauma Center at JRI in Brookline, MA. Dr Blaustein is a practicing clinical psychologist who specialises in the assessment and treatment of complex childhood trauma. She is co-developer of the Attachment, Self-Regulation, and Competency (ARC) treatment framework, and has provided extensive didactic and interactive training regarding the impact of and intervention for childhood-onset trauma.

Kristine Kinniburgh, LICSW, is Director of Child and Adolescent Services at the Trauma Center at JRI in Brookline, MA. She has worked with complexly traumatised children in a range of settings, including state funded residential

and after school programmes, hospital settings, alternative educational settings, transitional living programmes and in the Boston Public Schools. She is the originator and co-developer of the Attachment, Self-Regulation, and Competency (ARC) treatment framework, and has consulted on this framework with agencies across the US.

Glen Cooper has served as the site director for federally funded Head Start research projects with the University of Virginia and is a consultant for a NIMH grant for at-risk infants through the University of Maryland. He has been involved in social services for over 30 years. In addition to being licensed as a Marriage and Family Therapist and a Mental Health Counsellor, he is a designated Child Mental Health Specialist. Glen and his colleagues received the Governor's Child Abuse Prevention Award for their work in the Circle of Security Project.

Contact Glen at: 807 W 7th Ave, Spokane, WA 99204;
e-mail circleofsecurity@comcast.net.

Kent Hoffman is a clinical consultant for attachment related interventions at the University of Maryland, University of Virginia, Tulane University, and Tamar's Children (a project in Baltimore, MD utilising Circle of Security interventions with incarcerated mothers). He is also on the psychology faculty at Gonzaga University and is a training and supervising psychotherapist with the Center for Clinical Intervention at Marycliff Institute in Spokane, Washington. Kent was recently given the Child Advocate of the Year Award by Spokane Head Start and the Washington Children's Alliance.

Robert Marvin began his work in attachment in 1964 as one of Mary Ainsworth's undergraduate students at The Johns Hopkins University. Since 1980, Bob has served on the faculty in the departments of Pediatrics and Psychiatry at the University of Virginia. His work has focused since then on studying and treating attachment and other relationship problems in families who have children with chronic medical conditions, and more recently children who have been separated from their parents because of divorce, maltreatment, or foster and adoptive care.

Bert Powell is an Approved Supervisor in the American Association of Marriage and Family Therapy, an Adjunct Assistant Professor in the Graduate School of Counseling Psychology at Gonzaga University and an International Advisor to the editorial board of the *Journal of Attachment and Human Development*. In addition to his private practice he also provides consultation to the Spokane Police Department and the Spokane Public School's Behavioral Intervention

Program regarding the utilisation of attachment theory and principles of affect regulation with at-risk youth.

Mary Dozier is Amy E. du Pont Chair of Child Development in the Department of Psychology at the University of Delaware. She studies challenges confronting young children who have experienced early adversity.

Michelle Knights, MA, is a parent trainer for the Infant Caregiver Project at the University of Delaware. She is also working on her doctorate in Individual and Family Studies.

Elizabeth Peloso, MS, is the Project Director for the Infant Caregiver Project. She has particular expertise in developmental neurobiology.

Daniel Hughes is a psychologist who has specialised in working with children and young people with trauma/attachment problems. He is the author of two books on the treatment of foster and adopted children, including a new edition of *Building the bonds of Attachment* published this year. His latest book, *Attachment-focused family therapy*, is soon to be published. He lives and works in Maine, USA but is a frequent visitor to the UK, providing seminars and training for therapists and parents.

Joanne C. May, PhD, LP, LMFT, is founder of the Family Attachment and Counseling Center of Minnesota. Dr May has been in the mental health field for more than 50 years and holds competencies in individual, couples and family therapy, with special training in Post Traumatic Stress Disorder, EMDR, and attachment disorders in children and adolescents. Dr May is coauthor of *Connecting with Kids Through Stories: Using Narratives to Facilitate Attachment in Adopted Children*, and *Parenting with Stories: Creating a Foundation of Attachment for Parenting Your Child*.

Todd Nichols, MA, MPAff, is Executive Director of the Family Attachment Center. Mr. Nichols is coauthor of *Connecting with Kids Through Stories: Using Narratives to Facilitate Attachment in Adopted Children*. He served as President of the Association for Treatment and Training in the Attachment of Children (www.attach.org) from 2001–2005. Mr. Nichols is coauthor of Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems, an article in *Child Maltreatment* (February 2006).

Gail Palmer, MSW, is one of the founding members of the Ottawa Couple and Family Institute, and is a Registered Marriage and Family Therapist in Canada. She has worked closely with Sue Johnson, co-creator of Emotionally Focused Therapy,

and has become an experienced trainer in EFT; offering core skills training to a number of therapists across Canada and the US. She is an Approved Supervisor with the AAMFT and is a family therapy professor at Carlton University in Ottawa.

Per O. Svanberg, BSc, MSc, Dip Psychotherapy, PhD, AFBPsS, is Consultant Clinical Psychologist, Head of Psychology (Sunderland) and previously project lead for the Sunderland Infant Programme. Following his doctorate in the late 80s he became very interested in adult attachment. Having trained in the Adult Attachment Interview he became passionate about primary prevention and early intervention, an area of interest he has pursued since 1997–98 resulting in the development and evaluation of the Sunderland Infant Programme.

Section One

Attachment Theory into practice: An overview

Passionate about attachments

Richard Bowlby

I was persuaded to write this article when I was asked the simple but thought provoking question, ‘What are you passionate about?’ Although I do not expect everyone to agree with me, these are the beliefs I have developed after ten years of studying attachment theory – make of them what you will.

In 1995 I started giving talks about attachment theory to special interest groups in the health care professions and now, 10 years on, I am still doing the same. It was not my intention when I retired in 1999 to devote myself full time to promoting these ideas. I just wanted to convey the importance of the attachment bonds that develop between mothers and their small children to all sectors of society, and let everyone benefit from this valuable knowledge.

From 1958 I had watched my father, John Bowlby, struggle to get attachment theory more widely accepted, and saw the great resistance he met from professionals and public alike. I watched how desperately the majority of people avoided his theory and I saw the range of dismissive and aggressive tactics that many influential people used to prevent themselves from believing it. However, a band of dedicated followers have continued the research, and established attachment theory as the foremost paradigm for understanding children’s emotional development. An increasing number of healthcare professionals have discovered its great value too, but the vast majority of the general public would still look blank if they were asked what they knew of ‘attachment theory’.

I have been aware for some time that the media (and politicians) are perfectly at ease asking what are we going to do about family breakdown, drug and alcohol abuse, truancy, vandalism, paedophilia and child neglect, etc., but not asking why this is happening, or where this behaviour came from. Any question that might implicate an individual as contributing to the problem behaviour of a child, adolescent or adult is left unasked.

Children do not choose to be abused, neglected or put into institutional care, yet these and other negative childhood experiences are well established as contributing to subsequent behaviour problems. These children carry the stigma of their abuse with them into later life and are blamed as if they were solely responsible for their actions. They receive little

This paper was initially published in *Service and Practice Update*, 4(1), 2005.

or no sympathy or remedial care, and instead are too often labelled as evil, and discarded by society.

In my talks I present the factual observations of research psychologists to different interest groups in an accessible way using many video extracts as illustrations. I am aware of the nature of the information I present and how it will affect some members of the audience, but nevertheless I do address the aspects of attachment theory that I think will be of relevance to a particular audience, and hope they can take something away that will assist them in their work.

My father spent his career unravelling the complexities of the mother/infant attachment bond in the hope that the knowledge would influence the way society supported parents in caring for their children. He said, 'If we value our children, we must cherish their parents.' In 1987, the *Boston Globe* quoted him saying, 'What most astonishes me about family life in the United States is that mothers tell me they can't afford to look after their own babies in the richest country in the world.' He felt that society denied the enormous amount of time and care and attention that emotionally enriched parenting demands, and he felt that we too often short-change our children.

In my quest to spread this knowledge more widely I thought I would get a television producer to make a documentary about my father's work, to show how relationship difficulties in early childhood impact on people in later life and also on society at large. I managed to find a well-respected filmmaker who was enthusiastic about the project. A researcher was engaged to outline a suitable treatment for the programme so that it could be presented to commissioning editors for funding. However, to everyone's dismay, no-one wanted to commission a documentary about troubled mother/child relationships and the project was abandoned, a dead end just as my father had found. I was becoming suspicious that I was up against an even greater resistance to attachment theory than I had expected.

I was beginning to wonder if the problem was my emphasis on the negative outcomes of poor or broken attachment bonds that I had been focusing on. Were these descriptions of abuse and neglect so painful that the general public could not tolerate the images and the feelings they provoked? To test this idea I made an experimental video myself (I had been a scientific and medical photographer) which showed positive attachment bonds within a secure and well-supported family environment. This was carefully constructed with a commentary that explained the sensitive and loving images on the screen and highlighted the positive relationships and the strengthening attachment bonds of the babies, toddlers and small children.

I had the good fortune to have excellent feedback from two focus groups, one of healthcare professionals and one of expectant mothers with second babies, who all said the video was not useable in its present form and listed the many pitfalls I had stumbled into. These involved health and safety issues, cultural stereotypes, inappropriate gender and genetic references, socio-economic assumptions and omission of essential information, plus the advice to remove such emotive phrases as ‘children think you spell the word ‘love’ T.I.M.E.’

I set to rewriting the commentary and re-editing the video and then tried out the second version on several different audiences, collecting their various suggestions and comments (it was still not considered useable) and then produced a third version. I sent this to several experts in the field for their comments and incorporated these into a fourth version.

As I addressed each batch of problems the secure nature of the children’s attachments became more and more clear, but the viewers’ level of anxiety about showing it to their clients increased. By the time I had remedied all the social and factual errors and concentrated on the sensitive and loving nature of the relationships, virtually all the healthcare professionals recoiled, saying it was not appropriate to show such positive images to their troubled clients. One said to me ‘it wasn’t like that for me, you know, it makes me feel so bad seeing what I have missed and what I didn’t give my own children.’

To a large extent our sense of self is defined by a few intimate relationships. These attachment relationships, whether secure or insecure, loving or neglectful have a profound meaning to us and we protect our perception of them with great care (they may not be much, but they’re all we’ve got!). It seems that it is easier to watch other people’s pain and feel that our own problems are minor by comparison than to endure the pain of seeing what comfort and security we could have had but never did have. Many people reading this who use attachment theory as an integral part of their work may not realise the level of resistance there is outside their circle of professional colleagues. I have now abandoned this project as I realise that people don’t want to feel that someone is telling them how to love, another failure in my quest to disseminate this information.

The first two or three years of life is when the brain is being wired for relationships, and only by routinely experiencing human interaction from interested, committed and affectionate people throughout this period can children expect to develop long lasting and secure attachment bonds and an abiding sense of self-worth. Our society pays lip-service to the needs of parents and children, but making any lasting and secure relationship takes massive

amounts of time and commitment which is near impossible in the helter-skelter culture of material goods, mobile phones, television and computer games that we have created for our children.

Children need their parents' guidance and approval, with one providing a secure base throughout childhood into early adulthood, and the other giving children of all ages a partner to share the joy and excitement of play and exploration. Longitudinal research from Germany shows that these sorts of parental activities are vital to children's emotional and social development as they grow up. Grandparents are rarely available nowadays and many parents raising small children, especially single parents, desperately need their emotional and practical support in this challenging and valuable task.

The present culture of long working hours and inappropriate day-care arrangements coupled with the impact of excessive use of technology to occupy children's time is starving them of the opportunities to make trusting and appropriate human contact and to form long-term intimate relationships. Society's materialism undermines our ability to maintain clear boundaries for our children. We are confusing what is just 'tolerable' with what is 'optimal' for children's mental health and personal development, and society is now paying the devastating price for so many barely tolerable childhood years.

Creating secure attachment relationships with our children is becoming more and more difficult as time and opportunity are eroded. Although we may love our children with all our hearts not all children will feel our love or have a sense of being truly valued. They measure our love by the exacting standards of time and attention received. Unless each of us has a reasonable grasp of what children need for the development of their attachment bonds and we have the ability and commitment to provide it, we will continue to be swayed by cultural, social and financial pressures into making inappropriate choices for their care.

This subject will affect *everybody* at some level (including, or especially, those in high office). Many people live with fragile memories of their childhood and dislike reminders of the childhood they may have provided for their own children. Without reassuring support most lay people cannot bear looking too closely at these deeply personal issues, which they feel they have little chance of changing without intolerable levels of soul-searching and pain. Meanwhile large sections of our society continue to raise children without the valuable insights that exist but are not accessible by them, and I continue to look for bearable ways to give people sufficient knowledge for them to steer their own path through the minefield of attachment relationships.

Attachment Theory, debate, controversy and hope.

A clinician's perspective

Kim S. Golding

John Bowlby began developing the theory of Attachment in the 1930s. Whilst the term 'Attachment' would not be used until 1957 (Bowlby, R., 2004) the intervening decades saw a remarkable integration of evolutionary biology, developmental psychology, cognitive science and control systems theory to produce a coherent theory about the ties of an infant to his or her mother (Cassidy, 1999).

Attachment Theory suggests that the earliest years of a child's life are critical for later development. Infants are born biologically predisposed to form relationships from which they can experience security and comfort.

'Attachment' describes 'a pattern of behaviour which is care-seeking and care-eliciting from an individual who feels they are less capable of dealing with the world than the person to whom they are seeking care' (Bowlby, 1986 p11, in van Dijken, 1998).

Bowlby focused on the child as part of a dyadic relationship. Influenced by the multi-disciplinary environment of the child guidance clinic, he was interested in the family and real-life experience of the child. Bowlby viewed the problem of maternal deprivation as a social problem, the impact of which would be felt through successive generations (van Dijken, 1998; Bowlby, R, 2004). This was a radical view at the time; a direct alternative to the dominant psychoanalytic perspective that focused exclusively on the internal world of the child.

With its lack of acceptance by the psychoanalytic community and sitting uncomfortably with some social practices, Attachment Theory has always been controversial. (Bowlby R., 2004). Renewed interest in the theory and its application to clinical practice, has led to fresh controversy. As at its origins attention is again focused on children experiencing early deprivation, and there is a renewed interest in the integration of multidisciplinary scientific understanding.

A brief history of Attachment Theory

Bowlby first gained insight into the impact of disrupted relationships with a mother or mother-figure when he worked in a home for maladjusted boys. However, the true origins of what became a lifelong search to understand

This paper was presented at the Faculty for Children & Young People annual conference, September 2006, University of Hertfordshire.

maternal deprivation can probably be traced back to much earlier in his life. As a four-year-old boy John Bowlby experienced a traumatic separation from the nursemaid who was his primary attachment figure. He later related that he was 'sufficiently hurt to feel the pain of childhood separation – but was not so traumatised that he could not face working with it on a daily basis.' (Bowlby, R., 2004, p.12-13).

Bowlby explored the link between separation and psychopathology both through his study of young delinquents and, together with Robertson, the observation of children separated through hospitalisation. The lack of a permanent emotional relationship with a mother or mother substitute resulted in children who lacked affection, were unable to make permanent friends and who were deeply indifferent to what others thought of them (Cassidy, 1999; van Dijken, 1998). These observations became elaborated into a coherent theory published in his trilogy of books *Attachment and Loss* (Bowlby, 1982; 1973; 1980).

Mary Ainsworth contributed to this development. Her observational studies in Uganda and Baltimore led to the development of 'The Strange Situation' paradigm, exploring individual differences in attachment (Cassidy, 1999).

This was further elaborated by Main and Solomon's discovery of the disorganised pattern of attachment as a response to the dilemma of having the source of fear and comfort residing in the same parental figure. In addition they developed the adult attachment interview, a tool for exploring attachment patterns across generations (Marvin & Britner, 1999).

The dynamic-maturational model developed by Patricia Crittenden has added further depth to the study of individual differences and the development of patterns of relating through childhood (Crittenden *et al.*, 2001).

Attachment Theory therefore provides a framework for understanding child development and especially its origins in early relationships. Research has focused predominantly on infant attachment, individual differences, and ways to improve sensitivity of care-giving. Clinicians have explored applications of the theory, in particular interventions for children who have been maltreated and further traumatised by separation as they move into foster and adoptive homes. This has brought the theory full circle back to its origins in separation and loss.

Attachment Theory as a multi-level theory

Whilst Attachment Theory clearly has a biological basis much of the research is at the *behavioural level*. Researchers have explored infancy and the development of children between eight months and two years, the period when attachment

behaviour is most clearly observed. Whilst this has focused clinical attention on to the sensitivity of caregiving, this has not always translated well into practice. In particular a common belief developed that experience within attachment relationships before six months of age was less important. Fortunately studies of the developing brain are now focusing attention back on to this critical early experience.

The theoretical construct of the internal working model has additionally focused attention at the *cognitive level*. This memory model explains how early attachment experience guides later expectations about relationships. This has increased understanding about transgenerational continuities in attachment relationships.

More recently attention has focused on the impact of attachment experience at the *physiological level*. As neuroscientists elaborate our understanding of brain development, clinicians are highlighting the importance of early intervention and prevention (e.g. Brisch, 2002; Svanberg, 2005). These new understandings are additionally informing the development of a range of interventions aimed at helping children deprived of early sensitive care.

The process of attachment

The first year: Infants are born predisposed to respond to other people. They have an innate preference for looking at human faces compared to abstract designs, and can recognise their mother's face and the sound of her voice when only a few hours old (Oates, 1994). These innate abilities all emphasise the social world, highlighting the importance of relationships for the human species. The infant naturally relates to others in ways that will elicit interest and nurture, increasing the likelihood that contact with people will continue. Thus s/he calms when picked up, and smiles when talked to. This is the stage of *absorption* for mother and infant, a mutual preoccupation leading to acceptance and claiming (Stern, 1985). In learning about relationship the infant is also learning about his or her self. In finding each other the infant is developing a sense of self.

As infants mature they learn to actively seek attention, rather than just passively respond. Stern (1985) describes the importance of *attunement*, the inter-subjective sharing of affect. This emotional connection provides contingent responses to the infant's communications and needs. As the carer demonstrates reliability in meeting the infant's needs the infant learns that s/he has some ability to control the interaction to elicit care. Trust in the availability and responsivity of the carer develops.

As infants start to discriminate between people selective *attachment* bonds are forming. There is a preference for being comforted by carers rather than more unfamiliar people. These attachment bonds will be consolidated between six to nine months.

Physiologically the first year sees the formation of the brainstem. This part of the brain regulates physiological state, including stress arousal, sleep and fear (Perry, 2000). The mother's primary role is to be a caregiver, 90 per cent of her behaviour will be providing affection, play experience and nurture (Schoré, 1994). The carer ensures that the infant experiences arousal within a moderate range, they provide stimulation when the infant is in a low arousal state and modulation of high arousal states. Negative affect is transformed into positive affect allowing the baby to develop the capacity for focused attention (Schoré, 1994). Trevarthen (1990) suggests that the attachment relationship provides the opportunity for brain-to-brain interaction, promoting an epigenetic programme of brain growth. Essentially the experience of a responsive dyadic relationship builds attachment into the nervous system (in Schoré, 1994).

The second year: As children move into their second year an active attachment system predisposes them to seek proximity to and protest separation from the attachment figure when stress or discomfort increases. The child uses the adult as a secure base. With increased mobility the exploratory system is also evident, predisposing the child to explore and investigate the world around them. These two systems work in a complimentary fashion. When stress increases the attachment system operates and attention is focused onto the attachment figure. As the adult comforts and reassures the child there is an attenuation of the attachment system and the exploratory system strengthens focusing attention back onto the outside world. As long as the carer is attentive, reliable and sensitive to the child's needs a secure attachment develops. This in turn leads to an expanded range of exploration and interest in novelty. 'Whereas fear constricts, safety expands the range of exploration.' (Fosha, 2003, p.227)

The child's increasing ability to elicit care and engage in exploration is facilitated by the psychobiological state of attunement that the relationship offers. This in turn provides external regulation of affect when needed (Fosha, 2003). The development of the mid-brain, supported by this dyadic relationship, increases the child's capacity for regulation (Perry, 2000). The child becomes less dependent upon external regulation and more able to co-regulate with the carer. With continuing experience of sensitive caregiving this co-regulatory ability will develop into a capacity for self-regulation. The child learns that their feeling states can be understood, handled and contained and becomes able to manage this for him or herself (Howe, 2005). Thus 'the early

social environment, mediated by the primary caregiver, directly influences the final wiring of the circuits in the infant brain that are responsible for the future social and emotional coping capacities...the ultimate product of the social-emotional development is a particular system in the prefrontal area of the right brain that is capable of regulating emotion ...' (Schore, 2003).

This development of regulatory capacity is accompanied by development of a sense of psychological self, the development of mind. This too occurs within the relationship with the carer, providing the child with the capacity to make sense of their experience (Howe, 2005). Fonagy *et al.* (2002) suggest that infants are born with a biological need to feel understood. The carer, by reflecting upon own and infant's emotional state, helps the child to develop a strong capacity for mentalising. This further helps the child understand and regulate emotion.

Thus during the first two years of life the infant develops an attachment relationship within which they experience contingent communication, psychobiological attunement and feelings of safety (Siegal, 2003). This promotes the capacity for exploration alongside a developing ability to self-regulate and to make sense of experience. At the behavioural level an attachment relationship promotes feelings of safety and security; at the physiological level this relationship promotes neural integration.

Between two and four years: Towards the end of the second year of life and into the third year the carer shifts from a primarily caregiving role to one that also includes socialisation (Schore, 1994). The child is increasingly confident, able to explore a wider world and to relate to a variety of people. With increasing self-confidence the child needs to learn to maintain safety (e.g. don't run into the road) and to fit in socially (e.g. you don't hit another child). The attachment relationship is a primary source of socialisation. This process of socialisation is mediated by the experience of shame (Schore, 1994). The parent or carer creates a state of mis-attunement with the child as they demonstrate disapproval or prohibition. The child experiences shame as an increase in negative arousal. This is co-regulated by the carer. The carer then needs to create the conditions for re-attunement. The child once again experiences feeling loved and cared for and the relationship is repaired. This dyadic attunement, rupture and re-attunement provide the child with essential experience leading to the capacity for impulse control and socially appropriate behaviour (Schore, 1994).

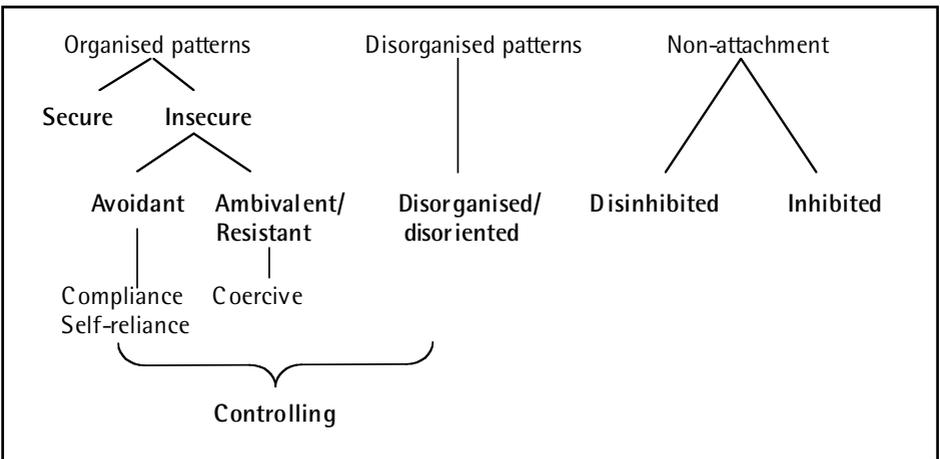
At the neurological level the cortex is developing, providing the child with capacity for thinking, planning and problem-solving. The development of the

limbic system additionally provides increased capacity to regulate complex emotional states, to develop social language and to interpret social information (Perry, 2000). The child comes to experience him/herself as being understood and cared for emotionally. Affect regulation and mentalisation abilities in turn foster the developing sense of self and agency (Fonagy *et al.*, 2002).

Insecure attachment, difficulties in attachment and attachment disorder

Insecure attachment develops when the child experiences insensitive, neglecting or rejecting parenting. This is reflected in the organisation of the behaviour that the child demonstrates (Ainsworth *et al.*, 1978). (See Figure 1).

Figure 1: Patterns of Attachment



Organised patterns of behaviour develop in order to increase the possibility of parents being responsive when children need them. The child adapts his or her behaviour in response to the behaviour of the parent.

The child may minimise attachment behaviour to maintain closeness to carers who are already rejecting. This is expressed through passive and withdrawn behaviour with little display of emotional distress (avoidant attachment).

Alternatively the child may maximise attachment behaviour to elicit care from inconsistent carers. This is expressed through demanding and clingy behaviour. Emotional distress is extreme with a resistance to being soothed and comforted (ambivalent–resistant attachment).

Disorganised patterns of behaviour develop when carers are frightened or frightening to the child. The child is unable to organise his or her behaviour at

times of stress because the carer is both the source of fear and the potential for safety. As they become older the children solve this dilemma through self-reliance and control. They do not trust the carer so they take control of the relationship. The child develops highly organised but controlling ways of interacting with the parent that build upon early patterns of avoidant or ambivalent relating (Crittenden *et al.*, 2001).

It can be helpful to think of these different behaviour patterns in relation to the child's Internal Working Model, which determines the response to self and others (see Figure 2).

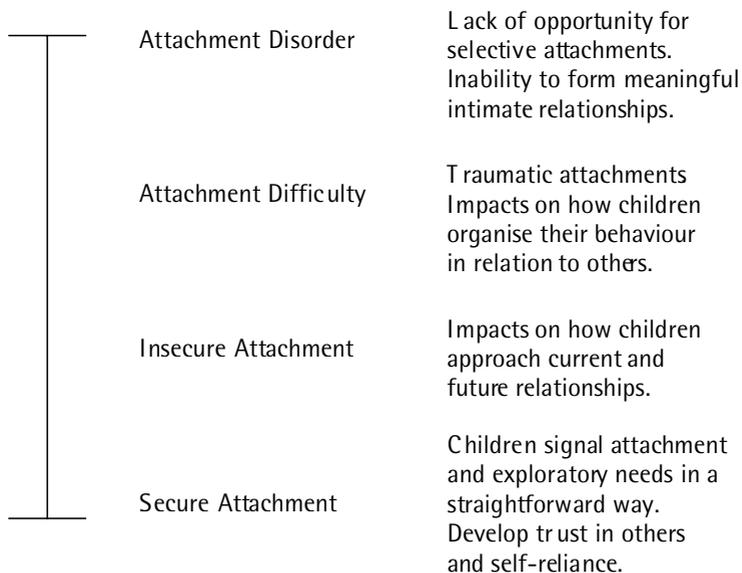
Figure 2: Secure, insecure and difficulties in attachment

<p>Secure Attachment Sensitive responsive caregiving Child feels: Trust in self Trust in others 'I am good, you are good'</p>	<p>Ambivalent Attachment Inconsistent, caregiving Child feels: Distress in self Needy of others 'You will attend to me, but I fear abandonment'</p>
<p>Avoidant Attachment Rejecting caregiving Child feels: Trust in self Distrust towards others 'I will do it by myself, I fear closeness'</p>	<p>Disorganized Attachment Frightening caregiving Child feels: Frightened of self Frightened of others 'I am powerful, I am scared, I fear'</p>

Problems in attachment have been described variously as insecure attachment, attachment difficulties and attachment disorder (see figure 3). These labels describe a range of difficulty from increased feelings of insecurity at one end to a failure to develop any selective attachments at the other. These differences in the level of difficulty relate to differences in the experiences of the children.

The experience of insensitive parenting can increase risk and reduce resilience for the child in the face of future difficulty. The child develops relationship strategies to enable them to feel safe within the insensitive relationship. These strategies get increasingly complex in the face of extreme insensitivity as the child matures. This impacts on the child's ability to elicit caregiving in a straightforward manner, and influences the way they relate to others in the future.

Figure 3: Secure, insecure and difficulties in attachment



Children with difficulties in attachment signal their needs in a distorted way, challenging sensitive caregiving. The child leads the relationship dance (Stern, 1977), rather than eliciting care and nurture in response to feelings of insecurity they express or hide needs in relation to expectations of the carer. Thus they may act as if they don't need nurture at times of distress (avoidant attachment) or they may seek nurture and comfort even when stress is low, resisting efforts to soothe and comfort them (ambivalent/resistant attachment). Only if the carers can respond to the child's hidden needs as well as their expressed need will the child learn to organise their behaviour around carer availability (Dozier *et al.*, 2002; Stovall & Dozier, 2000; Dozier, 2003).

Children with severe attachment difficulties have experienced parenting that is frightening or frightened. These children demonstrate a challenging range of behaviours organised around the need to control in order to feel less afraid and helpless. The child feels powerful, masking hidden feelings of helplessness and need for comfort. These strategies provide a fragile feeling of security, which can quickly break down with increased stress and neediness (Howe, 2005).

The term attachment disorder, sometimes called reactive attachment disorder (RAD), describes the group of children who have had little or no opportunity to develop a selective attachment because of the complete lack of consistent

caregiving. Children who have experienced severe neglect, and/or multiple caregivers and/or impoverished institutionalised care grow up with little capacity to develop meaningful relationships, and learn to relate to others through patterns of highly disinhibited or emotionally withdrawn behaviours. Whilst a pattern of behaviours associated with these difficulties has been described and labelled as a disorder there is continuing debate about the assessment of and diagnosis of this condition (O'Connor & Zeanah, 2003; Minde, 2003). In particular concern has been expressed that RAD is being overdiagnosed based on observations of high levels of problem behaviour in the child rather than on evidence of disturbed attachment (Barth *et al.*, 2005).

Physiological and behavioural consequences of traumatic attachment

Research suggests that the experience of caregiving as hostile and non-nurturing directly impacts on development within the brain (see Schore, 2003; Cairns, 2002). The experience of highly insensitive, traumatic attachments in the early years results in structural limitations to the right brain. This in turn leads to an inability to regulate emotional state under stress (Schore, 2003). Neurodevelopment becomes organised around hyperarousal and/or dissociation. The hyperaroused child is in a perpetual state of distress, whilst the dissociated child although experiencing high arousal shows few behavioural signs of this distress (Cairns, 2002). Rage and impulse regulation difficulties follow. The child lacks the capacity to assess risk, or to stop and think, and is often angry and destructive. Additionally if the child is not helped to regulate shame s/he will experience disintegrative shame, overwhelming the sense of self.

Poor caregiving also impacts on cognitive development. For example, whilst children may develop the ability to complete quite complex cognitive tasks they continue to fail with simple cause and effect learning around their behaviour (Cairns & Stanway, 2004).

Therapeutic needs of children with attachment difficulties

All children need the opportunity to experience a sensitive, attuned caregiving environment. Whether this experience is sufficient for recovery from early maltreatment will depend upon the age of the child. For example, a study of maltreated infants placed in nurturing foster care homes revealed that children placed earlier than 10 months of age developed secure attachment behaviour whilst those placed at an older age continued to demonstrate avoidant or resistant attachment behaviours when distressed (Stovall *et al.*, 2004). Reviews and meta-analytic studies confirm the success of interventions for infants and biological mothers. Interventions improve the sensitivity of parenting the child receives and to a lesser extent this increases the attachment security of the

infant (van Ijzendoorn *et al.*, 1995; Egeland *et al.*, 2000; Bakermans-Kranenburg *et al.*, 1998; 2003). It is likely that interventions need to focus both on increasing sensitivity of caregiving and improving attachment state of mind of the parent (Bakermans-Kranenburg *et al.*, 1998). Infants who are still in the process of developing initial attachment relationships therefore benefit from interventions aimed at providing the optimum conditions for this development. There is however debate about the benefit of short term versus long term interventions (see Berlin, 2005).

Research suggests that the internal working model of mothers predicts infant-child attachment more strongly than the parenting behaviours of the mother (see Berlin, 2005). This has implications for interventions, which may be further helped by current research that is elucidating the concept of sensitive parenting. This is moving away from a crude distinction between sensitive and insensitive towards an understanding of sensitivity in relation to the attachment needs of the child. For example, it appears that insensitive parenting that eventually provides comfort for the child is more likely to be associated with secure attachment than a parent able to be sensitive during play but becoming insensitive when attachment needs are activated. (Cassidy *et al.*, 2005). Preliminary findings such as this suggests that future research will lead to more tailored interventions with an increased focus on how a parent is sensitive rather than just whether they are sensitive.

Interventions with foster or adoptive carers and infants are likely to be more complex still. Dozier has explored the way that substitute carers respond to placed infants who are already signalling their needs in distorted ways. These carers need help to avoid responding to the infant in a complimentary fashion and therefore perpetuating the child's expectations of the carer (Dozier *et al.*, 2005).

The therapeutic needs of older children are likely to be different. These children will have more strongly established patterns of relating to others adapted to their early experience. These children therefore need to experience an environment within which they can develop different ways of relating to carers. To what extent these opportunities lead to developmental recovery, improvement or management remains an open question.

Developing interventions based on an understanding of attachment theory

Parenting interventions

Interventions aimed at helping parents and carers will have a number of goals. The first priority will be to provide an environment within which the child feels *safe and secure*. Children who feel unsafe rarely relax. They engage in only sporadic exploration as their focus is on ensuring survival (Howe, 2005).

Parents and carers need support and help to provide safe environments; to avoid being drawn in to the psychological world of the child and the recreation of early hostile environments (O'Connor & Zeanah, 2003). Carers need to provide nurturing, available care despite the behaviour of the child.

The second goal of parenting interventions is to help the child experience *comfort and co-regulation*. Carers provide the child with experiences of attunement, and relationship repair following episodes of mis-attunement. In this way the child's experience of negative affect and disconnection become transformed into positive affect and re-connection (Fosha, 2003). This requires parents to remain regulated in the face of difficult, challenging and rejecting behaviours from the child. Only if they stay regulated will they provide co-regulation for the child's distress and increasing dysregulation.

The third goal of parenting interventions is to promote the development of *resilience and psychological resources* within the child. Parents and carers will need a strong capacity for empathy, mind-mindedness and reflective function. They can then offer the child the experience of sensitive, mind-engaging and secure attachments within which resilience can be built up (Howe, 2005).

'There is evidence that just one relationship with a caregiver ... who is capable of autobiographical reflection, in other words a caregiver who provides a high reflective self-function, can enhance the resilience of an individual. Through just one relationship with an understanding other, trauma can be transformed and its effects neutralized or counteracted.' (Fosha, 2003, p.223)

Within the literature studies have explored the adaptation of existing parenting interventions, and the development of new interventions to help the parent or carer of a child with attachment difficulties. However, there are few experimental studies that can guide the best use of such interventions (see Golding, 2006a).

Interventions with child and carer

Parenting interventions are relatively uncontroversial. There is wide agreement that parenting help can at a minimum offer much needed support to carers and parents of children with attachment difficulties (Hayden *et al.*, 1999). The application of attachment theory to the development of therapeutic interventions for the older children has been more controversial. The debate rests upon a number of questions (see also Golding, 2006b):

1. Are interventions truly based upon attachment theory?
2. Beyond infancy can children be helped to recover from developmental trauma with the application of attachment theory?
3. Do attachment based interventions have an advantage over more traditional interventions that have been proven to be effective with other groups of children?

However, this broad debate has been overshadowed by concern about a small number of interventions that claim to have their roots in attachment theory, although these links are far from clear (see Prior & Glaser, 2006). The use of coercive holding techniques represents the most controversial of these.

Holding is used to encourage touch and eye contact. Designed to mimic the touch or holding experiences that are part of the attachment process between parents and infants the child lays across the laps of two therapists (or therapist and carer) and is strongly encouraged to maintain eye-contact. There are concerns that holding therapy can be intrusive, non-sensitive and counter-therapeutic, and that it can in fact further traumatise the child (O'Connor & Zeanah, 2003; Barth *et al.*, 2005; BAAF, 2006).

There are two related concerns. Firstly, that interventions are developed as 'attachment interventions', but appear to be antithetical to Attachment Theory (O'Connor & Nilsen, 2005). Secondly, that the term 'attachment' is poorly understood and misapplied, for example Ziv (2005) warns about the use of 'attachment' to describe a child's current behaviour rather than being linked to the child's relationship with an attachment figure. O'Connor & Nilsen (2005) further suggest that the misuse of the term 'attachment' is especially apparent for children living in foster care.

Unfortunately the appropriate level of concern that 'holding' interventions have raised means that potentially useful interventions are viewed through the same lens and potentially rejected by the research community (e.g. Barth *et al.*, 2005). In the meantime practitioners are left struggling to find ways of helping children with severe difficulties in trusting adults and dysfunctional ways to ensure that their safety needs are met, children who do not respond well to traditional cognitive and behavioural interventions (Howe, 2005). There is an urgent need for clinicians and researchers to work more closely together in the development of interventions for older children. 'What is also important to recognise is that attachment theory and research can benefit from the teachings of interventions and clinical practice as much as interventions can benefit from the teachings of attachment theory and research' (Ziv, 2005, p.64).

Whilst there is not a research base to guide practitioners, there is a theoretical basis. Attachment Theory can be used to explain the developmental difficulties of children who find close relationships with parents or carers particularly difficult (BAAF, 2006). This theory can also guide clinical interventions. Bowlby suggests that the first goal of therapeutic work is to provide security. A therapist who is 'reliable, attentive and sympathetically responsive ... to see and feel the world through his patient's eyes, namely to be empathic' (Bowlby, 1988, p.140). Bowlby further writes that the aim of therapy is to enable the 'patient' to construct or re-construct working models of self and attachment figures. To consider ideas and feelings about others that have been unimaginable and unthinkable. In this way Bowlby suggests '...he becomes less under the spell of forgotten miseries and better able to recognise companions in the present for what they are' (Bowlby, 1988, p.137).

For children living within the looked after system, these 'forgotten miseries' have most frequently arisen within their early relationships with parents. An important task for carers and therapists therefore is to provide a therapeutic and parenting environment within which children can internalise a different view of themselves and can enjoy different, healthier relationships. Children can then develop positive expectations of attachment figures, and from this base can begin the journey towards understanding their past, and developing resilience and psychological resources that will help them in the future. This is not to suggest that it is the children and not the parents who have to change (Barth *et al.*, 2005); rather, therapies are needed that are explicitly focused on the parenting experience provided for the child. This helps the child to experience increased safety and security within a responsive relationship. This then provides the basis for therapeutic change for the child and family.

With continuing debate about what is or is not an intervention based on attachment theory these guidelines can provide a useful yardstick against which interventions can be compared. Thus interventions that are coercive and encourage anger can be seen as counter to these guidelines and as less likely to provide for the child corrective attachment experiences (Golding, 2006b).

Interventions focused on helping the carer and child relationship have been developed (see Golding, 2006b and articles accompanying this paper). These interventions are based upon the idea that children can be helped to recover from early traumatic parenting experiences, often by providing them with the experience missed in infancy of a reliable and sensitive long-term relationship with a parent or carer. The therapist's task is to facilitate this child-parent relationship, helping the child to feel secure. This relationship in turn offers the child the experience of co-regulated emotional arousal and co-construction

of meaning from experience (e.g. see Hughes, 2004). Whilst preliminary research supports behavioural change when children experience these interventions (Becker-Weidman & Shell, 2005) it is not yet clear whether the children can also recover neurodevelopmentally. The theorists are divided on this question. Thus Schore suggests that 'the patient-therapist relationship acts as a growth promoting environment that supports the experience-dependent maturation of the right brain, especially those areas that have connections with the subcortical limbic structure that mediates emotional arousal (Schore, 1994, p.473). Perry (2000), however, suggests that we can help children to adapt, but the damage to the brain received early in life cannot be repaired.

Therapeutic work with the child

Providing individual therapy for a child is often seen as a priority for children who are expressing extreme, challenging or bizarre behaviour. However, individual therapy is often most beneficial once the child is feeling safe and secure, and after they have been helped to benefit from comfort and nurturing. O'Connor and Zeanah (2003) point out that a social-cognitive treatment approach, for example, does not focus on the attachment relationship. The question that therefore needs to be answered is whether children with attachment difficulties can benefit from such interventions without substantial change in their relationship with the carer. There is a view that the benefit of traditional child therapy will only be felt once the child has been enabled to experience and benefit from a protective environment, and sensitive parenting. This helps the child to build a sense of identity, to belong within family relationships and to learn the capacity to regulate emotion and behaviour (James, 1994). Parenting interventions and therapeutic work with child and parent/carer together are likely to be initial interventions of choice. 'Too narrow a focus on individual therapy can lead to an expectation that children will adjust to a world for which they are not equipped. The therapy becomes a way of 'making children fit' (Golding, 2006c, p306).

Any interventions that are applied to this group of children will need to address core difficulties of emotional regulation. Bottom-up approaches that focus directly on developing physiological and emotional regulation have been recommended (Fosha, 2003; Bhreathnach & Gogarty, 2000, in Howe, 2005; Minde, 2003; Hughes, 2003; Hanson & Spratt, 2000).

'Beginning with cognitive-behavioural techniques are unlikely to have much impact on traumatised children. Cognitive-behavioural approaches assume that the cortex can deal with the emotional limbic system. Under the challenge, arousal and threat of prematurely delivered cognitive therapies, traumatized children are more likely to go into survival mode of flight, fight or freeze and therapy halts.' (Howe, 2005, p246)

Conclusion

Attachment theory has a long, and controversial history. However, it provides a useful framework for understanding and working with children who have experienced developmental trauma and who have been left with difficulties in experiencing a secure attachment. An attachment framework can provide us with understanding of the importance of early relationships and the impact of this at the behavioural and physiological level. This has guided the development of a range of interventions. Interventions have been developed that aim to improve the sensitivity and attachment state of minds of parents leading to increased security of attachment for the infant. Such interventions are also explored for older infants and children whose capacity to attach have already been compromised. In these cases interventions also need to be informed by neurodevelopmental theory, focusing attention onto the difficulties of emotional regulation and reflective function.

Children traumatised within their early caregiving environments are left highly vulnerable. They are at increased risk of conduct, mental health and relationship difficulties. We need a range of interventions for the parents, the parent–child dyad and for the children themselves that can increase their resilience and give them improved capacity for relationship in the future. Only then will cycles of disadvantage be broken. Attachment Theory holds out the hope of a framework for developing such interventions.

References

- Ainsworth, M.D.S., Blehar, M.C., Waters, E. & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- BAAF (2006). *Attachment Disorders, their assessment and intervention/treatment. BAAF position statement 4*. British Association for Adoption and Fostering.
- Bakermans-Kranenburg, M.J., Juffer, F. & Van Ijzendoorn, M.H. (1998). Interventions with video feedback and attachment discussions: Does type of maternal insecurity make a difference? *Infant Mental Health Journal*, 19(2), 202–219.
- Bakermans-Kranenburg, M.J. & Van Ijzendoorn, M.H. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, 129(2), 195–215.
- Barth, R.P., Crea, T.M., John, K., Thoburn, J. & Quinton, D. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child and Family Social Work*, 10, 257–268.
- Becker-Weidman, A. & Shell, D. (2005). Creating capacity for attachment. *Dyadic developmental psychotherapy in the treatment of trauma attachment disorders*. Oklahoma City, Oklahoma: Wood 'n' Barnes.
- Berlin L.J. (2005). Interventions to enhance early attachment. The state of the field today. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson & M.T. Greenberg (Eds.) *Enhancing early attachments theory, research intervention and policy*. NY: The Guilford Press.

- Bowlby, J. (1982). *Attachment and loss, Vol. I Attachment* (2nd edn.) London: Hogarth Press; NY: Basic Books. (Original work published 1969.)
- Bowlby, J. (1975). *Attachment and loss, Vol. II Separation, anxiety and anger* (2nd edn.) NY: Basic Books. (Original work published 1969, Harmondsworth: Penguin.)
- Bowlby, J. (1981). *Attachment and loss. Vol. III Loss: Sadness and depression*. NY: Basic Books (Original work published 1981, Harmondsworth: Penguin.)
- Bowlby, J. (1998). *A secure base. Clinical applications of attachment theory* (2nd edn.) London: Routledge. (Original work published 1988.)
- Bowlby, R. (2004). *Fifty years of attachment theory*. The Donald Winnicott Memorial Lecture. London: Karnac.
- Brisch, K. H (2002). *Treating attachment disorders from theory to therapy* (English edn.), NY The Guilford Press.
- Cassidy, J. (1999). The nature of the child's ties. In J. Cassidy & P.R. Shaver, (Eds.) *Handbook of attachment. Theory, research and clinical applications* (chapter 1, p.3–20). London/New York: The Guilford Press.
- Cassidy, J. & Shaver, P. R (Eds.) (1999) *Handbook of Attachment. Theory, research and clinical applications*. London/New York: The Guilford Press.
- Cassidy, J. Woodhouse, S., Cooper G., Hoffman K., Powell B. & Rodenberg M. (2005). Examination of the precursors of infant attachment security. Implications for early intervention and intervention research. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson & M.T. Greenberg (Eds.) *Enhancing early attachments Theory, research intervention and policy*. NY: The Guilford Press.
- Cairns, K. (2002). *Attachment, trauma and resilience*. London: BAAF
- Cairns, K. & Stanway, C. (2004). *Learn the child. Helping looked after children to learn. A good practice guide for social workers, carers and teachers*. London: BAAF
- Crittenden, P.M., Landini, A. & Claussen, A.H. (2001). A dynamic-maturational approach to treatment of maltreated children. In J.N. Hughes, A.M. La Greca & J.C. Conoley (Eds.) *Handbook of psychological services for children and adolescents*. Oxford: Oxford University Press.
- Dozier, M. (2003) Attachment-based treatment for vulnerable children. *Attachment and Human Development*, 5(3), 253–257.
- Dozier, M., Albus, K., Fisher, A. & Sepulveda, S. (2002). Interventions for foster parents: Implications for developmental theory. *Development and Psychopathology*, 14, 843–860.
- Dozier, M., Lindheim, O. & Ackerman, J.P. (2005). Attachment and biobehavioral catch-up: An intervention targeting empirically identified needs of foster infants. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson & M.T. Greenberg (Eds.) *Enhancing early attachments Theory, research intervention and policy*. NY: The Guilford Press.
- Egeland, B., Weinfield, N.S., Bosquet, M. & Cheng, V.K. (2000). Remembering, repeating, and working through: lessons from attachment-based interventions. In J.D. Osofsky & H.E. Fitzgerald (Eds.) *Handbook of infant mental-health vol 4: Infant mental health in groups at high risk* (p.35–89). NY: Wiley.
- Fonagy, P., Gergely, G., Jurist, E.L & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. NY: Other Press.
- Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disorganized attachment. In M.F. Solomon & D.J. Siegel (Eds.) *Healing trauma. Attachment, mind, body and brain* (chapter 6, p.221–281). London: W.W Norton & Co.

- Golding, K.S. (2006a). Finding the light at the end of the tunnel: Parenting interventions for adoptive and foster carers. In K.S. Golding, H.R. Dent, R. Nissim & E. Stott (2006). *Thinking psychologically about children who are looked after and adopted. Space for reflection*. Chichester: John Wiley & Sons Ltd.
- Golding, K.S. (2006b) 'Forgotten Miseries'. Can Attachment Theory help guide interventions? In K.S. Golding, H.R. Dent, R. Nissim & E. Stott (2006). *Thinking psychologically about children who are looked after and adopted. Space for reflection*. Chichester: John Wiley & Sons Ltd.
- Golding, K.S. (2006c) Opening The Door: How can therapy help the child and young person living in foster or adoptive homes? In K.S. Golding, H.R. Dent, R. Nissim & E. Stott (2006). *Thinking psychologically about children who are looked after and adopted. Space for reflection*. Chichester: John Wiley & Sons Ltd.
- Golding K.S., Dent H.R., Nissim R. & Stott E. (2006). *Thinking psychologically about children who are looked after and adopted. Space for reflection*. Chichester: John Wiley & Sons Ltd.
- Hanson, R.F. & Spratt, E.G. (2000). Reactive attachment disorder: What we know about the disorder and implications for treatment. *Child Maltreatment*, 5(2), 137–145.
- Hayden, C., Goddard, J., Gorin, S. & Van Der Spek, N. (1999). *State child care, looking after children?* Jessica Kingsley Publishers.
- Howe, D. (2005). *Child abuse and neglect. Attachment, development and intervention*. Basingstoke, Hampshire: Palgrave, MacMillan.
- Hughes, D.A. (2003). Psychological interventions for the spectrum of attachment disorders and intrafamilial trauma. *Attachment and Human Development*, 5(3), 271–277.
- Hughes, D.A. (2004). An attachment-based treatment of maltreated children and young people. *Attachment & Human Development*, 6(3), 263–278.
- James, B. (1994). *Handbook for treatment of attachment-trauma problems in children*. NY: Free Press.
- Marvin, R.S. & Britner, P.A. (1999). Normative development: The ontogeny of attachment. In J. Cassidy & P.R. Shaver (Eds.) *Handbook of Attachment. Theory, research and clinical applications* (chapter 3, p.44–67). London/New York: The Guilford Press.
- Minde, K. (2003). Assessment and treatment of attachment disorders. *Current Opinions in Psychiatry*, 16, 377–381.
- Oates, J. (1994). First Relationships. In J. Oates (Ed.) *The foundations of child development* (p.259–298). Milton Keynes: The Open University/Oxford Blackwell Publishers.
- O'Connor, T. G. & Nilson J. (2005). Models versus metaphors in translating Attachment Theory to the clinic and community. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson & M.T. Greenberg (Eds.) *Enhancing early attachments Theory, research intervention and policy*. NY: The Guilford Press.
- O'Connor, T.G. & Zeanah, C. (2003). Attachment disorders: assessment strategies and treatment approaches. *Attachment and Human Development*, 5(3), 223–244.
- Perry, B. (2000). *Brain structure and function, I and II: Interdisciplinary education series, Vol 2, No 2*. Child Trauma Academy.
- Prior, V. & Glaser, D. (2006). *Understanding attachment and attachment disorders. Theory, evidence and practice*. London: Jessica Kingsley Publishers.
- Siegel, D.J. (2003). An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In M.F. Solomon & D.J. Siegel (Eds.) *Healing trauma. Attachment, mind, body and brain* (chapter 1, p.1–56). London: W.W Norton & Co.
- Schore, A.N. (1994). *Affect regulation and the origin of self: The neurobiology of emotional development*. Mahwah, NJ: Erlbaum.

- Schore, A.N. (2003). *Early relational trauma, disorganized attachment and the development of a predisposition to violence*. In M.F. Solomon & D.J. Siegel (Eds.) *Healing trauma. Attachment, mind, body and brain* (chapter 3, p.107–167). London: W.W Norton & Co.
- Stern D.N. (1985). *The interpersonal world of the infant*. NY: Basic Books.
- Stern, D.N. (1977). *The first relationship*. Cambridge MA: Harvard University Press.
- Stovall, K.C. & Dozier, M. (2000). The development of attachment in new relationships: Single subject analyses for 10 foster infants. *Development and Psychopathology*, 12, 133–156.
- Stovall, K.C. & Dozier, M. (2004). Forming attachments in foster care: Infant attachment behaviours during the first two months of placement. *Development & Psychopathology*, 14, 2, 253–271.
- Svanberg, P.O. (2005). Promoting attachment security in primary prevention using video feed-back: The Sunderland Infant Programme. Faculty for Children & Young People, British Psychological Society. *Service & Practice Update*, 4, (2), 17–21.
- van Dijken, S. (1998). *John Bowlby, his early life. A biographical journey into the roots of Attachment Theory*. London/New York: Free Association Books.
- van Ijzendoorn, M.H., Juffer, F. & Duyvesteyn, M.G.C. (1995). Breaking the intergenerational cycle of insecure attachment. A review of the effects of attachment-based interventions on maternal sensitivity and infant security. *Journal of Child Psychology & Psychiatry*, 36, 225–248
- Ziv, Y. (2005). Attachment-based intervention programs. Implications for Attachment Theory and research. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson & M.T. Greenberg (Eds.) *Enhancing early attachments Theory, research intervention and policy*. NY: The Guilford Press.

Section Two

Providing a secure base for infants and toddlers

Making a difference: Clinical psychology in primary prevention

P.O. Svanberg

Summary

Developing a secure attachment is central for a young child's future resilience and well-being. By using video feedback and focusing on primary prevention and very early intervention the Sunderland Infant Programme was developed and implemented in 1999–2000. This included close collaborative work between health visitors and psychologists, using a range and combination of psychological interventions including developmental guidance, interaction guidance and parent-infant psychotherapy. Through a comprehensive evaluation, it was demonstrated at follow-up that the proportion of children with a secure attachment in the intervention group was almost doubled, whilst the proportion of children with complex, 'clinical' attachment behaviours was more than halved in comparison with a control group. Additionally, mothers' sensitivity in their relationship with their infant significantly improved, which also significantly improved the infant's relationship with the parent. As a bonus it was also demonstrated that the intervention group also used health and social care less, saving on average £210 a year.

Background

There is now extensive research to show that the quality of the early relationship between the care-giver and the infant determines the form and organisation of the infant's attachment behaviour at 12 months (WHO, 2004). There is also a great deal of research showing how the infant's early attachment organisation impacts his or her developmental pathway (Svanberg, 1998). Given this background the Infant programme set out to demonstrate that using a range of mostly brief psychological interventions, it would be possible to significantly improve the parent-infant relationship in the first year of baby's life. Specifically the aim was to increase the proportion of children showing secure attachment behaviour and to reduce the proportion of children showing complex, non-normative attachment behaviour.

This paper was initially published in *Service and Practice Update*, 4(1), 2005.

The objectives were

- to develop and use promotional material emphasising the central importance of a sensitive, responsive relationship for a child's attachment needs and future resilience, i.e. developmental guidance;
- to train and support a group of health visitors to enable them to use video feedback in their routine practice, i.e. interaction guidance;
- to offer a range of psychological interventions for families identified through the screening process as presenting with complex needs, i.e. parent-infant psychotherapy as well as other psychological therapies when appropriate; and
- to evaluate this range of interventions against a 'routine health visitor care' control group.

Service model

Health visitors promoted the project during the primary visit at 10–14 days, inviting mothers to participate to 'better understand their baby's unique way of communicating'. Consenting mothers (ca 60%) and babies undertook a 3–4 minute play interaction when baby was 10–16 weeks. This video-clip was analysed and scored in a regular, weekly consultation session with a psychologist using the CARE-Index (Crittenden, 1997-2004).

Following the video-clip assessment the clinical psychologist together with the health visitor developed a tentative formulation which then generated an intervention plan which was basically a set of recommendations to the health visitor in terms of feedback to the mother regarding the video-taped interaction or what type of intervention is called for. This may take one or more of the following forms:

- When the interaction is sensitive-cooperative and mother and infant are clearly getting on with each other well, the health visitor will provide a straightforward feedback using the video clip. Additionally the health visitor may also provide 'developmental guidance', e.g. the health visitor provides information to mother about milestones and expectations regarding the infant's emotional development.
- In interactions where the parent was either quite controlling/intrusive or unresponsive/unengaged, the video feedback focused on interaction guidance by emphasising the snippets of sensitive behaviour shown. In

addition we also developed an intervention protocol for the health visitor providing a framework for therapeutic interventions (with regular supervision) over a number of additional visits.

Finally in a small proportion of interactions the analysis reveals that the parent is almost entirely unable to provide a sensitive, attuned relationship and this is most frequently due to unresolved psychological problems for the mother herself. The health visitor's task then becomes one of helping the psychologist engage with the family in order to offer psychological therapy. Almost always these are 'hard to reach' families.

Challenges

The most serious challenge was undoubtedly due to the NHS and local authority reorganisation 2001–2002 which meant that the small group of 'project champions' at the local strategic level moved and were replaced with new personnel unfamiliar with the project. Whilst working in a multi-agency team has few problems at the coal face the separate management structures and accountabilities presented considerable challenges particularly in terms of the 'churn' at senior management level.

In terms of the service provided, an unanticipated challenge was the considerable amount of anxiety the health visitors felt as they were learning and adapting to new practice. By developing a monthly support group this was contained.

Working through a primary prevention model and also using video and video feedback, which was sometimes perceived as intrusive, meant that engaging parents into the project was a consistent challenge. By developing a protocol to support the engagement of 'hard to reach' families, we attempted to ameliorate this but it remained a challenge. From the point of the evaluation it was also quite difficult to recruit families to the control group, who often participated out of a sense of altruism.

Evaluation

Unusually we also received in the initial stages funding to enable us to undertake a comprehensive evaluation. A full report on this has been submitted (Svanberg, submitted).

Participants

Following Sure Start requirements the locality was selected to be one of the most deprived in the country. Data from the Index of Multiple Deprivation (Department of the Environment, 2000) indicate that the locality is within the

2 per cent most deprived electoral wards in England. A control group locality was selected to be equivalent in measures of deprivation. Parents in the Intervention Group were recruited by the health visitors participating in the study and parents in the Control Group were recruited by their local health visitors, who were not trained in the CARE-Index. In terms of enrolment all new mothers were offered participation, 61.3 per cent of mothers opted in to the programme and 38.7 per cent 'refused'. With regard to attrition 44 per cent of families completed the whole evaluation including the Strange Situation (SSP) and 56 per cent of families completed only the 12 month CARE-Index. The proportion of Control Group families who completed was considerably larger, i.e. 66 per cent (SSP) and 73 per cent (CARE-Index). In the Intervention Group 134 dyads remained and 107 dropped out. The only significant difference between these two groups was related to mother's marital status. Mothers who dropped out were less likely to be married or in a stable relationship. In the Control Group 60 dyads remained and 22 dropped out.

Measures

The CARE-Index

The CARE-Index was developed specifically to assess relationships at risk (Crittenden, 1988; Crittenden & DiLalla, 1988). It differs from many other assessments in two major ways. Firstly it focuses on assessing the complementary relationship between the care-giver and the child and secondly it recognises the presence of 'covert hostility' and false positive affect in the care-giver and the serious impact this may have on the infant or toddler. Although preceding the development of the Dynamic-Maturational attachment model (Crittenden, 2000) the CARE-Index is firmly based in this theoretical model and is thus able to identify a number of less than optimal interaction strategies in the situations when the care-giver is less than optimally sensitive. The method was devised to be used for children 0–24 months old and provides scores for both mother and baby, i.e. sensitivity, controlling-ness, unresponsiveness for the mother/care-giver and co-operative-ness, difficult-ness, passivity and various compulsive patterns for the infant. A lack of sensitivity in the caregiver is highly predictive of insecure attachment in the infant.

Modified and extended strange situation

The Strange Situation Procedure (SSP), developed by Ainsworth *et. al.* (1978) has become the gold standard in the assessment of infants' and young children's attachment behaviour. Over the years additional coding systems have been developed, the most commonly known being the Disorganised/Disorientated and Cannot Classify categories developed by Mary Main and co-workers (Main & Solomon, 1986).

Crittenden developed the Pre-School Attachment Assessment (PAA) (Crittenden, 1988) validated by Teti and Gelfand, (1997). She has since developed a number of additions and modifications to the Strange Situation (Crittenden, 2002). Space does not allow a comprehensive description of this model. Readers are referred to www.patcrittenden.com.

Service utilisation

The final measure used was a Service Utilisation Questionnaire developed from the work of Browne *et. al.* (1990) Used at the 12 month follow-up this questionnaire ascertained the number and type of public health and social services the family had been in contact with in the preceding two months.

Results

Table 1: Absolute numbers and proportion of attachment groupings at 12 months follow-up

	Intervention Group		Control Group	
Securely attached	59	55%	16	30%
Avoidant	19	18%	9	17%
Ambivalent	14	14%	6	11%
Complex, non-normative	15	14%	23	43%

The differences between the groups are highly statistically significant. The proportion of children in the Intervention Group who were securely attached was almost double that in the control group. More important – because we know these are children who later on are very likely to develop psychological problems – was perhaps the finding that the intervention more than halved the proportion of children with complex, non-normative attachment behaviour in comparison to the control group.

Table 2 : Interactional variables; ANCOVA results at 12 month after adjusting for mother's age at baseline.

Variable	F	df	Significance
Sensitivity (mother)	23.39	193	.0005
Co-operativeness (baby)	17.25	193	.0005

Similar results were found after adjusting for mother’s marital status at baseline, demonstrating that the intervention improved mothers’ sensitive responsiveness, which impacted on baby’s co-operativeness establishing a more secure and positive relationship between the two of them. It would appear that by using video feedback and a relationship focus we were able to nudge the early relationship into a more positive pathway, perhaps facilitating a virtuous spiral. Participating workers found the work highly rewarding as it at times involved ‘helping people fall in love with each other’.

Table 3: Mean costs in pound sterling of service utilisation events in the 2 months preceding the 12 month follow-up

	Programme Group			Control Group		
	Child	Mother	Total	Child	Mother	Total
G.P. appts	19.8	13.9	33.7	22.9	13.1	36.0
Out Patient appts	15.9	6.8	22.7	16.1	9.4	25.5
A&E	19.7	2.1	21.8	21.4	4.3	25.7
Nurse homevisit	11.7	2.8	14.5	6.2	1.8	8.0
Clinical Psychologist	4.2	N/A	4.2	0	0	0
Hospital stays (24 hr)	26.6	0	26.6	32.7	19.7	52.4
Total (including events not in this table)	119.50	31.60	150.40	113.7	71.7	185.40

On average each intervention group family accrued a saving of £210 a year in terms of health and social care costs. In an average English health district of 2500 births a year and an uptake of 60 per cent this would mean an accrued annual saving of £315,000.

Although not formally evaluated, the new way of working had a very positive impact on health visiting practice according to the small group of health visitors who were part of the project’s team, providing a clear theoretical model as well as a series of intervention protocols.

Given these highly successful outcomes it has been a puzzle to understand the reasons why the programme has been terminated.

Acknowledgements

Many thanks should go to many people but particular acknowledgements are due to Trudie Jennings.

References

- Ainsworth, M.D.S., Blehar, M.C., Waters, E. & Wall, S. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Browne, G.B., Arpin, K., Corey, P., Fitch, M. & Gafni, A. (1990). Individual correlates of health service utilization and the cost of poor adjustment to chronic illness. *Med Care*, 28(1), 43–58.
- Crittenden, P.M. (1988). Relationships at risk. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp.136-176). Hillsdale: Lawrence Erlbaum Associates.
- Crittenden, P.M. (1997-2004). *Care-Index manual*. Family Relations Institute, Miami.
- Crittenden, P.M. (2000). A dynamic-maturational exploration of the meaning of security and adaptation: Empirical, cultural and theoretical considerations. In P.M. Crittenden & A.H. Claussen (Eds.) *The organisation of attachment relationships: Maturation, culture and context*. Cambridge: Cambridge University Press.
- Crittenden, P.M. (2002). *Modifications and expansions to the Infant Strange Situation*. Unpublished manuscript, Miami, FL.
- Crittenden, P.M. & DiLalla, D.L. (1988). Compulsive compliance: The development of an inhibitory coping strategy in infancy. *Journal of Abnormal Child Psychology*, 16(5), 585–599.
- Department of the Environment, Transport and the Regions (2000). *Indices of deprivation*. London: DofETR.
- Main, M. & Solomon, J. (1986). Discovery of an insecure disorganized/disoriented attachment pattern: Procedures, findings and implications for classification of behaviour. In M. Yogman & T.B. Brazelton (Eds.) *Affective development in infancy* (pp.95–124). Norwood, NJ: Ablex.
- Svanberg, P.O. (1998). Attachment, resilience and prevention. *Journal of Mental Health*, 7(6), 543–578.
- Svanberg, P.O. (submitted). Promoting attachment security in primary prevention using video feed-back: The Sunderland Infant programme.
- Teti, D.M., & Gelfand, D.M. (1997). The preschool assessment of attachment: Construct validity in a sample of depressed and nondepressed families. *Development and Psychopathology*, 9(3), 517–536.
- WHO (2004). *The importance of caregiver-child interactions for the survival and healthy development of young children*. Department of Child and Adolescent Health and development, World Health Organisation.

Clinical application of Attachment Theory: The Circle of Security approach

Glen Cooper, Kent Hoffman, Bob Marvin and Bert Powell

The Circle of Security project was born of a collaboration between attachment research and psychotherapy practice, informed by object relations and family systems. As the four of us joined forces, we began to bridge the gap between the worlds of research and clinical practice. These worlds all too often spin in their own discrete orbits. Initially, we used findings from attachment research to train our eyes and to increase our understanding of the intricacies of parent-child interaction. Over time, we began to apply the theory more directly.

We carefully studied videotapes of parent/child interactions and developed observational skills and knowledge. As we began to recognise and gain an understanding of specific patterns (such as avoidant and ambivalent attachments in children, and preoccupied and dismissing states of mind in caregivers) we enhanced our practice with individuals, couples and families. These previously unseen patterns, which make up the bulk of care giving behaviours, are procedural memories. When we act from procedural memories, it does not feel like something is being remembered, and therefore these patterns of behaviour often remain unconscious. Having access to the detailed descriptions which attachment research has developed regarding these unconscious procedures, we were able to design therapeutic interventions that address specific interactional strengths and defensive struggles. Similarly, emerging research findings on disorganised attachment highlight the negative outcomes of disorganisation and led us to focus our interventions on the known factors of these fear-based attachments.

Of equal importance are the well-established research findings on secure attachment. Attachment theory provides a coherent framework to understand the reciprocal relationship between autonomy and dependence. This is extremely useful in working in all treatment modalities. Having the clarity, based on a large body of work, about what interactions are significant under which circumstances helps define goals and evaluate the ongoing progress of treatment.

When working with infants and parents without the benefit of research, it is easy to feel like Alice in Wonderland, inquiring of the Cheshire Cat which way she ought to go.

This paper was initially published in *Service and Practice Update*, 4(3), 2005.

“That depends a good deal on where you want to get to,” said the Cat.
“I don’t much care where—” said Alice.
“Then it doesn’t matter which way you go,” said the Cat.
“—so long as I get somewhere,” Alice added as an explanation.
“Oh, you’re sure to do that,” said the Cat, “if you only walk long enough.”

Research on secure attachment makes it clear that it does matter where we get to, it provides a map of how to get there, and helps us determine when we have arrived.

While attachment theory certainly enriched our use of family systems theory and object relations theory, we wondered if we could apply it more concretely. The answer became clear when we saw how our study of attachment theory had an unintended consequence. As we explored the theory and watched the videotapes we found ourselves questioning, both in our professional roles and in our personal life, our assumptions about relationships. We felt compelled to rethink our definition of healthy relationships, the role that relationships played in our lives, and the previously unconscious procedures that we employed in those relationships. In much of our training as psychotherapists, separation and individuation were the central goals of therapy, as well as life. Bowlby’s bold assertion that ‘intimate attachments to other human beings are the hub around which a person’s life revolves’ (Bowlby, 1980) was convincingly verified by closely observing parent/child interactions.

The transformation we experienced was more than re-examining theoretical issues. Of course, that is part of the process of learning any new theory. There is, however, something especially unsettling about watching videotapes of parent/child interactions. As we began training professionals to develop a clear understanding of what they were observing in the videotapes, we noticed that something got under their skin. In part, this has to do with these images resonating with, and bringing to the surface, procedural memories that are at the heart of our own experiences of being parented – and of parenting. Not surprisingly, professionals who managed their discomfort long enough to reflect on what they were experiencing and shared it with others reported that the process led to changes in their relationships.

We began to wonder if training parents in attachment theory would lead to similar changes in self-awareness and care giving patterns. We received a USDHHS University–Head Start Partnership Grant to create a group therapy protocol to test our theory. In this protocol, parents meet together (without their children) to view videotaped interactions of themselves with their children. Our first challenge was to translate attachment theory into a form

that the low socioeconomic status parents whom we serve could readily grasp. Then we developed a protocol to support parents in the vulnerable work of exposing their struggles with their children. We also looked at ways to help parents manage their emotional states long enough to enter into reflection and dialogue about the experience. Even with all these pieces in place, we questioned whether parents could utilise the experience of reflective dialogue to make conscious their unconscious parenting procedures and thus create an opportunity to choose a more secure parenting style. Though it seemed like a long shot, the research literature suggests that the payoff, in terms of children's life trajectories being significantly improved, could be great.

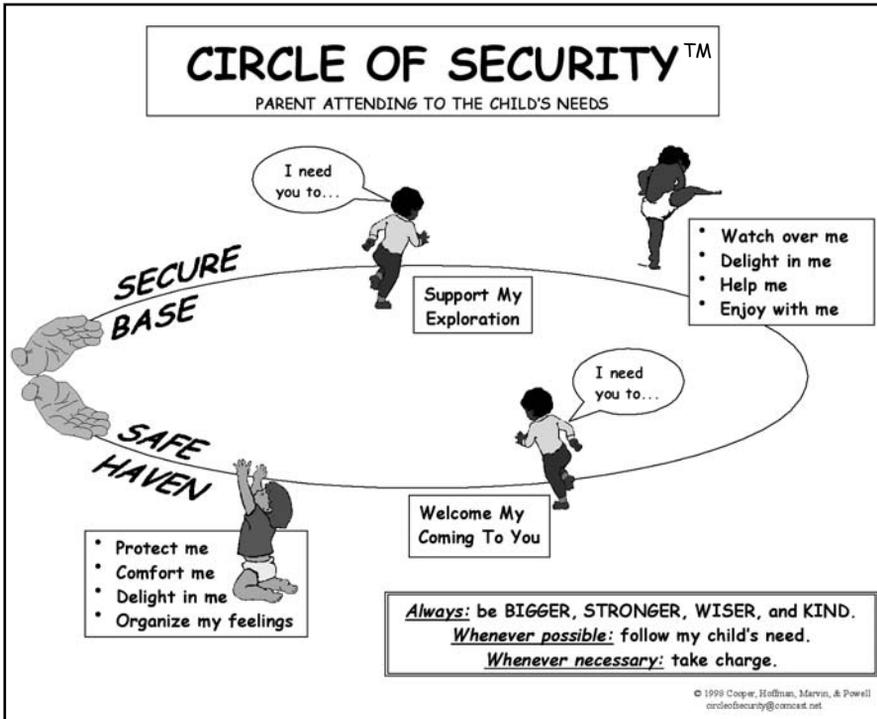
The twist on the golden rule, 'Do unto others as you would have others do unto others', sums up our thinking about the parallel process of the clinician's relationship with the parent being transmitted to the child. As therapists, we use our knowledge and experience with attachment theory to create a 'secure base' from which parents can explore. As parents explore attachment theory and reflect on the experience of viewing videotapes, they, in turn, use their knowledge and experience of attachment theory to create secure bases for their children. Our goal in the 20-week group protocol is to create an experience that helps parents shift from defensive parenting procedures, based on their own history, to empathic parenting. At its heart, empathic parenting is the tendency to respond to accurate inferences about children's feelings and motivations as what we call a 'Bigger, Stronger, Wiser and Kind' caregiver. It is essential for parents to make this empathic shift if they are to sensitively respond to their children's needs.

Establishing what Mary Ainsworth referred to as a 'secure base from which to explore' and 'a safe haven to which one can return' is our preliminary goal in the group work. In the first group session, by showing videotaped clips from the pre intervention assessment (Ainsworth's Strange Situation Assessment) set to the song *You Are So Beautiful*, we overtly communicate to the participants that we honour them as parents. We tell the parents that this is the song that their children are singing to them. Initially, we had concerns that this would be too sentimental for our high-risk population, but the group members are genuinely touched and recognised that we, as well as their children, saw them as beautiful parents. We continue to focus on and celebrate the parents' positive intentionality throughout the 20 weeks.

The next step is to train parents to utilise our map of children's attachment and exploratory needs. We call this map the Circle of Security (see Figure 1). Armed with this simple graphic, parents are able to track behavioural sequences and discern the meaning of those behaviours. Bringing a sense of

order to what often appears chaotic, makes it easier for parents to determine the attachment needs underlying children's behaviours

Figure 1: the Circle of Security™



Giving parents a map of attachment and exploratory needs is not sufficient to correct their inaccurate internal representations of themselves or their children. It is easy to believe that we act the way we think we should act, rather than how we actually do act. Often, after looking at themselves on videotape, parents are shocked by their interactions with their children. They report that they had no idea they were so intrusive, or unavailable, or controlling, etc. Parents need to learn to carefully observe interactions and make accurate inferences about their children's needs. To do this we developed a procedure called 'Seeing and Guessing' in which parents in the group watch videotape clips of themselves with their children. First they develop a behavioural description that the group can agree upon (Seeing) and then the group members make inferences (Guessing) about where the child is on the Circle of Security (i.e. what attachment need is being expressed). When a parent leaps to a conclusion about what a child needs or is feeling in a given moment, the

therapist rewinds the video and asks the parent to describe the behaviours that lead them to that conclusion. The practice of verbalising a behavioural description of the child's utterances, actions or facial expressions, helps parents determine if their initial inference is accurate. This process is used in every session and, over time, creates a mechanism for parents to re-examine their self and object representations.

Once parents feel safe, have a map to work from, and can develop behavioural descriptions and accurate inferences about their children, we invite them into reflective dialogue. This dialogue explores both what the parents are doing and not yet doing to meet their children's attachment needs. The therapist carefully evaluates the pre-assessment strange situation and determines the pivotal defensive strategy of each parent/child dyad. We call this the lynchpin struggle. After the two introductory sessions, one parent each week is shown specifically edited clips from their pre-intervention assessment. The clinician guides the parent through the process of reflective dialogue while the other parents in the group provide support and observations about the clips. Each parent has three sessions over the course of the group to review their videotape. The first review focuses on strengths and the other two focus, at the level each parent is willing, on the lynchpin struggle. Woven into this process is information about, and support for, emotion regulation for parents. As parents enhance their capacity to name and regulate their own emotional process, it puts them in a better position to help their children develop emotional regulation skills.

Data analysis on the three-year project, recently published in the *Journal of Consulting and Clinical Psychology* (see Hoffman *et al.*, 2006), shows a significant within-subject shift from Disordered (attachment patterns associated with the most troubling outcomes for children) to Ordered child attachment patterns (patterns associated with much more favorable life trajectories). In addition, only one of the children in the pre-intervention secure group shifted to an insecure classification. Furthermore, the preliminary data suggests a significant increase in the number of children classified as Secure, and a decrease in the number of caregivers classified as Disordered. Research is continuing on the Circle of Security group approach as well as on its adaptations for use in home visiting programmes, interventions with individual parents or couples, parent education, and residential care. The Circle of Security protocol is also being modified for use in elementary and preschools, and with couples and families in an office setting. This approach has been used with a wide variety of populations including mothers and fathers, incarcerated mothers, foster and adoptive parents, and teenage parents.

It is quite surprising how quickly parents develop a sense of safety in the group and how well they comprehend basic attachment theory, develop observational and inferential skills, and engage in reflective dialogue. Many parents report that talking about their own history of attachment as well as their children's experience is a new and rewarding experience. It is certainly rewarding for us to watch parents shift from defensive care-giving patterns which are based on their procedural memories and history, to empathic care-giving which is responsive to their children's changing needs. One father summed up his experience of this empathic shift by saying of his three-year-old daughter, 'I always thought that she was just being mean, doing things just to bug me, and I never thought about it in the way of "what does she need?" I never put it into a question; I always made it a statement.' The major shift in this dad's internal representation of his child and the concurrent change in how he sees himself as a parent is the kind of deep change we observe with so many of the parents we work with using the Circle of Security.

This project has been supported by USDHHS University–Head Start Partnership Grants #90YF0018, and 90YD0108.

Reference & bibliography

Bowlby, J. (1980) Loss: sadness and depression, vol. 3 of *Attachment and loss*, London: Hogarth Press; New York: Basic Books; Harmondsworth: Penguin (1981).
Hoffman, K., Marvin R., Cooper, G. & Powell, B. (2006). Changing toddlers' and preschoolers attachment classifications: The circle of security intervention. *Journal of Consulting and Clinical Psychology*, 74(6), 1017–1026.

For more information on the Circle of Security see:
Berlin, L.J., Ziv, Y., Amaya-Jackson, L.M. & Greenberg, M.T. (2005). *Enhancing early attachments: Theory, research, intervention, and policy*. New York: Guilford Press.
Cooper, G., Hoffman, K., Powell, B. & Marvin, R. (2005). The Circle of Security intervention: Differential diagnosis and differential treatment. In L.J. Berlin, Y. Ziv, L.M. Amaya-Jackson & M.T. Greenberg (Eds.) *Enhancing early attachments: Theory, research, intervention, and policy* (pp.127–151). New York: Guilford Press.
www.Circleofsecurity.org

Attachment and biobehavioral catch-up: An intervention for foster parents

Mary Dozier, Michelle Knights and Elizabeth Peloso

Infants and toddlers who are placed in foster care undergo a disruption in their relationship with primary caregivers at a developmental point when maintaining that relationship is a key, biologically-based task. Such children face an enormous challenge in forming attachments to new, surrogate caregivers, and in developing regulatory capabilities. Our intervention was designed to target these specific issues. In particular, foster parents are trained to provide nurturance when children's behaviours push them away; provide nurturance when foster parents have to 'over-ride' their own inclinations; and provide a predictable interpersonal world such that children develop better regulatory capabilities.

Consider the example of Joshua, placed into foster care at the age of 13 months, when his mother was incarcerated because of drug-trafficking. Joshua appeared healthy physically when placed into the care of a foster parent who had had 10 children placed with her in the past. But, according to the foster mother, Joshua showed both avoidant (turning away) and resistant (angry, fussing) behaviours when distressed. Even one month after placement, Joshua was not showing an organised pattern of attachment behaviours with his foster mother. His sleep and his production of cortisol, a stress hormone, were disturbed throughout placement. When this foster mother went on an extended vacation, Joshua was placed in a different foster home. This new foster mother (Ms L) had never fostered a child before and hoped to adopt a child at some point. As with the first foster mother, Joshua pushed this foster mother away for the first several months of care. Ms L, however, participated enthusiastically in our training programme. Although initially hurt by Joshua's pushing her away, she was able to persist in providing him with a nurturing environment. When the assessment of attachment quality (i.e. the Strange Situation) was conducted three months later, Joshua was classified as having a secure attachment to his foster mother. Although his production of the stress hormone cortisol was atypical for a period of about eight months, he eventually showed a pattern more typical of children his age.

This paper was initially published in *Service and Practice Update*, 4(3), 2005.

Development of an intervention for foster infants

Over the last ten years, we have been developing an intervention for caregivers of infants and toddlers who have experienced early disruptions in care and/or maltreatment. Our intervention has been informed first of all by careful observation of young children's attempts to cope with new relationships and with ongoing challenges. We then systematically assessed whether our informal observations were borne out by empirical support. On the basis of these informal observations and systematic research efforts, we identified three key issues that present difficulty for infants and toddlers in foster care, and developed intervention components that specifically target these key issues. In this article, we describe the intervention and the empirical rationale for the intervention.

Issue 1: Young foster children often push new caregivers away. Attachment research has demonstrated that mothers generally 'lead the (relationship) dance' (Stern, 1977). For example, mothers' state of mind with regard to attachment influences the child's attachment security even when assessed prior to the child's birth (van Ijzendoorn, 1995). However, at least in the first several months of placement we have found that children appear to lead the relationship dance among foster toddler/parent dyads. We assessed this by asking foster parents to complete a daily diary regarding how their children responded when distressed during the day. Foster parents indicated that children placed after about 10 months of age showed predominantly avoidant or resistant behaviour (Stovall-McClough & Dozier, 2004; Stovall & Dozier, 2000) for the first several months of placement. Of greatest concern to us was that foster parents tended to respond *in kind*. That is, when children behaved in avoidant ways, foster parents behaved as if the children did not need them; when children behaved in resistant ways, foster parent behaved angrily.

We developed our first intervention component to target this issue. Foster parents were helped to see that foster toddlers needed nurturance even though they might not appear to need it. They learned to behave in nurturing ways, even though the child failed to elicit the nurturance.

Issue 2: Caregivers' own issues may interfere with their providing nurturance.

Whereas children from intact dyads can accommodate to non-nurturing parents, children who have experienced disruptions in care need nurturing caregivers. We found that children in foster care could only organise their attachments when caregivers behaved in nurturing ways to them (Dozier *et al.*, 2001). Although a logical solution might seem to be placing children in the homes of nurturing caregivers, this is not feasible in most places. Rather, we chose to intervene with parents to help them 'override' their own issues such

that they responded in nurturing ways to children even when it did not come naturally to them.

Issue 3: Young foster children are often dysregulated at biological and biobehavioral levels. Even several years after placement, young children who have been placed into foster care are often dysregulated at biobehavioural and behavioural levels.

At the biobehavioural level, we have found that foster children's production of a stress hormone, cortisol, is often atypical relative to other children (Dozier *et al.*, 2005). In particular, some children show very low levels of cortisol across the day whereas others show high levels. At the behavioural level we, as well as others, have found that foster children show high levels of disruptive behaviour, and specific deficits in inhibitory control.

This dysregulation among young foster children is targeted by our third intervention component. Children are helped to develop regulatory capabilities by the provision of a predictable, controllable interpersonal world. Foster parents are taught to follow their child's lead, allowing the child to 'take charge' of interactions when possible. Foster parents are also helped to see the importance of touching and snuggling their child.¹

Summary

The intervention we have developed targets three issues that have been identified as critical in the development of infants and toddlers in foster care. First, young foster children often push caregivers away; therefore, foster parents are taught to re-interpret behavioural signals. Second, many parents are not naturally nurturing; foster parents are taught the importance of providing nurturance even though it may not come naturally. Third, children are often dysregulated at behavioural and biobehavioural levels; foster parents are taught to provide children with an environment that helps them develop regulatory capabilities. This intervention is provided in a series of 10 in-home sessions according to a manualised protocol.

¹ Our approach is informed especially by attachment and stress neurobiology. It is important to differentiate attachment theory as we are referring to here, and attachment therapy or holding therapy. We suggest that the intervention described here derives clearly and logically from attachment theory as originally intended by John Bowlby and Mary Ainsworth. Forced holding and restraint do not derive from attachment theory and, indeed, are at odds with the theory. It is vital that our intervention and attachment more generally not be confused with holding therapy.

References

- Dozier, M., Stovall, K.C., Albus, K.E., Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development, 72*, 1467–1477.
- Dozier, M., Dozier, D. & Manni, M. (2002). Recognizing the special needs of infants' and toddlers' foster parents: Development of a relational intervention. *Zero to Three Bulletin, 22*, 7–13.
- Stern, D. (1977). *The first relationship*. Cambridge, MA: Harvard University Press.
- Stovall, K.C. & Dozier M. (2000). The development of attachment in new relationships: Single subject analyses for ten foster infants. *Development and Psychopathology, 12*, 133–156.
- Stovall-McClough, K.C. & Dozier, M. (2004). Forming attachments in foster care: Infant attachment behaviors in the first two months of placement. *Development and Psychopathology, 16*, 253–271.
- Van Ijzendoorn, M. (1995). Adult attachment representations, parental responsiveness, and infant attachment: a meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological Bulletin, 117*, 387–403.

Section 3

Providing the family as a secure base for therapy with children and adolescents

Intervening beyond the child: The intertwining nature of attachment and trauma

Margaret E. Blaustein and Kristine M. Kinniburgh

The role of the caregiving system in child development

Early childhood experiences play a crucial role in long-term outcomes. In normative development, the attachment system provides the safe container that allows children to cope with and filter the vast amount of new experiences they are exposed to on a daily basis. Within the safety of that attachment system, children are able to explore their worlds, and develop a range of skills, including the ability to regulate their body and emotions, build an early understanding of self and others, and, over time, develop an array of increasingly sophisticated developmental competencies (Schore, 2001).

The attachment system may also act as a key resiliency factor for children who are exposed to distressing experiences (Shapiro & Levendosky, 1999). A secure attachment can act as a buffer to mitigate the impact of overwhelming stressors, and to support recovery and healing.

When attachment systems are compromised or distressed, children develop adaptations that help keep them safe. However, a consequence of these adaptations is often a failure to adequately develop key competencies, including notably the ability to regulate emotions and experience. This lack of age-appropriate coping and continued reliance on more rudimentary skills often leads to significant difficulties as children progress through childhood. Many of the problem behaviours which emerge in the elementary school years and persist over time – and which lead to service system referral – may be traced back to early disruptions in caregiving.

The intersect of attachment with childhood trauma

The role of exposure to traumatic stress in childhood has been well documented. Children who have experienced traumatic events have an array of difficulties which include, but are not limited to posttraumatic stress disorder (PTSD). Beyond PTSD, these children may demonstrate behavioural difficulties, trouble with relationships, increased rates of academic failure, and high-risk behaviours such as substance abuse and sexual risk-taking (Cook *et al.*, 2005).

Experiencing multiple childhood adversities carries incremental and potentially widespread risk (Edwards *et al.*, 2003). The symptom picture for a child who has experienced chronic and/or multiple traumas is qualitatively distinct from one who has experienced an acute traumatic event (Terr, 1991). The role of the attachment system may be crucial in understanding this differential impact. For these children, not only is the caregiving system unable to buffer experiences, the caregiving system itself becomes the source of distress. The significance of the overlay of maltreatment and impaired attachment has led to attempts to better understand this dual impact, and to classify those types of trauma which occur within the caregiving system as distinct from non-interpersonal or adult-onset traumatic events.

Recent definitions of complex trauma in childhood have emphasised the occurrence of multiple traumatic events which occur within the context of the early caregiving system (Cook *et al.*, 2005). A proposal has been made for a new diagnosis to better capture those forms of developmentally adverse interpersonal trauma, emphasising the global impact of this experience across developmental domains (van der Kolk, 2005).

Often, interventions for children who have experienced trauma target the posttraumatic symptoms while neglecting the larger caregiving system and the array of impacted developmental tasks. Given the frequent overlay of trauma exposure in childhood with disrupted attachment, it is crucial that interventions go beyond the specific posttraumatic sequelae and prioritise interventions that increase the capacity of the caregiving system to support healthy development.

Attachment, Self-regulation and Competency (ARC): Development of a treatment paradigm

The Attachment, Self-Regulation and Competency (ARC) model is a components-based framework which is designed to address vulnerabilities created by exposure to overwhelming life circumstance taking place within the early caregiving system (Kinniburgh & Blaustein, 2005; Kinniburgh, Blaustein *et al.*, 2005). The model is grounded in both attachment and traumatic stress theories, and recognises the core effects of trauma exposure on relational engagement, self-regulation and developmental competencies.

ARC is a strengths-based model, which emphasises the importance of building or re-building safe relational systems. In the context of that safe system, the model focuses on skill-building, stabilising internal distress and enhancing regulatory capacity in order to provide children with generalisable skills which enhance resilient outcome.

In many ways, the model of ARC mirrors the healthy development that takes place within the normative secure attachment system, in which the safe relationship provides the foundation for healthy outcomes.

Description of ARC

ARC is a theoretical framework rather than a manualised protocol. ARC-informed treatment is meant to be implemented in an individually tailored way, and the ARC guidebook does not provide session-by-session sequencing of intervention. Rather, the framework identifies ten key 'building blocks', or intervention targets, within the three broad domains of Attachment, Self-Regulation and Competency. For each target, the ARC guidebook provides a menu of possible strategies to address these targets, and offers developmental considerations.

Attachment

The Attachment domain targets the child's caregiving system. ARC recognises that this caregiving system may be biological parents, but may also be other relatives, foster or adoptive parents, residential staff within a milieu, and even the therapist. Because of the importance of the caregiving system, it is crucial to identify and work with key caregivers, whoever they may be.

Within the **Attachment** domain, four key building blocks are targeted:

- 1) The ability of the caregiver to recognise and regulate their own emotional experience is crucial. Caregivers are provided with psychoeducation about trauma and children's distressing responses. Clinical work includes depersonalising child behaviours and actions, validating caregivers' own responses, and improving their ability to identify, understand, and appropriately manage affect.
- 2) Attunement is the capacity of caregivers and children to accurately read each other's cues and respond effectively; it is the foundation for rewarding dyadic experience. Intervention targets caregivers' ability to recognise and respond to emotional needs underlying a child's distressing behaviours or symptoms, with psychoeducation about trauma triggers and responses often providing the framework. Positive engagement between caregiver and child is actively targeted.
- 3) Caregiver ability to respond consistently and appropriately to child behaviours is often compromised. Intervention targets the building of effective parenting skills for children who have experienced trauma. Clinicians actively work with caregivers to identify and implement successful tools.

- 4) Many children and families have experienced both external and internal chaos. Predictability and consistency may increase perceived safety and help with regulation. Clinicians work with caregiving system to develop routines targeted to key trouble-spots, such as bedtime or transitions.

Self-Regulation

Impaired self-regulation is a key feature among children exposed to complex trauma (van der Kolk, 2005). Traumatic stress overwhelms the limited coping skills available to a developing child. In the absence of a caregiving system that supports development of more sophisticated skills or provides external regulation, children are either unable to regulate, are forced to disconnect from their feelings, or use unhealthy coping skills.

The **Self-Regulation** domain targets three key building blocks:

- 1) Children are often unable to identify internal emotional experience, or to understand where these emotions come from. ARC works to support children in building a vocabulary for emotional experience, and in building connections among identified emotions and precipitating events, physiological states, behaviours, coping styles, and the impact of past experiences on current situations.
- 2) Children who have experienced trauma often live within bodies that feel overwhelmed or shut down, with few strategies to modulate arousal effectively. Intervention targets children's ability to tune into, tolerate, and sustain connection to internal states, and to identify and use strategies to manage their emotions.
- 3) Sharing emotional experience is a key aspect of human relationships; inability to effectively communicate affect prevents children from being able to form and maintain ongoing healthy attachments. Intervention works with children to identify safe emotional resources, and build skills to effectively communicate inner experience.

Competency

Children who experience chronic trauma within the context of their early caregiving system must invest their energy into survival, rather than in the development of age-appropriate competencies. As such, children may lag behind peers in a variety of developmental domains, or fail to develop a sense of confidence and efficacy in task performance.

ARC goes beyond the targeting of pathology, to support mastery of key developmental tasks. The **Competency** domain targets three (plus) building blocks:

- 1) Children who have experienced chronic trauma may have difficulty with problem-solving and other executive function tasks; often, they fail to feel a sense of personal agency, or the ability to have some impact on the world around them. Clinicians work actively with children to build an understanding of the link between actions and outcomes, and to increase capacity to consider, implement and evaluate effective choices.
- 2) A key developmental process is the growth of a sense of self. Trauma impacts self-concept through internalisation of negative self-concept, fragmentation of experience and lack of early exploration. Treatment targets the building of a sense of self as unique and positive; the building of coherence across experiences; and the development of future orientation.
- 3) Children may present for treatment with an array of impacts across developmental domains. ARC emphasises the importance of clinicians considering the array of developmental tasks crucial to healthy development, including but not limited to social skills, school connection and achievement, motor skills, community connection, and independent responsibility and autonomy. It is important to assess a child's developmental capacity within any given domain and target discrepancies between stage and age.

Preliminary data

An adapted implementation of the ARC framework in collaboration with a large special-needs adoption agency (Bethany Christian Services, Holland, MI), with a goal of decreasing failed/disrupted adoption placements, is now in its second year of implementation. Using key principles from the ARC framework, a multi-pronged intervention approach applicable to this population was developed, including individual and dyadic child/family treatment, child treatment groups, and parent education and support groups. Results of initial pilot data, which will be detailed in another publication (Blaustein *et al.*, in progress), indicate significant decrease in key targeted symptoms such as child posttraumatic stress symptoms and behavioural difficulties as well as caregiver distress, and significant increase in adaptive skills.

Conclusion

The goal of the ARC framework is to promote thoughtful, flexible approaches to clinical work with complexly traumatised youth and their families, which

draw from the theoretical and empirical knowledge base, while honouring the individual skill set of the practitioner. ARC-informed intervention does not focus on a single diagnostic category or symptom presentation. It recognises that the child is not simply a composite of their deficits but rather a whole being, with strengths, vulnerabilities, challenges and resources. ARC seeks to recognise the factors that derail normative development, and to work with children, their families and their systems to build or rebuild healthy developmental pathways.

References

- Blaustein, M., Kinniburgh, K., Carew, N., Peterson, M., Abbott, D., Spinazzola, J. (2006). Pilot evaluation of ARC treatment framework. Manuscript in preparation.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., deRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390–398.
- Edwards, V.J., Holden, G.W., Anda, R.F. & Felitti, V.J. (2003). Experiencing multiple forms of childhood maltreatment and adult mental health: Results from the Adverse Childhood Experiences (ACE) study. *American Journal of Psychiatry*, 160(8), 1453–60.
- Kinniburgh, K. & Blaustein, M. (2005). *Attachment, Self-Regulation and Competency (ARC): A treatment framework for intervention with complexly traumatized youth*. (Treatment manual available from the primary authors, The Trauma Center at JRI, 1269 Beacon Street, Brookline, MA 02446).
- Kinniburgh, K., Blaustein, M., Spinazzola, J. & van der Kolk, B. (2005). Attachment, Self-Regulation and Competency: A comprehensive framework for intervention with childhood complex trauma. *Psychiatric Annals*, 35(5), 424–430.
- Schore, A. (2001). Effects of a secure attachment on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22, 7–66.
- Shapiro, D. & Levendosky, A. (1999). Adolescent survivors of childhood sexual abuse: The mediating role of attachment style and coping in psychological and interpersonal functioning. *Child Abuse and Neglect*, 11, 1175–1191.
- Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, 148, 10–20.
- van der Kolk, B. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401–408.

An attachment-focused treatment for foster and adoptive families

Daniel A. Hughes

Children and youth exposed to intrafamilial abuse, neglect and loss are at risk of developing attachment disorganisation which, in turn, places them at risk for manifesting various symptoms of psychopathology, including oppositional-defiant behaviours, aggressiveness and dissociation, as well as anxiety and depression (Lyons-Ruth & Jacobvitz, 1999). These children often manifest a pervasive need to control the people and events of their daily life, as well as to avoid any area of frustration and distress. The foster carers and adoptive parents who are committed to raising these children and youth are often uncertain about how best to raise them. Their confusing and conflicting behaviours frequently elicit uncertain or reactive responses from those responsible for their care. Unresolved attachment themes from the caregivers' own histories make it even more difficult to interact with these children in ways that will facilitate attachment security (Dozier *et al.* 2001).

Attachment theory provides an excellent guide for developing interventions that facilitate attachment security for these children who have seldom felt safe, who have difficulty relying on their foster and adoptive parents, and whose patterns of avoidance and control make traditional treatment and parenting interventions less likely to be effective.

From the safety provided by a secure attachment, the child can become engaged in the exploration of his world. His primary way of learning about self and other, events and objects, is through the meaning that is provided by his parents. If his parents experience him as being lovable, enjoyable, interesting, and delightful, he experiences himself as having those qualities. In a similar manner, the meaning of his parents as well as the objects and events of his daily life is formed by the initiatives and responses of his parents. This process is known as intersubjectivity and it is the primary means whereby young children come to organise their experiences and integrate them into their narratives (Trevarthen, 2001). When children are exposed to abuse and neglect these intersubjective experiences are sparse and overwhelmingly negative. The child experiences the emerging sense of 'self' as being shameful. He begins to show little initiative to learn more about self since he assumes that he is 'bad' and 'unlovable'. In a similar manner, he does not attempt to learn about his parents' thoughts and feelings since his initial experiences are that they dislike him and may intend to hurt him. His inner life – his organisation of experience

This paper was initially published in *Service and Practice Update*, 4(4), 26–28, December 2005.

– remains poorly developed, fragmented and hidden in shame. Children who demonstrate features of attachment disorganisation in their behaviour show a parallel disorganisation of their inner experiences due to a lack of varied and welcoming intersubjective experiences with their parents.

Dyadic Developmental Psychotherapy (DDP) is a treatment modality that is based upon principles of attachment and intersubjectivity theories (Hughes, 2004). It has been developed over the past 15 years through the treatment of many abused and neglected foster and adopted children, and more recently in the general family treatment. An initial study of its effectiveness has recently been published (Becker-Weidman, 2006a, 2006b).

Becker-Weidman compared the results of treatment for 34 Ss who were receiving DDP with 30 Ss who were receiving traditional treatment that was being provided in the community at the time (primarily CBT, play therapy, and/or in-home services). All were foster or adoptive children. At the onset of treatment there were no significant differences between the treatment and control groups on the Child Behavior Check List (CBCL). One year after treatment stopped those in the DDP treatment group had made significant improvements on seven CBCL syndromes representing problems of externalisation and internatisation (2006a) and the control group demonstrated no significant improvement on any CBCL scale. Four years after treatment stopped those in the DDP group continued to manifest significant improvements on the same seven syndromes, whereas those in the control group were actually significantly worse on four syndromes and showed no improvement on the others. (2006b).

The following represents central features of DDP:

1. Treatment is family-centred whenever possible. Central treatment goals involve facilitating attachment security between the child and his parents or carers through the here-and-now process of therapy, including varied intersubjective experiences during which the parents discover and respond to positive qualities in the child while experiencing themselves as capable parents who can have a positive impact on their child. The therapist facilitates this intersubjective process through discovering these qualities in the child and enabling the parents to experience them. The therapist, in a similar manner, discovers positive traits in the parents, which enables them to become engaged with more confidence and which enables their children to see their positive intentions and affect that they hold for their child. The therapist is a source of both safety and intersubjective discovery for both parent and child. At various times during the sessions the focus is

on conflict-resolution, providing comfort for past traumas and recent stress, having joint experiences of joy and pride as well as reflecting on their joint activities. Throughout the therapist is a mentor and coach for all members of the family.

Any related difficulties from the carer's attachment history are addressed, often in sessions where the child is not present.

2. The therapist maintains a general treatment stance – or attitude – that is similar to that of the parent toward her child during moments of intersubjectivity. The attitude involves playfulness, acceptance, curiosity and empathy. Playfulness encourages experiences of reciprocal enjoyment while focusing on interests and successes. It serves to give the family a break from the difficult issues that are also being addressed and it facilitates the child's ability to experience and regulate positive affective states. Acceptance creates psychological safety by conveying that while behaviours may be evaluated, the child himself is not. The experience of the child – his perceptions, thoughts, feelings and intentions – are always accepted, though the behaviour that evolves from these experiences may not be. Curiosity is continuously being directed toward the experiences of the family members. The child's experience tends to be negative and fragmented. By directing non-judgmental curiosity toward the experience, the child is likely to become open to the intersubjective experience of self, other and events, and co-create new meanings that are more able to become integrated into the narrative. Empathy is being directed toward the experiences that are being co-created as they emerge in order to enable the affect to be co-regulated. With empathy, the child is able to experience both the therapist and parents as being with him as he explores past experiences of trauma and shame.
3. During treatment the therapist follows the child's lead when possible and takes the lead herself when necessary to address themes that the child works to compulsively avoid. The therapist sets a pace in this process that respects the child's anxiety and shame, reducing the intensity and focus as necessary to enable the child to remain engaged in the process. The child is not confronted about his behaviours if confrontation implies anger and judgment about his motives. Rather, difficulties in his functioning are addressed with empathy, while accepting the child's distress over the exploration and enabling him to remain engaged in the process. Whenever there are breaks in the intersubjective process, these breaks are repaired before new themes are addressed.

4. Treatment primarily focuses on providing intersubjective experiences, which are characterised by joint affect, attention, and intentions. In doing so, the emerging conversations are characterised by heightened nonverbal communication conveying matched vitality affect. This enables the family members to 'feel felt' and ensures that emerging affect is being co-regulated. The meanings of the dialogues which emerge are carried both nonverbally and verbally. All verbal expressions are made within the context of acceptance, curiosity, playfulness and/or empathy.
5. Being intersubjective, the treatments sessions have an impact on the family members and also the therapist. The therapist does not maintain a detached, neutral stance but rather becomes affectively and reflectively engaged with each family member and with the family as a whole. As the family members experience the impact that they are having on the therapist, their sense of self-efficacy is enhanced. They have more confidence in their abilities to be engaged in meaningful, reciprocal relationships with the other members of the family.
6. Treatment goals involve the development and integration of both affective and reflective abilities. These two central aspects of experience are both engaged, deepen and become more comprehensive and coherent as they permeate the narrative of each one in the family.
7. Parenting recommendations are congruent with the moment-to-moment process of therapy. Parents are encouraged to manifest the same playful, accepting, curious and empathic attitude that is characteristic of treatment. Parents are given specific suggestions for interventions that are consistent with the treatment gains. The core parenting interventions involve providing safety, structure, supervision and success. Interventions are not punitive, nor are they based on the primacy of obedience.

DDP is a model of treatment that is consistent with theories of attachment and intersubjectivity. It does not involve any use of coercive holding, dysregulating confrontations or emphasis on obedience. It contains many features of more traditional relationship-based treatments that have been present for decades and which are considered to be empirically sound (Kirschenbaum & Jourdan, 2005). Attachment security and intersubjective experiences are core features of stable family relationship and their development are crucial if abused and neglected children and youth are to be able to begin a new life within their new families. Through facilitating these experiences and strengthening the functioning of the family the therapist will be able to encourage attachment security for the child and enable him to pursue his optimal development.

References

- Becker-Weidman, A. (2006a). Treatment for children with trauma-attachment disorders: Dyadic Developmental Psychotherapy. *Child and Adolescent Social Work Journal*, 23, 2 April, 147–171.
- Becker-Weidman, A. (2006b). Dyadic Developmental Psychotherapy: a multi-year follow-up. In S.M. Sturt (Ed.) *New Developments in Child Abuse Research*. Nova Science Publishers.
- Dozier, M., Stovall, K.C., Albus, K.E. & Bates, B. (2001). Attachment for infants in foster care: the role of caregiver state of mind. *Child Development*, 72, 1467–1477.
- Hughes, D. (2004). An attachment-based treatment of maltreated children and young people. *Attachment & Human Development*, 6, 263–278.
- Kirschenbaum, H. & Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, training*, 42, 37–51.
- Lyons-Ruth, K. & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. Shaver (Eds.) *Handbook of Attachment*. New York: Guilford Press.
- Trevarthen, C. (2001). Intrinsic motives for companionship in understanding: Their origin, development, and significance for infant mental health. *Infant Mental Health Journal*, 22, 95–131.

Family attachment narrative therapy

Joanne C. May and Todd Nichols

The experience of maltreatment by an attachment figure seems to prevent many children from trusting adults who could provide care and protection. Based on attachment theory and research, soothing, gentle, non-provocative, non-intrusive narratives, told by parents, promote an attuned attachment relationship and provide an alternative restorative experience designed to shift and change the child's destructive internal working model.

Background

Family Attachment Narrative Therapy was introduced in 1995 in response to the needs of behaviourally disturbed children and their adoptive parents. Many of the children displayed attitudes and behaviour that made them very difficult to parent. Most had experienced neglect, abuse and abandonment by their original families. Some had spent months or years living in a crowded, understaffed orphanage. Even though they were now living with loving, responsible parents, these children seemed to be prisoners of their maladaptive history. If all things were possible, we would have wanted families to go back and start over. In reality, we could not erase the child's early history of maltreatment. We could, however, encourage an alternative mind set by including narratives or stories told by parents. We hypothesised that narratives could be the experience that would shift the child's negative, self destructive, internal working model. Subsequent research supported our hypothesis that the experience of narrative is fundamentally the same as being in or observing the real event (Zwaan, 1999; Zwaan & Radvansky, 1998).

Theoretical foundation

Central to our theoretical foundation is John Bowlby's attachment theory and his concept of an internal working model. Bowlby posited that the child's attachment to a primary caregiver is an innate, biologically driven condition necessary for survival and that this first important connection serves as a basis the child will use to evaluate self, the environment and all future relationships (Bowlby, 1982; 1973; 1980). When the child's early experience includes maltreatment by a primary attachment figure, this is the model the child uses to form preconceptions, interpretive tendencies and behavioral biases (Sroufe *et al.*, 1999). Fortified by associated expectations, beliefs and attitudes, maladaptive relationship patterns tend to be internalised and predictive of the way affection is received and expressed in future relationships (Carlson & Sroufe, 1995).

The use of parent narratives in healing and shifting the child's negative internal working model is also theoretically supported. The ability to use narratives or stories to describe an experience, contemplate a scenario and plan for the future is a unique quality of the human race. It is through stories that children learn family rules and expectations. As the child develops the capacity to use words to describe an experience or share thoughts and feeling with the parent, a common perspective is shared and internalised. This is the perspective that is then told in story form with others and with self. When this process does not take place, behaviour seems to be imitative, instinctive and impulsive (Charon, 1985).

Children with secure attachment relationships tend to tell stories in which the protagonist struggles but then finds a solution that leads to a successful outcome (Solomon *et al.*, 1995). These coherent narratives include the factual content of the story line and the subjective, social and emotional meaning of the internal life of the characters (Siegel, 1999). In contrast, children exposed to attachment disruption and family violence typically tell incoherent, terrifying stories of violence and death without a comforting solution (Main *et al.*, 1985). Fonagy *et al.* (1991) hypothesises that some victims of childhood maltreatment cope by refusing to think about the internal thoughts of the parent because they fear the parent's destructive intent toward them. This disruption of the child's ability to decipher mental states in themselves and others leaves them responding to an inaccurate impression of the thoughts and feelings of others.

Family attachment therapy model of therapy

Parent narratives not only provide a model of congruence, they also communicate a message of availability, responsiveness, care and protection. Narratives make explicit the welcoming parental thoughts and feelings that would have occurred had this child and parent started out together. In addition, narratives demonstrate the parent's intuitive understanding of the child's fearful emotions and motivations.

This model posits that the parent possesses an innate need and ability to provide care and protection that can be activated in the form of narratives that verbally attune to the child's internal state and explicitly challenge the preconceptions, beliefs and attitudes that comprise the self destructive, motivating internal working model. This supposition is supported by the theory and research of George and Solomon (1999). Their work concentrates on the role of the caregiver in attachment theory. Just as the child seeks proximity to be cared for and protected by the parent (Bowlby, 1982; 1973; 1980), the parent is biologically driven to provide care and protection. Similarly, as the infant is physiologically comforted when the parent is available and responsive,

the parent experiences strong emotions of satisfaction and pleasure when she is able to effectively attend to her child's needs. Consistent with our clinical observation, George and Solomon (1999) also note that the parent's intellectual, behavioural or adjustment problems do not present a barrier to the caregiver's intuitive understanding of the child's need for care and protection.

Activating the attachment system

Family Attachment Narrative Therapy is unique because it is the parent that accomplishes the therapeutic work with the child. Rather than assuming the role of expert, the task of the therapist is to facilitate the parent's innate ability to attune to their child's internal process. This means the therapist elevates the parent to the status of expert in identifying the components of their child's internal working model.

This process begins as the therapist employs an affirming, inquiring, questioning method of eliciting the parent's intuitive knowledge of the child's motivating thoughts and emotions. Rather than focusing on strategies to control the child's problem behaviour, the therapist asks questions such as: What kind of behaviour does your child exhibit? How does your child relate to you? Is your child as emotionally mature as other children you know? How does your child relate to pets? Does your child like to be in control? The questions asked during this phase do not judge, nor does the therapist attempt to offer solutions. Instead, the therapist communicates an empathic understanding of the parent's frustration and anger. The therapist next asks for as many details as the parent knows about the child's history. When the factual information is sparse, the therapist might say something such as, In your mother's (father's) heart, what do you think your child experienced? This process focuses attention away from the present problem behaviour to an intuitive realization of the enormity of the child's experience of maltreatment. Activation continues as the parent is asked to imagine what their child would have been like had they started out together. This series of questions almost always results in the parent embracing and accepting the child's innate personality or temperament traits in a way that enhances positive individual aspects of the child's character. Finally, the parent is asked a series of questions such as: What do you think your child was feeling and thinking when he was neglected, abused and abandoned? What conclusions do you think your child formed about self and others because of the experience of maltreatment? What do you think your child is feeling and thinking when he is oppositional and finds it impossible to comply with the simplest request? What is your child feeling and thinking when she always has to be in control? This interactive questioning phase moves the parent from anger and despair to an empathic understanding of their child's

thoughts, feelings and behaviour. As the therapist asks for information that only the parent knows, the relationship between parent and therapist becomes a partnership in which the parent is the expert on their own child and the therapist provides expertise on children in general. Sessions now have a brainstorming character as together, the therapist and parent concentrate on the child's internal working model rather than the presenting problem behaviour.

The parent as the family attachment narrative therapist

Although the parent does receive information and examples that are illustrative of each narrative type listed below, the stories they tell are not scripted by the therapist. Frequently, neither the therapist nor the parent knows the exact content prior to the telling of a narrative. Most parents simply speak from the heart, although occasionally a parent will write out what they want to communicate.

Claiming narratives

The first narrative that parents tell has been termed a Claiming Narrative. This first person narrative communicates the message that the child deserves to be wanted, celebrated, cherished, loved and cared for by parents who can provide care and safety. The narrative explicitly describes the parent's positive emotions and intentions toward the child thus challenging the child's negative, self-defeating belief. Not only is the child the recipient of the parent's nurturing message of acceptance, the parent is able to visualise a helpless baby in need of care and protection. This narrative does not attempt to change the child's actual history. Instead, it encourages an alternative, positive way of viewing self and others.

Developmental narratives

These narratives continue the nurturing, attunement-building message of the Claiming Narratives. They also have an educational feature as they inform the child about typical, age related behaviour that is common and accepted for each stage of development. This component often seems to encourage the child to evaluate and change so that behaviour is more congruent with chronological age. The first person stories that are common for Claiming and Developmental Narratives provide an opportunity to educate the child on the thoughts and feelings of the parent thus enhancing the child's ability to accurately determine the parent's motivating internal process.

Trauma narratives

Whereas Claiming and Developmental Narratives are designed to enhance attachment to the present parents, Trauma Narratives concentrate on healing

the child's actual history of maltreatment. The narrative now becomes a third person story in which a protagonist has life experiences that resonate with the child's traumatic memories. Because it is a third person story, it does not have to be factually accurate. It does, however, allow the parent to use the protagonist to demonstrate their intuitive understanding of the child's perception, emotions, memories and intentions.

Successful child narratives

These third person narratives are usually instructive and use a protagonist to help the child navigate problems of daily living. These narratives often provide the child with a role model who introduces new ways of thinking and responding to real life challenges.

The evidence base for Family Attachment Narrative Therapy is being developed. One case study has been published in a peer-reviewed journal (May, 2005). Preliminary outcomes research indicates significant improvement in several measures of behaviour and social development (Nichols and Yenkosky, 2004). Additional effectiveness research is underway.

Since first introduced as a family therapy modality, Family Attachment Narrative Therapy has been refined, expanded and adapted to work with adolescents and children living with biological parents (Nichols, Lacher & May, 2002; Lacher, Nichols & May, 2005). Specific elements have also been used to work with children and adolescents living in group and residential treatment facilities. It is a therapy that is deceptively simple and profoundly complex and can be used by all parents who long for that attuned, intimate connection with their child.

References

- Bowlby, J. (1982). *Attachment and loss, Vol. 1: Attachment*. New York: Basic Books. (Original work published 1969.)
- Bowlby, J. (1973). *Attachment and loss, Vol. 2: Separation*. New York: Basic Books.
- Bowlby, J. (1980). *Attachment and loss, Vol. 3: Loss*. New York: Basic Books.
- Carlson, E.A. & Sroufe, L.A. (1995) The contribution of attachment theory to developmental psychopathology. In D. Cicchetti & D. Cohen (Eds.) *Developmental processes and psychopathology: Vol. 1. Theoretical perspectives and methodological approaches* (pp. 581–617). New York: Cambridge University.
- Charon, J.M. (1985). *Symbolic Interactionism: An introduction, interpretation, and integration*. Englewood Cliffs, NJ: Prentice Hall.
- George, C. & Solomon, J. (1999). Attachment and caregiving: The caregiving behavioral system. In J. Cassidy & P. Shaver (Eds.) *Handbook of attachment: Theory, research and clinical applications* (pp. 649–670). New York: Guilford Press.
- Fonagy, P., Steel, M., Moran, G., Steel, H. & Higgitt, A.C. (1991). The capacity for understanding mental States: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, 13, 200–216.

- Lacher, D., Nichols, T. & May, J. (2005). *Connecting with kids through stories: Using narratives to facilitate attachment in adopted children*. London: Jessica Kingsley.
- May, J.C. (2005). Family Attachment Narrative Therapy: Healing the experience of early childhood maltreatment. *Journal of Marital and Family Therapy*, 31(3), 221–237.
- Main, M., Kaplan, N. & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.) *Growing points of attachment theory and research. Monographs of the Society for Research in Child Development*, 50 (2–3, Serial No. 209), 66–104.
- Nichols, M., Lacher, D. & May, J. (2002). *Parenting with stories: Creating a foundation of attachment for parenting your child*. Deephaven, MN: Family Attachment Center.
- Nichols, T. & Yenkosky, J. (2004). *Using Narratives Told by Parents to Improve Behavior in Older Adopted Children with Preplacement Trauma Histories*. Unpublished manuscript.
- Siegel, D.J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford.
- Solomon, J., George, C. & DeJong, A. (1995). Children classified as controlling at age six: Evidence of disorganized representational strategies and aggression at home and school. *Development and Psychopathology*, 7, 447–464.
- Sroufe, L.A., Carlson, E.A., Levy, A.K. & Egeland, B. (1999). Implications of attachment theory for Developmental psychopathology. *Developmental Psychology*, 11, 1–13.
- Zwaan, R.A. (1990). Situation models: the mental leap into imagined worlds. *Current Directions in Psychological Science*, 8, 15–18.
- Zwaan, R.A. & Radvansky, G.A. (1998). Situation models in language comprehension and memory. *Psychological Bulletin*, 123, 162–185.

Emotionally focused family therapy

Gail Palmer

Emotionally Focused Family Therapy (EFFT) is a model of family therapy based on attachment theory. EFFT privileges the attachment relationships that form the family union and focuses interventions on repairing and strengthening the attachment bonds between family members. As such EFFT works with the family system from the inside out; building safe and secure relationships between family members that then lead to a cohesive and connected family unit. It is assumed by the EFFT therapist that secure attachment relationships in a family will allow for effective problem-solving, a flexible well-functioning system and a responsive resource for all family members.

Attachment theory postulates that infants are born to strive to be attached to a caregiver in order to ensure survival and growth. They demonstrate proximity-seeking behaviours including smiling and clinging to which caregivers respond through holding and soothing behaviours. This results in the development of trust and a secure attachment. Families are the primary resource for meeting the human need for attachment (Bowlby, 1988). The attachment bond between parent and child is a reciprocal ongoing relationship that is evolved and created over time and has a deep impact on every aspect of life (Levy & Orlans, 2000). Secure attachment is characterised by a pattern of seeking and maintaining closeness to a family member and the confidence that the significant other will be emotionally responsive and accessible, particularly when the need for support and comfort is high (Ainsworth, 1973; Bowlby, 1969). Generally, if there is a consistent pattern of responsiveness over time the family will become a secure base for the child, which allows the child to explore and develop in the outside world. Consequently the absence of secure attachment provides considerable distress, particularly for developing children, and accounts for increased vulnerability to emotional, relational, social, behavioural and physical problems.

Attachment theory provides the frame for understanding family members' emotional experiences. Research has shown that there is a tendency among families that are securely attached to be organised, flexible and cohesive (Cobb, 1996) whereas insecure attachments between family members have been associated with symptoms amongst adolescent children (Allen & Land, 1999). Emotional experiences play a large part in shaping the interactions between family members (Johnson, 1998). EFFT focuses on the emotional expression of attachment needs and works with a family to create positive and bonding interactions between family members.

One study of EFFT with eating disordered adolescents and their families (Johnson, Maddeauz & Blouin, 1998) yielded promising results following 10 sessions of EFFT, with a significant reduction of symptoms, including bingeing and vomiting and also depression and hostility. EFFT is routinely utilised with depressed and suicidal adolescents (Johnson & Lee, 2000) and with emotionally disturbed children and their families (Palmer & Efron, 2005).

Basic goals and theoretical points

Families present in therapy with conflicts and problems that are comprised of negative interactional patterns. These patterns are both symptomatic and reinforcing of unmet attachment needs. The goal for EFFT is to modify the negative interactions to increase the accessibility and responsiveness of family members and create a secure family base for children to grow and leave from. The therapist begins by framing the family problem in attachment terms and normalises the family conflict as arising out of an attachment crisis. For example, a defiant and withdrawn adolescent with critical and intrusive parents can be seen as a family struggling with a difficult transition in the family life cycle: the emerging independence of the adolescent, the new and uncertain role for the parents and the new stage for the family, struggling with how to stay connected. Instead of the child or the parents being seen as the problem, the therapist frames the negative interactions that have developed as a result of this struggle as being the problem, and helps the family to identify the cycle as creating the distress within the family. The therapist then works to help create positive interactions that will promote attachment security and define the family as a safe haven.

EFFT stages and interventions

Stage 1: Assessment and de-escalation:

During the assessment phase, the EFFT therapist sees the whole family and works with them to identify the negative interactional cycle that is creating the family distress and maintaining the attachment insecurity. In this phase, it is vital that the therapist builds a therapeutic alliance with each family member and begins to understand how each person experiences his or her place in the family system. In the first contact, the therapist is gathering a family story; how has this family developed and reached this stage in their family life cycle. The problem that brought the family to therapy is identified and how each family member views the problem is elicited. Family strengths are also identified and the ways in which family members are close and connected to one another are highlighted and heightened. In the beginning sessions, the therapist is privileging attachment in the way questions are asked and how the story of the family is constructed. The therapist tracks the interactional cycle around closeness/distance and the question of how does this family connect and

disconnect is the continual theme. Consequently parents looking for help in parenting their children are not engaged in parental education but rather in creating a more securely attached framework within their family so that they are better able to solve their parenting issues.

The goal for the assessment phase is to reframe the problem in terms of the negative interactional cycle and to begin to identify the underlying unmet attachment needs. The effect of reframing the problem as the negative cycle and not the child or the parent is to de-escalate the conflict and to motivate the family with the goal of increased closeness and connection. Most children and parents come to therapy feeling guilty and feeling like they have failed as a family, which may be demonstrated in angry or acting-out behaviours. Reframing the problem as being the negative cycle helps provide hope and encouragement to the family and helps to soften the conflict.

The negative cycle is tracked to include the interactional responses and positions of each family member. Who is withdrawing and who is pursuing is identified and how each member plays out the family drama is explored. For example, in a family that recently presented for therapy with four children, there was one adolescent boy who was the identified client and the primary negative cycle evolved around his interaction with his parents and his siblings. The father tended to be controlling and harsh with his son while the mother alternated between being critical, intrusive and over-protective. The parents were in the positions of pursuers as they were continually attempting to make contact with their son in a forceful and negative manner; as the father stated, 'it takes a hammer to get his attention'. The young man would back away from and avoid contact with his parents, exhibiting sullen and defiant behaviour; responding to the therapist's initial inquiries with silence or 'I don't know'. The remaining children also played a role by either withdrawing themselves – the oldest sibling did not show up for the first appointment – or escalating further the conflict by negatively engaging the identified client, as did the youngest sister. By the end of the assessment phase, the therapist will have a sense of which are the key relationships where attachment needs are most problematic and the emotional responses that are triggering the negative interactional patterns. This provides the focus for the working through the sessions.

Stage 2: Restructuring interaction

The middle phase of therapy is comprised of dyadic sessions, including identified child and parent, parental subsystem and sibling subsystem. This format allows for the attachment needs of each family relationship to be addressed directly and to focus on increased emotional responsiveness within the relationship. Focusing on each attachment relationship in the family

communicates the importance and vital nature of these relationships and provides the necessary space for open expression of attachment emotions between each family member. Seeing one parent with an identified child allows for this relationship to grow and change and avoids triangulating either child or parent. Changes made within this dyad are then transmitted into the triad, specifically both parents and the identified child. Intervening with the subsystems in the family also allows for the mobilising of emotional resources within subsystems, for example between parents or between siblings, and builds on the strengths and supports available in these groupings. For example, in the family of four the parents needed help in joining and supporting each other in their parenting in order to decrease the reactivity between them and their son.

The goal of this phase is to help family members identify and express their attachment emotions directly so that they are more central to the family's awareness and become part of the family's dialogue. The EFFT therapist seeds secure attachment by working through the following steps within each dyad:

- accessing the underlying feelings and attachment needs;
- reframing the problem in terms of the unmet attachment needs;
- promoting the acceptance of the others' emotional experience; and
- facilitating the expression of attachment needs and creating new interactional responses.

During this stage, attachment emotions and accompanying fears are accessed and explored. The EFFT therapist uses validation, normalisation and empathic reflection to begin to focus on the underlying attachment emotions and expands and deepens these through the use of empathic conjecture and heightening. The therapist begins to access more adaptive responses through exploration, inference and seeding secure attachment. The EFFT therapist holds the map for the family to be defined as a secure base by envisioning relationships that are supportive, comforting, nurturing and safe and identifies and promotes emotional responses and behaviours that create this safe haven. For example, the adolescent boy was framed as wanting and needing to continue to count and depend on his parents for support and he was helped to express his fear of their rejection and judgement of him: 'I am so afraid you just see me as a loser.' His parents also expressed their fear and uncertainty about how to parent their son and how to stay connected to him while still providing the direction and guidance he needed. The therapist began by having the parents begin to identify their underlying emotions and expressing

their fears about their role as parent, their own sadness around not being connected to their son. This then moved to work with the son in identifying his underlying fears around rejection, unlovability, failure and his continuing attachment needs for his parents. By unlocking the negative cycle of criticise/defend and helping the son and the parents talk more directly about their needs in this relationship, the expression of positive affect and increased collaboration and problem solving was able to occur between the adolescent and parents. The son was then able to work openly with his parents on establishing a plan for retribution around an acting-out incident and establish a course for future behaviour.

The therapist helps create new interactions within session by enactment exercises, facilitating the direct expression of attachment emotions to one another. Homework tasks are also given to create new experiences for family members between family sessions. For example, the defiant son and the hostile father, once deescalated from their negative interactional cycle, were encouraged to go skiing together, an activity they both enjoyed, which allowed them to stay in contact with one another in a positive way.

Stage 3: Consolidation

The final stage of therapy is consolidation where the EFFT therapist works to nurture and maintain secure bonding through intimate exchanges and family rituals. The therapist heightens and validates the family's strengths and reinforces family rituals that promote and encourage family connection and emotional support. The entire family is often seen at this stage to consolidate the changes and reinforce the rituals. For example, the family with four children established routines such as family dinners and rituals like Friday night movie night that promoted the goodwill between members and the accessibility of each family member. Generally the end of EFFT is characterised by a secure and cohesive family system.

EFFT is a model of family therapy that is informed by attachment theory and intervenes on the powerful attachment emotions that organise the family dance (Johnson, 2006). The creation of a secure base for family members results in parents who are accessible and attuned to the attachment needs of their children and are able to be there for them when they are needed. As a result, children are able to feel protected and safe and are also able to venture out in the world with a sense of confidence in a developmentally appropriate way.

References

- Ainsworth, M.D.S. (1973). The development of infant-mother attachment. In B.M. Caldwell & H.N. Ricciuti (Eds.), *Review of child development research, vol 3* (pp. 1–94). Chicago: University of Chicago Press.
- Allen, J.P. & Land, D. (1999). Attachment in adolescence. In J. Cassidy & P.R. Shaver (Eds.) *Handbook of attachment: Theory, research and clinical applications* (pp. 319–335). New York: Guildford Press.
- Bowlby, J. (1969). *Attachment and loss. Vol. 1: Attachment*. New York: Basic Books.
- Bowlby, J. (1988). *A secure base*. New York: Basic Books.
- Cobb, R. & Bartholomew, K. (1996). *Attachment representations, childhood rejection and loneliness*. Paper presented at the International Conference on Personal Relationships, Banff, Canada.
- Johnson, S.M. (1998). Emotionally focused interventions: Using the power of emotion. In F. Dattilio (Ed.) *Case studies in couple and family therapy: Systemic and cognitive perspectives* (pp. 450–472). New York: Guildford Press.
- Wooley, S. & Johnson, S.M. (2006). Emotionally focused interventions. In J. Lebow (Ed.) *Handbook of clinical family therapy* (pp. 384–405). New York City, New York: Wiley.
- Johnson, S., Maddeux C. & Blouin J. (1998). Emotionally focused family therapy for bulimia: Changing attachment patterns. *Psychotherapy: Theory, Research & Practice, 35*, 238–247.
- Johnson, S. & Lee, A. (2000). Emotionally focused family therapy: Children in therapy. In E. Bailey (Ed.) *Working with children in family therapy* (pp. 112–116). New York: Guildford Press.
- Levy, T. & Orlans, M. (2000). Attachment disorder as an antecedent to violence and antisocial pattern in children. In T.M. Levy (Ed.) *Attachment interventions* (pp. 1–25). London: Academic Press.
- Palmer, G. & Efron, D. (in press). Emotionally focused family therapy. In L. Vande Creek and J.B. Allen (Eds.) *Innovations in clinical practice: Focus on group, couples and family therapy*. Florida: Professional Resource Press.

Section 4.

Providing a group as a secure base for carers and parents to explore parenting.

Developing specialised parenting interventions for foster carers and adoptive parents

Kim S. Golding

Foster carers and adoptive parents are caring for children who have been separated from their birth families for a variety of reasons. This often follows a period of inadequate parenting and time spent in short-term placements within the care system. A significant number of these children have a difficult time adjusting to a new family, influenced by their previous experience. This makes the task of parenting the children more complex than the task of parenting birth children. The children can be behaviourally challenging, underpinned by emotional and relationship difficulties, and foster carers and adoptive parents need a high level of parenting skill tailored to the special needs of the children they are caring for. A study of the parenting skills of foster carers during the first year of placement highlights the difficult parenting task they have volunteered for (Quinton *et al.*, 1998). This study found that 60 per cent of carers were experiencing at least some difficulty with their parenting role. The ability to tolerate and manage the difficult behaviour presented by the children was influenced by the quality of the relationship the carer had formed with the child. The study highlights the importance of support for carers to develop their parenting role. This needs to pay attention to the development of a relationship as well as to the management of behaviour.

In addition many children living within foster or adoptive homes have experienced some degree of developmental trauma as a consequence of being exposed to inappropriate and frightening parenting early in life. Substitute parenting of these children therefore is even further away from typical parenting. Parents also need to help the children to recover from this early experience. For example, Kinniburgh *et al.* (2005) suggest that the provision of a safe environment and healthy attachments between the child and carer are prerequisite for healthy recovery.

Attachment theory provides a framework for understanding how children learn about and develop relationships. The initial attachment relationships, within which children experience security and care, provide children with confidence in their care-eliciting ability and promote their exploration and learning in the

world. Stern (1985) talks about a relationship dance in which the child signals attachment needs and parents respond in an attuned and sensitive way leading to a secure attachment.

For many of the children living in foster care and with adoptive families, their experience of the attachment dance has been very different, leading to the development of a range of strategies to ensure they feel safe. In substitute families the child is often dancing very different steps to those the carer or parent expects. Thus the child both signals and hides different attachment needs in response to past experience.

A study of infants placed with foster carers after they were 10 months old demonstrated how typical it is for the carers to be pulled into the dance of the children, responding to their behaviour in a complementary way. For example if the infant displayed avoidant behaviours the carer tended to remain distant, avoiding contact with the child. When the child displayed more ambivalent-resistant behaviours the foster carers tended to be frustrated or irritated because of their inability to comfort the child. The parenting they received therefore perpetuated the child's early models of relationship (Stovall & Dozier, 2000; Dozier *et al.*, this paper). These authors suggest that the task of the substitute parent is to respond to both the expressed and hidden needs of the child, challenging the internal working model of parenting the child has developed. In effect the carer has to lead the child into a new dance within which s/he can express his or her needs openly and respond to sensitive parenting. The carer or parent has to be both available and responsive to the child whilst also gently challenging of the child's beliefs about families and thus the way s/he organises his or her behaviour around these beliefs.

The Stovall and Dozier study (2000) further revealed that the attachment state of mind of the foster carer was important for the ultimate security of the foster child. Thus carers with autonomous states of mind cared for children demonstrating more secure behaviour than those with carers with non-autonomous states of mind. It seems that there is a further complexity to the dance of carer or adoptive parent and child. The behaviour of the children may trigger unresolved issues from the carers' own parenting history. This in turn can further impact on the child as the dance becomes increasingly disjointed. This research therefore suggests that parenting a foster or adoptive child who has experienced disrupted and difficult early attachment relationships is complex.

The Adoption and Attachment study (Hodges *et al.*, 2003) aims to track the way attachment representations in internal working models change over time for

adopted children This research suggests that the negative view of self that children learn early in life is the most difficult to change. Even after a year or two of living in a different family the child will continue to hold negative predictions about parents and family, although they may also now have positive predictions as well. Thus the child may hold conflicting models about how families work. They may know that parents hurt children, but they now also know that parents love and take care of children.

Support services for foster carers and adoptive parents need to find the most effective and helpful ways of providing support to the parents and carers whilst improving their skill at both managing the behaviour and enhancing the development of the children. This support needs to be mindful of research exploring the parenting of substitute carers and the difficulty children have in changing their internal working models. Attention to the attachment needs of the children and a focus on relationship development will be important. Interventions currently used to support carers and adoptive parents include training (Minnis & Devine, 2001), consultation (e.g. Golding, 2004) and dyadic psychotherapy (Hughes, 2004 and this paper). It is likely that some level of parenting work will be provided within these.

Parent training is widely seen as a successful intervention for helping parents who are caring for children with behaviour problems. (National Institute for Clinical Excellence, 2006). Parenting interventions with foster and adoptive parents, however, need to go beyond the social learning theory focus of many available programmes (Howe, 2005). It is for this reason that some practitioners and researchers are adapting traditional programmes (Henderson & Sargent, 2005). Attachment Theory has additionally provided the impetus for the development of completely new parenting programmes aimed specifically at helping foster carers and adoptive parents caring for children with difficulties in attachment. The Attachment and Biobehavioural Catch-up Programme developed for foster carers looking after infants and toddlers in the USA was described earlier (Dozier *et al.*, this publication). In addition two parenting programmes have been developed within the UK specifically aimed at helping foster carers and adoptive parents with children of all ages. These programmes are described next.

References

- Golding, K.S. (2004). Providing Specialist Psychological Support to Foster Carers: A Consultation Model. *Child and Adolescent Mental Health*, 9(2), 71–76.
- Henderson, K. & Sargent, N. (2005). Developing the Incredible Years Webster-Stratton parenting skills training programme for use with adoptive families. *Adoption & Fostering*, 29(4), 34–44.
- Hodges, J., Steele, M., Hillman, S., Henderson, K. & Kaniuk, J. (2003). Changes in attachment representations over the first year of adoptive placement: Narratives of maltreated children. *Journal of Clinical Child Psychology and Psychiatry*, 8, 3 July 2003, 351–367.
- Howe, D. (2005). *Child abuse and neglect. Attachment, development and intervention*. Basingstoke, Hampshire: Palgrave, MacMillan.
- Hughes, D.A. (2004) An attachment-based treatment of maltreated children and young people. *Attachment & Human Development*, 6(3), 263–278.
- Kinniburgh, K.J., Blaustein, M., Spinazzola, J. & van der Kolk, B. (2005). Attachment, self-regulation and competency. A comprehensive intervention framework for children with complex trauma. *Psychiatric Annals*, 35(5), 424–430.
- Minnis, H. & Devine, C. (2001). The effect of foster carer training on the emotional and behavioural functioning of looked after children. *Adoption and Fostering*, 25(1), 44–54.
- National Institute for Health and Clinical Excellence (2006). *Review of Parent-training and education programmes in the management of children with conduct disorders*. NICE/Social Care Institute for Excellence (SCIE).
- Quinton, D., Rushton, A., Dance, C. & Mayes, D. (1998). *Joining new families: A study of adoption and fostering in middle childhood*. Chichester: Wiley.
- Stern D.N. (1985) *The interpersonal world of the infant*. NY: Basic Books.
- Stovall, K.C., & Dozier, M. (2000). The development of attachment in new relationships: Single subject analyses for ten foster infants. *Development & Psychopathology*, 12(2), 133–156.

Fostering attachments. A parenting training group for foster carers and adoptive parents

Kim S. Golding

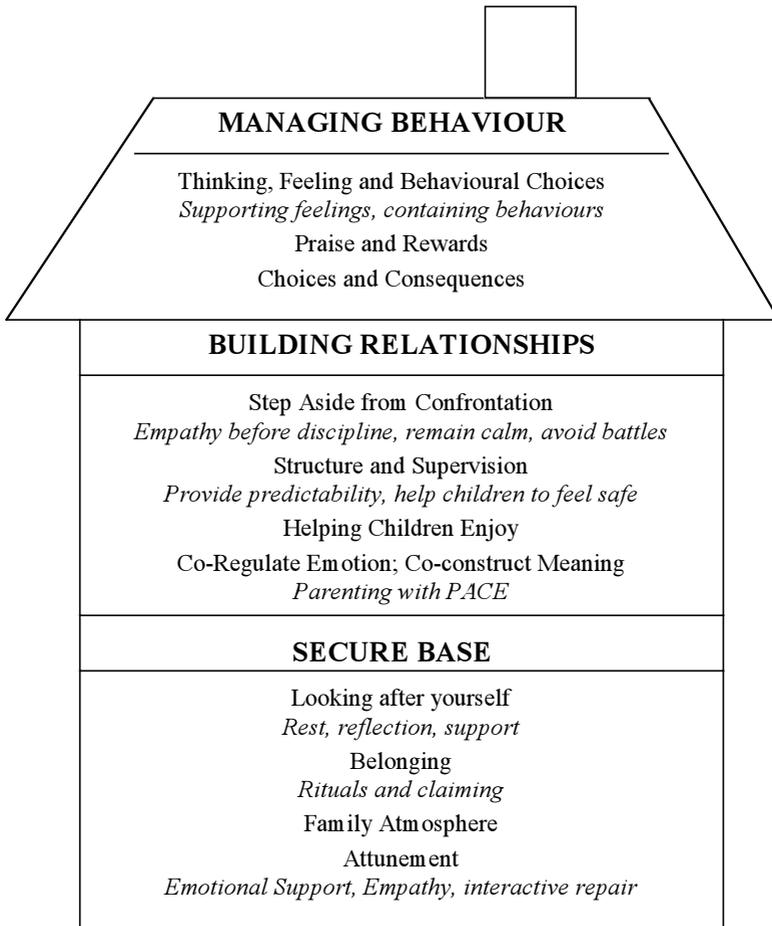
The Fostering Attachments group has been running in Worcestershire for the last five years. It was developed to meet the need for a parenting programme that provided foster carers and adoptive parents with a greater understanding of attachment theory and advice and support to help them with the challenge of parenting children with difficulties in attachment. In 2006 the training manual was revised and rewritten based on evaluation and feedback from these groups (Golding, 2006a).

The programme is divided into three modules with six sessions per module. This takes the carers and parents through an understanding of attachment theory, patterns of attachment and implications for parenting. This leads into the House Model of Parenting (See Golding, 2006b and Figure 1) providing guidance on how to help the children experience the family as a secure base. This in turn provides a context within which the parent or carer can develop stronger relationships with the children. Ideas for behavioural management build upon this foundation of security and trust.

Throughout this group carers and parents are introduced to a range of parenting ideas to help strengthen the children's attachment relationships. This in turn can provide children with the relationship experience needed to develop emotional regulation skills (Schore, 1994) and to enhance their capacity for reflective function (Fonagy *et al.*, 2002). For example the use of attunement and interactive repair (Stern, 1985); parenting with PACE (Hughes, 2004) and arousal-relaxation cycles (Fahlberg, 1996) are all explored.

Module 1. Attachment Theory takes the group participants through an understanding of attachment theory. The process of attachment throughout childhood is explored. This leads into a description of the internal working model and the patterns of attachment that can develop based on the parenting experience of the children. The impact of attachment experience on child development is considered together with a discussion of how the children cope when they move into foster and adoptive homes. This section ends with a consideration of the implications of Attachment Theory for parenting. Participants are helped to consider the parenting needs of children demonstrating different attachment patterns. This is based on the idea of hidden and expressed attachment needs as parents learn to be responsive and sensitive as well as gently challenging.

Figure 1: Summary of the House Model of Parenting



Module 2. A Model for Parenting the Child with Attachment Difficulties. Part 1 Providing a Secure Base introduces the House model (see Figure 1). This leads into specific consideration of how to provide empathy and support to children to help them to manage their own strong feelings. Children who reject empathy and carers who run out of empathy are considered. Participants are

also introduced to the importance of understanding their own early attachment experience and an exercise is included to help them to do this. The importance of attunement for infant development leads into a consideration of using attunement with older children demonstrating difficult behaviour. The use of relationship-based play provides some thoughts about developing relationships and the participants are invited to consider the importance of family atmosphere and the challenge of maintaining a calm, positive atmosphere with children who are determined to re-enact their own early experience. Participants are helped to understand this with some information about the impact of early experience on both the developing brain and on the development of attachment relationships. Next thought is given to helping a child to experience a sense of belonging, and how angry behaviour can interfere with this process. The final part of this module focuses on the important topic of carers and parents looking after themselves. The importance of rest, relaxation and reflection is considered, and two exercises are included to help group members think about their level of stress.

Module 3. A Model for Parenting the Child with Attachment Difficulties. Part 2: Building Relationships and Managing Behaviour. Section 3 begins with an exploration of how to help children enjoy being part of the family. The experience of shame is probably the most important emotion that interferes with this enjoyment. Participants are helped to understand the role of shame in socialisation and what happens when this process does not go well. The parenting attitude of PACE, developed by Dan Hughes, is then outlined and its role in helping children recover from overwhelming shame and to benefit from discipline is explained. The use of stories to strengthen relationship is also considered. The group then moves into a consideration of managing behaviour, which builds upon the development of relationship so far considered. The use of appropriate structure and supervision and dealing with confrontational and coercive behaviour are explored together with some ideas for helping children develop problem-solving abilities. The links between thinking, feeling and behaviour provide a context for an exploration of behavioural management using choices, rewards and consequences. Within these sessions special consideration is given to the relatively common but very difficult behaviours of lying, stealing and self-harming before concluding with a final look at the House Model.

Evaluation

The pilot Fostering Attachments Group involved 10 foster carers, seven of whom continued to attend for the whole time. Three of the carers discontinued because of their own circumstances but did return to a later group. This first group was evaluated using pre- and post-group questionnaires,

although resources did not allow a controlled experimental study (Golding & Picken, 2004). This evaluation suggested that the children's behaviour did improve whilst the carers attended the group. For example, peer problems, hyperactivity problems and total difficulties all reduced on the Strengths and Difficulties Questionnaire as reported by the carers. These changes were statistically significant. Whilst this was not a randomised control trial we did compare these changes to a similar group of 10 children whose carers had received a routine service but without group training over a similar level of time. The Strengths and Difficulties Questionnaire showed some small improvements in pro-social behaviours and peer difficulties. Total difficulties did not change and conduct difficulties worsened. None of these differences reached statistical significance. This provides some support for the efficacy of the group training.

Since this time a further two groups have been run and a third group is due to be completed by the end of 2006. The foster carers and adoptive parents who have participated in these groups are highly satisfied, reporting increased levels of confidence and improvements in the children's behaviour.

Conclusion

The Fostering Attachments Group has been developed for foster carers and adoptive parents caring for children with difficulties in attachment. The group training provides the carers and parents with opportunities to learn about Attachment Theory and to think about how this can influence the way they care for the children on a day-to-day basis. This group provides an opportunity to increase the support available for the carers and parents both professionally and from each other. In addition the training aims to increase understanding of the children and their behavioural and emotional needs through an increased understanding of attachment and developmental theory. This in turn increases the skill and confidence of the carers and parents looking after children with a range of difficulties.

References

- Fahlberg, V.I. (1996). *A child's journey through placement*. London: BAAF.
- Fonagy, P., Gergely, G., Jurist, E.L. & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. NY: Other Press
- Golding, K.S. (2006a). *Fostering attachments with children who are looked after and adopted. A group for foster carers and adoptive parents. Training Manual*. (Unpublished document.)
- Golding, K.S. (2006b). Finding the light at the end of the tunnel: Parenting interventions for adoptive and foster carers. In K.S. Golding, H.R. Dent, R. Nissim & E. Stott, *Thinking psychologically about children who are looked after and adopted. Space for reflection*. Chichester: John Wiley & Sons Ltd.
- Golding, K. & Picken, W. (2004). Group work for foster carers caring for children with complex problems. *Adoption & Fostering*, 28(1), 25–37.
- Hughes, D.A. (2004). An attachment-based treatment of maltreated children and young people. *Attachment & Human Development*, 6(3), 263–278.
- Schore, A.N. (1994). *Affect regulation and the origin of self: The neurobiology of emotional development*. Mahwah, NJ: Erlbaum.
- Stern, D.N. (1985). *The interpersonal world of the infant*. NY: Basic Books.

Attachment for foster care and adoption: A training programme

Mary Beek and Gillian Schofield

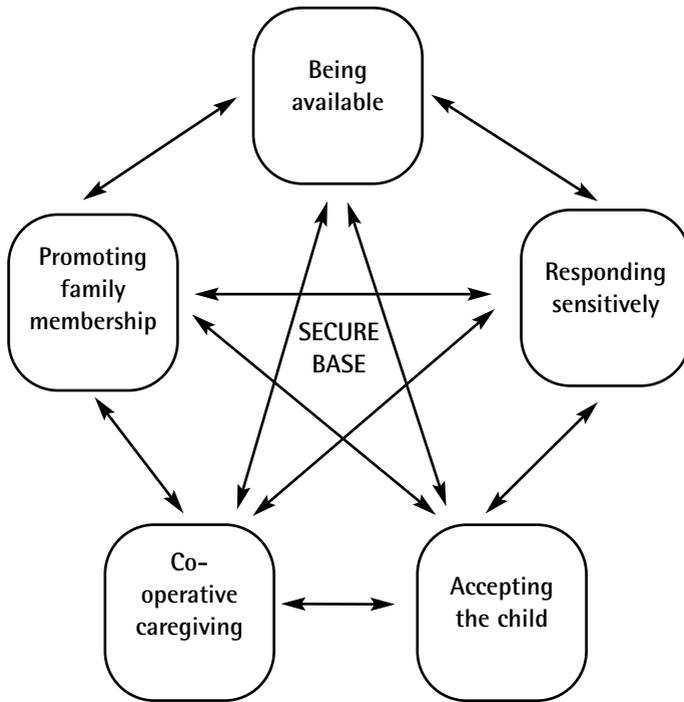
This training programme is designed for use with foster carers, adoptive parents and professionals who train and support them. The attachment based parenting model presented in the programme focuses on the moment-by-moment interactions of daily family life as the vehicle through which children from backgrounds of abuse, neglect and separation can become more secure and resilient. It is suggested that the ordinary routines of caring, nurturing, feeding, playing and communicating provide therapeutic opportunities for caregivers to change the way children think and feel about themselves and others, build their trust and increase their sense of security.

The programme is based on the four dimensions of caregiving identified by Mary Ainsworth as being associated with secure attachment patterns in infants, i.e. *availability, sensitivity, acceptance* and *co-operation* (Ainsworth *et al.*, 1971). Although these dimensions arose from Ainsworth's studies of infants with their caregivers at home and in the Strange Situation, we have also used these dimensions in a longitudinal study of children growing up in foster care from middle childhood through adolescence, funded by the Nuffield Foundation (Schofield *et al.*, 2000; Beek & Schofield, 2004). To these four dimensions we have added a fifth dimension, *family membership*, since in family placement the experience of being part of the family plays an important role in children's experience of security. The dimensions interact with each other (see Figure 1). The programme is accompanied by a training DVD/video and builds on a more detailed account of attachment theory and the parenting dimensions set out in the *Attachment Handbook for Foster Care and Adoption* (Schofield & Beek, 2006) with which trainers would be expected to be familiar.

In outline, the training programme consists of an introduction, a module exploring core concepts in attachment theory and then modules for each of the five parenting dimensions. There is a section of the DVD/video for use with each module.

Each parenting dimension is linked with the developmental benefit that this dimension offers to children.

Figure 1



- Module 1 Core concepts in attachment theory
- Module 2. Being available – helping children to trust
- Module 3. Responding sensitively – helping children to manage feelings and behaviour
- Module 4. Accepting the child - building self esteem
- Module 5. Co-operative caregiving – helping children to feel effective
- Module 6. Promoting family membership – helping children to belong

In our choice of language we have attempted to use words and concepts that would be straightforwardly accessible to foster carers and adoptive parents and tried to avoid excessive jargon. However, each dimension has very clear links with the now extensive research on attachment (see Cassidy & Shaver, 1999), both in terms of the parenting or caregiving being described and the developmental outcomes.

Each parenting module has exercises structured around a parenting cycle of ‘mind-mindedness’ (Miens, 1997). This is based on the premise at the heart of attachment theory, that the way in which a caregiver *thinks and feels* about a child’s behaviour and what is going on in the mind of the child will determine his or her own *parenting behaviour*. Parenting behaviours then convey certain messages to the mind of the child about what is in the mind of the parent, in particular how the child is thought about. The child’s *thinking and feeling* in response to those messages will impact on his or her *behaviour and development*.

A summary of the key ideas in each module will clarify how the programme uses this cycle and makes the conceptual links to attachment theory.

Module 1. Core concepts in attachment theory

This module takes as its starting point two core concepts – the child’s need to experience the caregiver as a secure base for exploration and the importance of the mental representations that constitute the child’s internal working models (i.e. sets of beliefs and expectations of self and others) (Bowlby, 1982; 1973; 1980). In exploring the concept of the secure base, an adapted Fahlberg cycle is used to explain the role of caregiver mind-mindedness and responsiveness in managing the child’s anxiety (Fahlberg, 1994). The section on the DVD/video for this module shows parent-child interaction in infancy and early childhood, in particular the role of parental attunement and commentary in supporting the child’s capacity to think and to manage anxiety. It includes film of a secure child in the Strange Situation, which demonstrates the secure base attachment/exploration balance in action, but also aids discussion of internal working models. Exercises include discussion of the film clips and the nature of secure and insecure attachment patterns.

Module 2. Being available – helping children to trust

This module sets the scene for the other modules, but has also been found in practice to have the advantage of being conceptually the most familiar and non-threatening to carers and adopters. Being available is about providing the best environment for children’s healthy emotional development, one in which they can take for granted that nurture, comfort and protection are readily available from the caregiver when needed. Such an environment provides a secure base for exploration and forms the foundation on which *trust* in the self and others will be built. The module invites participants to reflect on their own experience of having a secure base (whether in a family of origin or a current partnership or friendship) and to think about what children who have not experienced a secure base in their early lives and find it hard to trust may think and feel as they enter a foster or adoptive family. Case material is used to illustrate how this may affect children at different ages and stages. This pattern

of exercises – combining reflections on participants’ own experiences, the experiences of children and the range of helpful responses as caregivers – is followed throughout subsequent modules. Similarly, the DVD/video section for this and subsequent modules offers a range of ideas, as foster carers and adoptive parents talk about what has worked for them in relation to this dimension and young people who grew up in foster care or adoption recall what they found helpful.

Module 3. Responding sensitively – helping children to manage feelings and behaviour

This module is based on the key attachment concept that it is a fundamental task for parents, from infancy onwards, to help their children to organise their thinking and regulate their emotions and behaviour. In order to do this in foster care or adoption, the caregiver must have the capacity to tune in to the state of mind that lies behind the behaviour of this particular child, to gauge the child’s thoughts and feelings and to respond appropriately. This module draws particularly on the concept of mind-mindedness, so that the term ‘sensitive’ is used here in the way in which Ainsworth used it, i.e. to suggest the caregiver’s capacity to see and reflect on the world as the child sees it. The exercises focus on helping caregivers to help troubled and often confused children to make sense of themselves, other people and the world around them, to give children the ‘scaffolding’ they did not have in early childhood and to enable children to reflect on and manage their feelings, relationships and behaviour more effectively.

Module 4. Accepting the child – building self esteem

From the earliest interactions with their newborn infants, parents and other close caregivers begin the process of conveying a positive sense of self. This module encourages participants to appreciate how, as foster and adoptive children grow and develop from infancy through early childhood into the primary school years and adolescence, caregivers need to help them to maintain their self-esteem in the face of everyday challenges. Caregivers need to *generate* environments in which children can feel a sense of achievement, accomplish tasks, receive praise and experience themselves as valued and special.

However, Module 4 offers a model of self-esteem building that goes beyond helping children to feel good about themselves. It focuses also on helping caregivers to think about and accept children’s strengths and difficulties and to enable children to do the same. The importance of caregivers’ own self-esteem and acceptance of their own strengths *and* difficulties is stressed in the module. The module emphasises that progress in the development of children’s self-

esteem (and resilience) is as much to do with capacity for recovery after setbacks as with feeling good about successes. The module suggests that when children can accept themselves it can also help them to accept others without being too jealous or judgemental. Eventually children can transfer this level of acceptance into future relationships – with friends, partners and as parents with their own children. Participants are thus encouraged to take a longer term and broader developmental view of caregiving that builds self-esteem.

Module 5. Co-operative caregiving – helping children to feel effective

Within this module, the balance between providing safe boundaries while promoting the infant's, child's or adolescent's autonomy and effectiveness is explored. It is an area that foster carers and adoptive parents often find difficult. Because of the varied kinds of challenging behaviour that children in their care will often show, control rather than co-operation often takes over the parenting agenda. Co-operative relationships need to be developed both when managing a child's difficult behaviour and during joint relaxed and playful activity, promoting a collaborative approach to both problem solving and fun.

In summary, co-operative caregiving as presented in this module is based on three important principles:

- From infancy onwards, the child is viewed as a separate, autonomous individual, who needs opportunities to explore safely but freely and to make choices, decisions and discoveries.
- The caregiver is responsible for the welfare of the child and remains in charge, but when interference or boundary setting is necessary the caregiver prefers to seek the child's co-operation and to form an alliance based on negotiation of their different goals and to compromise within reasonable and explained boundaries.
- The more appropriately effective the child becomes and feels himself to be, the more likely he is to co-operate with others, in relationships based on mutual respect for each others' perspective.

The message of this module is that from parenting based on these principles, children are likely to become increasingly socially effective, competent and co-operative, while also being more likely to show resilience in the face of adversity, when assertiveness and negotiation with others are both likely to be required.

Module 6. Promoting family membership – helping children to belong

Key to this module is the notion that family membership can offer feelings of solidarity, unconditional acceptance and shared identity, often reinforced by shared jokes, activities and family rituals around mealtimes or celebrations. Families establish certain mutual rights, duties and responsibilities that operate between parents and children, brothers and sisters and wider family members, but families also provide a set of expectations, norms and values for living in society. This module invites participants to reflect on the meaning of family membership for them and the challenges of offering a sense of belonging in their family to foster and adoptive children who will have birth families to whom they also belong. Exercises in this module emphasise the developmental benefit for children of being helped to feel comfortably part of more than one family, but also explore some of the differences between short-term and permanent placements.

The programme has been developed in consultation with a range of professionals, caregivers and adoptive parents. The materials have been used with and well received by varied groups of foster carers and adopters. Although it has not been independently evaluated, the programme builds on and brings together ideas and exercises that are often used in training foster carers and adopters, but places them in a rigorous theoretical framework informed by attachment theory and research.

References

- Ainsworth, M.D.S., Bell, S. & Stayton, D. (1971). Individual differences in strange-situation behavior of one year olds. In H. Schaffer (Ed.) *The Origins of Human Social Relations*. New York: Academic Press, pp. 17–52.
- Beek, M. & Schofield, G. (2004). *Providing a secure base in long-term foster care*. London: BAAF.
- Beek, M. & Schofield, G. (2006). *Attachment for foster care and adoption: Training programme*. London: BAAF.
- Beek, M. & Schofield, G. (2006). *Attachment for foster care and adoption: Training DVD/video*. London: BAAF.
- Bowlby, J. (1982). *Attachment and loss: Vol I Attachment*. London: Hogarth Press. (Originally published 1969.)
- Bowlby, J. (1973). *Attachment and Loss: Vol II Separation, Anxiety and Anger*. London: Hogarth Press.
- Bowlby, J. (1980). *Attachment and Loss: Vol III Loss, Sadness and Depression*. London: Hogarth Press.
- Cassidy, J. & Shaver, P. (1999) (Eds.) *Handbook of Attachment: Theory, research and clinical applications*. London: Guilford Press.
- Fahlberg, V. (1994) *A child's journey through placement* (2nd edn.). London: BAAF.
- Miens, E. (1997). *Security of attachment and the social development of cognition*. Hove: Psychology Press.
- Schofield, G., Beek, M., Sargent, . & Thoburn, J. (2000). *Growing up in foster care*. London: BAAF.
- Schofield, G. & Beek, M. (2006). *Attachment handbook for foster care and adoption*. London: BAAF.

The British Psychological Society was founded in 1901 and incorporated by Royal Charter in 1965.

Our principal object is to promote the advancement and diffusion of a knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of Members of the Society by setting up a high standard of professional education and knowledge

The Society has more than 44,000 members and:

- has offices in England, Northern Ireland, Scotland and Wales;
- accredits around 800 undergraduate degrees;
- accredits over 160 postgraduate professional training courses;
- confers Fellowships for distinguished achievements;
- confers Chartered status for professionally qualified psychologists;
- awards grants to support research and scholarship;
- publishes 11 scientific journals and also jointly publishes *Evidence Based Mental Health* with the British Medical Association and the Royal College of Psychiatrists;
- publishes books in partnership with Blackwells;
- publishes *The Psychologist* each month;
- supports the recruitment of psychologists through *Psychologist Appointments* and www.psychapp.co.uk;
- provides a free 'Research Digest' by e-mail and at www.bps-research-digest.blogspot.com, primarily aimed at school and university students;

- publishes newsletters for its constituent groups;
- maintains a website (www.bps.org.uk);
- has international links with psychological societies and associations throughout the world;
- provides a service for the news media and the public;
- has an Ethics Committee and provides service to the Professional Conduct Board;
- maintains a Register of nearly 14,000 Chartered Psychologists;
- prepares policy statements and responses to government consultations;
- holds conferences, workshops, continuing professional development and training events;
- recognises distinguished contributions to psychological science and practice through individual awards and honours.

The Society continues to work to enhance:

- recruitment – the target is 50,000 members;
- services to members – by responding to needs;
- public understanding of psychology – addressed by regular media activity and outreach events;
- influence on public policy – through the work of its Policy Support Unit, Boards and Parliamentary Officer;
- membership activities – to fully utilise the strengths and diversity of the Society membership.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 254 9568 Fax: 0116 247 0787
E-mail: mail@bps.org.uk Website: www.bps.org.uk

ISBN 978-1-85433-450-3

