
Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress

Richard P. Barth*, Thomas M. Crea†, Karen John‡, June Thoburn§ and David Quinton¶

*Frank A. Daniels Distinguished Professor and †Doctoral student, School of Social Work, University of North Carolina, Chapel Hill, North Carolina, USA, ‡Lecturer and ¶Professor Emeritus, School for Policy Studies, University of Bristol, Bristol, UK, and §Emeritus Professor of Social Work, University of East Anglia, Norwich, UK

Correspondence:

Richard P. Barth,
School of Social Work,
Jordan Institute for Families,
University of North Carolina,
Chapel Hill, NC 27599-3550,
USA
E-mail: rbarth@unc.edu

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ABSTRACT

Elements of attachment theory have been embraced by practitioners endeavouring to assist foster and adopted children and their parents. Attachment theory articulates the potential risks of experiencing multiple caregivers; emphasizes the importance of close social relationships to development; and recognizes that substitute parents may not always have close relationships with children who have experienced adversities before joining them. Attachment theory offers concerned parents what they believe to be a scientific explanation about their lack of the close, satisfying parent–child relationship they desire. Yet the scientific base of attachment theory is limited both in terms of its ability to predict future behaviours, and especially with regard to its use as the underpinning theory for therapeutic intervention with children experiencing conduct problems. There is a critical need to review the role of attachment theory in child and family services and to consider its place among other explanations for children’s disturbing behaviour. An important step towards pursuing alternative approaches is for researchers and practitioners to understand the reasons the attachment paradigm appeals to so many adoptive and foster parents, given the apparent widespread prevalence of attachment-based interventions. Such understanding might assist in the development of adoption-sensitive uses of appropriate evidence-based treatment approaches.

INTRODUCTION

Attachment theory and attachment therapy have gained considerable status in social science and social work, especially in fostering and adoption (Arredondo & Edwards 2000; Haight *et al.* 2003). Attachment theory is arguably the most popular theory for explaining parent–child behaviour by professionals involved with child welfare services and is referenced in the abstracts of nearly 1000 articles retrieved in the Social Science Citation database of the Institute for Scientific Analysis (ISI) since 1996, and 1600 times in the American Psychological Association’s PsycInfo

database since 1988. Attachment research is primarily conducted by developmental scientists but has more recently been adapted by clinicians. Attachment theory is cited as the basis for two practice innovations in recent decades: attachment-based therapy (ABT) and bonding studies (BS) and is the theoretical approach used to underpin the diagnosis of reactive attachment disorder (RAD). The impact on services has been profound: Hill *et al.*’s (1992) review of 100 Scottish cases in which children were freed for adoption found that the quality of parent–child attachment was referenced in every case (usually with reference to birth parents). The RAD diagnosis has led to the

rapid growth of agencies and conferences for adoptive parents and is partially responsible for some of the dubious and even harmful therapies developed to treat it.

Yet, attachment-based therapies and studies are not nearly as well represented or regarded in the scientific literature as they are in contemporary children's services practice (e.g. see O'Connor & Zeanah 2003). A search for papers citing attachment therapy including those concerned with 'holding therapy' yielded four such articles in ISI, with only one being a modest, albeit positive, evaluation of therapeutic outcomes (Myeroff *et al.* 1999). One of the papers was a warning about the dangers of holding therapy (Mercer 2001). Mary Dozier (2003), an American researcher of early childhood foster care and attachment, wrote a paper opposed to holding therapy. Her paper explains that holding therapy, sometimes known simply as 'attachment therapy', does not emanate in any logical way from attachment theory or from attachment research. In addition, the psychoanalytic underpinnings of attachment theory have generally not provided a strong basis for effective treatment of children (Weisz *et al.* 1987). Rutter's (1996) review of the attachment literature also concludes with an argument to reject these traditional psychoanalytic theories of development, on which some proponents of attachment theory rely, and to reorient our current emphasis on 'maternal bonding' to infants and disorders of attachment.

However, as O'Connor & Zeanah (2003) recently summarized with regard to diagnosis and treatment interventions: 'Despite more than 20 years since the establishment of "disorders of attachment" . . . there is still no consensual definition or assessment strategy; nor are there established guidelines for treatment or management' (p. 241). In light of these debates, this paper examines the rationale for the development of attachment-based therapies in the treatment of RAD and the appeal of such therapies to many parents, especially adoptive and long-term foster parents, and practitioners. Like many others, we argue that efficacious services for children and parents depend on the development of interventions based on stronger theoretical and evidentiary grounds (O'Connor & Zeanah 2003). To help advance the development of evidence-based interventions, we suggest a careful examination of the prevailing practice principles and guidelines for those charged with helping adoptive or foster parents care for their troubled children.

THE LIMITS OF WHAT ATTACHMENT THEORIES CAN TELL US

Accounts of disordered attachment first appeared in the 1930s and 1940s when a number of scholars observed the unhealthy consequences of raising children in institutions (Levy 1937; Goldfarb 1943, 1945; Spitz 1946). A psychiatrist and Kleinian psychoanalyst John Bowlby (1951) then began to write about the adverse influence on development of inadequate maternal care and called attention to the acute distress of young children separated from their primary caregivers. This distress was viewed as a fundamental human response, and in the book he wrote two years later for non-professionals, Bowlby asserted that a close mother-infant relationship was essential for socio-emotional adjustment: ' . . . what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother-substitute – one person who steadily mothers him) in which both find satisfaction and enjoyment' (Bowlby 1953, p. 11). This presumption seems sound enough, although it marks the transition from observational studies of distress to inferences about the meaning of a child's desire to avoid such distress.

The following half century has taken the concept much further, and endeavoured to reify toddlers' reactions to separation from their caregivers during controlled experiments into discrete types of secure and insecure attachment (Ainsworth 1989). This work was followed by predictions about how children classified as being securely or insecurely attached as toddlers would develop differentially in early childhood (Sroufe 1983) and later, classification of adults according to attachment types (Main & Hesse 1992).

The challenges to attachment-based theories of development have come more recently, as the emergence of longitudinal studies offers a basis for checking the reliability of predictions based on attachment theory. Sroufe, Egeland, and colleagues (Roisman *et al.* 2002), following a sample of high-risk and maltreated children to adulthood, find substantial discrepancies between predictions based on early childhood assessments of attachment and adult relationship outcomes. They suggest that their results provide evidence that, although attachment has been found to be stable over time in other samples, attachment representations are vulnerable to difficult and chaotic life experiences and thus lack predictive power when considering the future life chances of the sorts

of children needing child welfare services (Weinfeld *et al.* 2000). Sroufe *et al.* (1999) summarized the difficulties in using attachment theory to make predictions:

Early experience does not cause later pathology in a linear way; yet, it has special significance due to the complex, systemic, transactional nature of development. Prior history is part of current context, playing a role in selection, engagement, and interpretation of subsequent experience and in the use of available environmental supports. Finally, except in very extreme cases, early anxious attachment is not a direct cause of psychopathology but is an initiator of pathways probabilistically associated with later pathology. (p. 1)

Other studies have found little or no evidence of a link between psychological problems in older adopted children and insecure attachment relationships in infancy. Singer *et al.* (1985) found a similar quality of attachment between adoptive and non-adoptive families. These researchers also found that for middle class families, lack of early contact with an adopted child does not predict anxious adoptive mother–infant attachment. In addition, the authors argue that higher rates of psychological and academic problems among adopted children cannot be traced to insecure attachment patterns between adoptive mothers and children in infancy. Juffer & Rosenboom (1997) found that 74% of the adopted infants were securely attached to their parents, irrespective of country of origin or whether parents also had biological children. These findings suggest that the adoption experience itself, and all that the pre- and post-adoptive experiences may mean for the child and caregiver, is not a predictor of negative parent–infant relations, outside of other factors such as early emotional or physical deprivation.

More generally, although much legitimate research evidence is accumulating about attachment in early childhood and adjustment in later childhood, these studies are characteristically short-term and descriptive, and mostly based on children in non-adoptive families. Attachment theory cannot be used with any confidence to predict how children will develop over longer periods of time. Those professionals who would convince parents that their children may have attachment impairments – and that these will vex their children and families forever – are not reading the caveats from developmental scholars. While attachment problems may predispose a child towards future behaviour problems, these problems must be evaluated and treated within the context of the child's current environment. Such scholars would also fore-

warn against confusing evidence of risk as a strong basis for prediction.

REACTIVE ATTACHMENT DISORDER

Reactive attachment disorder (RAD) as a diagnosis relies heavily on attachment-based theories and in turn is the diagnosis that has led to the development of attachment-based therapies. According to DSM-IV-R, RAD is diagnosed only when there is a known history of pathogenic care, expressed as: (i) persistent disregard for basic emotional needs for comfort, stimulation, and affection; (ii) persistent disregard for basic physical needs; (iii) and/or repeated changes of primary caregivers (American Psychiatric Association 2000). Although the American Psychiatric Association (2000) indicates that RAD is 'uncommon', this is not the view of adoption specialists. Maldonado-Duran *et al.* (2003) indicate that:

In some facilities, clinicians have become very interested in attachment disturbances. As a result, they may view any behavioural disturbance in a child as caused by disruptions in attachment and therefore diagnose the behaviour as an attachment disorder. This may create problems for the clinician because the current definition of the disorder implies pathogenic care (e.g. neglect or multiple caregivers in rapid succession). (p. 295)

Overemphasizing the attachment paradigm's relationship to psychological disorders and behaviour problems is perilous. Werner-Wilson & Davenport (2003) argue that conceptualizations of attachment have become muddled, as have other psychological concepts like identity and self-esteem, and that uses of attachment theory have drifted too far from their origins to retain validity as bases for intervention. They conclude – as do Zeanah (1996) and O'Connor & Rutter (2000) – that the conceptualization of attachment that has led to the over-diagnosis of RAD is only very loosely related to attachment theory. They urge family therapists who recognize that attachment is an important family dynamic to avoid pathologizing children, and instead to focus on helping families to provide a better base for secure attachments.

PREVALENCE OF RAD

Acknowledging the limited epidemiological data, the DSM-IV-R considers RAD as 'very uncommon' (American Psychiatric Association 2000, p. 129), but other recent sources suggest that RAD is relatively

widespread, at least in the USA. Werner-Wilson & Davenport (2003) cite a range of non-peer-reviewed sources indicating that there may be as many as one million children, and half of all adopted children, diagnosed with RAD in the USA. In England, the prevalence of disorders of attachment (as defined by DSM-IV-R or ICD-10; World Health Organization 1992) is unknown (Kurtz *et al.* 1996) and these disorders were subsumed into the 'emotional disorder' category in the most recent Office of National Statistics Survey (Meltzer *et al.* 2003). Nevertheless, as in the USA, troublesome behaviours among fostered or later adopted children are often attributed by practitioners to disordered attachment (Richardson & Joughin 2002).

One reason why RAD may be over-diagnosed is that it is one of the few disorders in the DSM-IV-R nosology that explicitly indicates its appropriateness for children under five years old. In addition, many practitioners ignore many of the core RAD criteria (Zeanah 1996). Instead they base the diagnosis on a child's general level of problem behaviour rather than on evidence of disturbed attachment, assume 'pathogenic care' as an aetiology for the disorder (allowing both infant adoptions and adoptions of children from well-managed orphanages to be ruled in), and overlook the criterion that the problem behaviours must *not* be explainable based solely on a child's developmental delay, although, admittedly, it is unclear how one makes this determination.

Our practice experience informs us that the use of RAD is not limited to young children or to children who have had pathogenic care, but is also applied to children adopted as newborns from well-planned domestic adoptions. In essence, the over-diagnosis of RAD is generating an oversized opportunity for interventions that appear to address RAD.

ATTACHMENT-BASED THERAPIES

A substantial amount of the clinical writing about attachment-based therapies regards the child as the primary target of clinical intervention (Cline 1979; Levy & Orlans 1998). Treatment of RAD from this clinical perspective is based on the assumption that the child has repressed rage resulting from earlier negative experiences that interferes with the ability to form an attachment, so clinical interventions are designed to help the child release this rage and teach the child that the new parents can be trusted as caregivers. Basing their interventions on attachment the-

ories, the approach of Dozier (2003) in the USA and Cairns (2002) in the UK is to teach the foster parents to take the lead in maintaining positive interactions with foster children who are rejecting or withdrawing. Because most attachment therapies do not routinely place adoptive and foster parents in the position of showing an overriding warmth and concern, however, the lesson they teach can be counterproductive and even hazardous. The meta-message of such interventions can be that parents do not need to accommodate to children and that the expected process of change in the adjustment of family members to each other is unidirectional.

Other practitioners of attachment therapies conclude that a break in the arousal-relaxation cycle is a source of problematic behaviours in attachment-disordered children (Fahlberg 1991). If birth or substitute caregivers have failed to meet children's emotional and physical needs in early childhood, children will cease to trust caregivers to provide these needs and will instead trust only themselves (Thomas 1997). Attachment therapists may refer to Bowlby's contention that emotionally deprived children exhibit underdeveloped personalities and consciences, and display 'impulsive and uncontrolled' behaviour (Bowlby 1951, p. 59). Such therapies seek to repair the break in the need cycle by confronting the child, identifying and tearing down psychological defences, and rebuilding the trust of the child through a combination of coercive holding and nurturing touch (ATTACH, Inc. 2004). These therapies are 'regressive, forceful, loving and confrontive', with the ultimate goal of instilling trust in the child through forcing him/her to accept being controlled by others (Cline 1979, p. 162).

Holding therapy, which aims to repair rapidly the relationship between a parent and child, is attachment theory's most visible therapeutic spin-off, particularly in the USA. This approach is primarily addressed to children who have been diagnosed with RAD, either formally or by their parents. Holding therapy has been used with thousands of parents (mainly but not exclusively in the USA) without the benefit of rigorous research and includes three primary treatment components that are directed towards the child: (i) prolonged restraint for a purpose other than protection; (ii) prolonged noxious stimulation (e.g. tickling, poking ribs); and (iii) interference with bodily functions. An early UK article (Crawford *et al.* 1986) describes holding therapy as an act in which the child is held securely by the parent, as the child

progresses through the stages of bargaining, anger, rage, acceptance, and bonding. Welch (1989) asserts that holding therapy is designed to remedy attachment disorders in children and hypothesizes that intense physical contact with the mother can break through withdrawal and create strong ties with the mother. Laibow (1988) also asserts that this process is intended to mend damaged bonds between the parent and child but goes on to state that at times, the child will recall pre- and perinatal memories. Empirical evidence to support these claims or the proposed benefits of holding therapy is lacking. To quote Howard Steele (2003) in his Editor's introduction to the recent special issue of *Attachment and Human Development*:

We must acknowledge there is, as yet, no systematic evidence-based approach for treating children with attachment disorders. Moreover, the very concept of 'attachment disorders' is a controversial one because of the substantial remaining questions about assessment and diagnosis. Holding therapies have not been shown to be an effective clinical tool, and according to some practices may be seriously harmful and counter-therapeutic. (p. 219)

Indeed, this technique has a strong potential for 'misuse and misapplication' (Saunders *et al.* 2003, p. 103) and is ethically questionable, given the prohibition in many states against physical contact between therapists and clients. For these reasons, the US Office for Victims of Crime recently released treatment guidelines that single out holding therapy as the one intervention more likely to do harm than good (Saunders *et al.* 2003).

REASONS PARENTS PURSUE ATTACHMENT THERAPIES

Although there is little direct research on adoptive or foster parents' reasons for pursuing the 'attachment therapies' described above, reading of case studies and journalistic accounts provides some insight. Attachment therapy appears to provide a radical intervention to address behaviours that parents believe predict negative and even horrific outcomes for their children. Also, parents often feel increasingly distant from children whom they view as actively destructive and antisocial (Mercer *et al.* 2003) and sense that children are moving beyond parental control into a world of sociopathy. This may be so even though teachers and other adults do not view their child so negatively (Mercer 2001). This pessimistic view of their children's future is sometimes encouraged by

attachment therapists who point to Ted Bundy, Jeffrey Dahmer, Saddam Hussein and Adolf Hitler as being attachment disordered (Thomas 1997). In the case of Candace Newmaker, the adoptive mother was told that her child might be expected to grow up and become a psychopath and murder her (Mercer *et al.* 2003). Europeans have less of a homicidal tradition, and probably fewer fears of matricide, but scholars there have also argued that children with attachment disorder may grow up and experience 'psychic homelessness' (Hoksbergen & ter Laak 2000). Such predictions promote negative parental expectations and often initiate desperate attempts to achieve rapid change in their children. Moreover, these predictions are not founded in empirical evidence based on causal linkages between early attachment problems and future behaviours (Sroufe *et al.* 1999; Weinfield *et al.* 2000).

Parents are often given a dramatic view of the meaning of attachment and the trauma that their children may have experienced with biological parents, a view which sets parents up to take drastic preventive or rehabilitative action. For example, Levy & Orlans (1998) begin their volume on treating attachment disorders ominously:

There is a time bomb ready to explode . . . More and more children are failing to develop secure attachments to loving protective caregivers – the most important foundation for healthy development. They are flooding our child welfare system with an overwhelming array of problems . . . (p. 1)

Commenting on the attractions of attachment therapies to adoptive and foster parents, O'Connor & Zeanah (2003) remind us that they often feel inadequate or rejected when their children do not turn to them for comfort when distressed. There may be additional confusion or frustration when parents have been successful in raising other 'securely attached' children. Feeling hopeless, parents may conclude that they are not up to raising such children (Lieberman 2003). Several authors note that adoptive and foster parents frequently express high need for support and that these needs are likely to be unrecognized and unmet in generic mental health services (Thoburn *et al.* 2000; Boris 2003; Lieberman 2003; O'Connor & Zeanah 2003). Writing about the situation in the UK, Jonathan Green (2003) points out that:

Intensive and dramatic therapies . . . have intuitive appeal for serious disorders; they seem a fitting response somehow, like intensive care units for life threatening illness or intrusive behavioural treatments for autism. (p. 263)

TOWARDS A STRONGER EVIDENCE BASE FOR INTERVENTIONS WITH TROUBLED FOSTER AND ADOPTED CHILDREN

Scholars seeking to increase the use of evidence-based interventions are accepting that they must understand how existing interventions are meeting the needs of therapists and clients, and provide a rationale that alternative methods may more effectively meet those needs (Torrey *et al.* 2003). Such an effort can begin by acknowledging parental concern about their children's behaviours and addressing them in a way that is most likely to help and less likely to harm. The solution may be to ensure that therapists and adoptive and foster families are made aware of other theoretical approaches for explaining and predicting behaviour and to make available a wider range of approaches for which there is some evidence of efficacy to drive intervention design (Scott 2003). A starting point would be greater familiarity with the longitudinal research and retrospective studies on adoption outcomes which suggest that adopted children often struggle to do as well as biological children in two-parent households, but that most eventually catch up rather well (Feigelman 1997; Howe 1997; Thoburn *et al.* 2000; Lindblad *et al.* 2003). Parents who are concerned that their adopted children do not currently show the behaviour they expect should not despair in the belief that their children are on a straight path to infamy. They may, more likely, be on a meandering and thorny path to a relatively normal adulthood.

Finding substitutes for the current conceptualizations of RAD and attachment-based therapies is difficult to achieve, because interventions outside the adoption field generally address more mainstream diagnostic conditions like 'conduct disorder' (Webster-Stratton & Hammond 1997; Fisher *et al.* 2000). Although the parents of children with conduct disorders are also often distressed about the strained relationships they have with their child, this is not the primary concern of these interventions. Thus, the promise of evidence-based interventions for adopted children with these difficulties can be dismissed by those therapists and parents who believe that children with RAD are qualitatively different from other children with conduct disorders. This concern is often justified – adopted children may develop problems in ways that are different from biological children – and may result in the many adoptive parents who indicate that therapists are not 'adoption sensitive' (Howe 1996; Thoburn *et al.* 2000; Barth & Miller 2001). This is, in part, a shorthand complaint for the con-

clusion that the therapists hold the parents responsible for parenting in such a way that they caused all the problems of their children, without understanding that the problems of adopted children are multiply determined. Conversely, these parents have difficulty trusting therapists who focus all their intentions, and impute much of their interpretation of the family dynamics from interactions in the moment, without taking into account the history of the relationship and the child's pre-placement experience.

In order to bridge the conceptual gap between what therapies offer to parents and what is offered by other interventions for which there is some evidence of effectiveness, at least with non-adoptive families, we explicitly focus on what seems to attract adoptive and foster parents to the conceptual world of attachment and its derivative diagnoses and treatments. Classical attachment theory, and some more recent accounts of its relevance as a framework for understanding and treating difficulties that emerge in adoptive families, support the use of sensitive and responsive caregiving, but other approaches to treatment also emphasize this essential component of responsive parenting (Barth *et al.* 2005). We suggest that a wider range of evidence-based interventions should be available and that steps be taken to help make those interventions more sensitive to the unique needs of adoptive and foster families.

One attraction of attachment-based therapists is the explicit reference to their understanding of the vulnerabilities and perceptions of adoptive parents and the parents' concern about the distress children may have felt before joining their families. These include: (i) a painful sense of loss from not feeling closer to their children and a fear that their child would grow up to have distant and dysfunctional relationships throughout life; (ii) the desire to have a coherent and evidence-based perspective on their parenting experience and the belief that RAD and holding therapy have a strong explanatory and predictive power; and (iii) the failure of prior service providers to offer a coherent explanation or intervention. Addressing the underlying concerns of adoptive parents and of those practitioners who have been trained to conceptualize parent-child difficulties essentially or even exclusively in terms of adoptive status and attachment should help in directing them towards more evidence-based interventions.

Some attachment therapies also may be attractive because, by locating the blame for the child's current difficulties with prior carers, they appear to relieve adoptive and foster parents of the responsibility to

change aspects of their own behaviour and aspirations. Parenting is very difficult, and many parents of children in trouble, including biological and adoptive parents, believe that the reason for their problems is not essentially because of their parental behaviour (Gauld 1993). Many will point to reasons why their behaviour is appropriate to the circumstances of raising a difficult child. Substitute parents of troubled children are aware that their children's experience of parenting before as well as after placement will affect children's behaviour and relationships. These adoption-based explanations are often supported by knowing that other children in the family are doing well or that the children who came to live with them as older children already had well-established problems. If parents have read popular books about the interplay of genetics and socialization (e.g. Harris 1999), they may also believe that their children's problems are not because of their parenting practices. In that case, parents may be susceptible to the argument of some attachment therapists that it is the children who need to change, not the parents. They may miss the more nuanced interpretation that even though the parent's behaviour did not cause the parent-child problems, changes in their ways of parenting may mitigate the difficulties that their current problems represent for them and their children.

TOWARDS EVIDENCE-BASED APPROACHES TO MEETING THE NEEDS OF ADOPTIVE AND FOSTER PARENTS

Attachment therapies apparently address the desire of parents to find a way to improve lifelong outcomes for their children, especially a way that offers a past explanation and does not heavily emphasize changing their current interactions with, and expectations of, their children. This is not to suggest that adoptive and foster parents are not willing to make substantial sacrifices for their children – there is much evidence in qualitative research studies that they are (Howe 1997; Thoburn *et al.* 2000). However, they may be reluctant to sharply modify parenting practices that have worked with other children and that cannot be reasonably said to have created their child's problem. Parents, and professionals, often come to believe that the attachment paradigm is a well-tested one and may not know of the limited scientific basis of attachment therapies or the possibilities of other approaches. The concluding section of this paper endeavours to propose alternatives to the current over-reliance on attachment theory and therapies.

PAINFUL SENSE OF LOSS FROM LACK OF CLOSENESS AND FEAR FOR CHILD'S SOCIAL DEVELOPMENT

Parents who are attracted by attachment therapies may feel hopeless about the present and the future. As discussed earlier, RAD has become a commonly used label to describe a child who is acting in ways that are discordant with parental expectations. Although some of these children are seriously troubled, attachment labels and therapy are also used for children who are difficult for parents to care for and become difficult to care about. The ability to relate to another person is a skill that runs on a long continuum, a skill that can change and be demonstrated more or less well depending on the context. As such, classifications such as 'attachment disordered' do not help to promote openness in parents about their children's development nor hope about their future well-being. Parents of troubled children need to find effective interventions to deal with children's behaviours within the current context of the adoptive family.

Although adoptive parents, who are often well-educated, may be seeking a science-based response to the perceived problems of their children, our review identified little science to support the notion that 'attachment' issues cause these behaviours. Whereas some of the children who receive attachment therapy have experienced seriously substandard and harmful parenting, the impact of these experiences on their current behaviour may not be mediated through attachment. Indeed, the discussion of attachment is often circular – the child has difficulties in social relationships (attachment), and therefore s/he has attachment disorder. There may be many reasons for difficulties in social relationships that are largely independent of attachment problems. Indeed, studies from the USA and Sweden find that lower middle class families have more success as adoptive parents than highly educated and employed families (Barth & Berry 1988; Hjern & Vinnerljung 2002); findings from the UK are less clear. The US and Swedish findings may be explained by a too singular concern about the educational and social attainment of their children, rather than difficulties in attachment (Barth 2002). Children's externalizing problems may also contribute to parent-child alienation, as parents struggle with the challenge of providing a consistent, strong, positive response to the negative actions of their children. Indeed, the RAD diagnosis includes reference to a range of conduct problems that must co-occur with the other criteria discussed above.

Thus, adopted children might respond well to interventions for general groups of conduct-disordered children. Nevertheless, many adoptive parents incorporate factors external to their parent-child interactions, including genetic and bio-social trauma, and perceive their family's interactions as being substantively different than those in a biological family. They may conclude, not without some good reason, that the conduct problems of their children are therefore not likely to be amenable to treatments that do not acknowledge such causes. Therapists who take too strict a behavioural position – that is, that the parents caused the problems by inadvertently reinforcing poor behaviour and failing to reward positive behaviour – may agitate parents' legitimate concerns and leave them responding to the therapeutic experience as adoption insensitive (Smith & Howard 1999). This strict behavioural position need not, however, be the sole thrust of a social and cognitive skills intervention which must also accommodate pre-existing differences in children and recognize the many paths that families follow to points of high conflict. Interventions developed for young children in foster care (Dozier *et al.* 2002) as well as for older children in foster home care (e.g. Pallett *et al.* 2002; Chamberlain 2003; Beek & Schofield 2004; Sinclair *et al.* 2004a,b) have shown that foster parents value the assistance they receive in managing interpersonal interactions with children and in developing sound and satisfying strategies for addressing the problem behaviours that interfere with parent-child satisfaction. These interventions are conducted in the context of a support group of foster parents and a trusting and partnership-based relationship with a social worker, which also allows family members to gain some perspective about the challenges of parenting. These groups also help families assiduously identify the gains that are being made, rather than to focus on the continued discrepancy between what parents hope for and what they get.

A newer generation of interventions to address children's problems, arising from anxiety and trauma (e.g. Kolko & Swenson 2002), often include parents in therapeutic roles. They do not, however, forcefully address the parent-child relationship. Evidence-based interventions for conduct disorders do not necessarily posit parent-child relationship disorders. That is, these interventions are intended to increase positive parental supervision of children, minimize children's associations with antisocial peers, provide consistent discipline, and increase encouragement of youth (Chamberlain 2003). Such interventions may lead to a reduction in children's problem behaviours and

parents feeling closer to their children, but these approaches require significant changes in parenting behaviour (Patterson *et al.* 2002). These interventions may only gradually – if at all – increase mutuality of feeling between parents and children. For parents who cannot tolerate prolonged tensions between themselves and their children, attachment therapy promises a faster resolution – a promise without evidence behind it. We would argue that it is the parent-child relationship that is the central reason for adoptive parents to come to therapy. Evidence-based interventions that address parental-child relationships and the parent's expectations about them – e.g. Functional Family Therapy (Alexander & Parsons 1997) – also deserve testing with adoptive families.

THE DESIRE FOR A SCIENTIFICALLY SOUND FRAMEWORK THAT ADDRESSES PARENT-CHILD INTERACTIONS

Attachment-based theories were never intended as an explanation of children's underlying temperament, yet temperamental differences clearly influence differential engagement in social relationships. Underlying temperament has been implicated in the two very different behaviour patterns associated with RAD: one highly inhibited and one disinhibited (Zeanah & Fox 2004). Although there is not a consistent set of findings about attachment and temperament, the possibility certainly exists that temperament is primarily responsible for the behaviour of children who have limited skills or interest in social relationships with their parents. The range of children's temperaments is extensive. The current misunderstanding of children with difficult temperaments echoes the historical response to autism. The explanation and treatment of autism was once dominated by psychoanalytic treatments that focused on a Freudian aetiology of children's autism and gave no stock to any possibility of underlying organic issues, and that resulted in lengthy segregation of autistic children into residential treatment (Bettleheim 1967). Perhaps in a similarly flawed response, attachment therapists now assume that the reasons for the disorder lie solely in the children's exposure to maltreatment or limited early opportunities to develop social relationships, and the basic assumption is the same. The child's development is conceived of as limited and frozen for entirely psychological reasons. Interventions based on social and cognitive learning theories offer additional and (at least in general populations) more tested interventions – indeed, the bulk of interventions identified as

promising with abused and neglected children and children with conduct problems have a common social learning ancestry (Barth *et al.* 2005).

Finally, children's transitions into foster and adoptive families may be positively viewed through a life course perspective. This empirically grounded theoretical orientation considers the importance of social constraints and timing on human development, as well as of the connections between individual lives and social relationships, and of varying historical and contextual circumstances (Elder 1996). In the case of foster and adopted children, who likely experience a radical and often comprehensive change in environment, the effect of positive parenting may drastically alter the developmental trajectories of these children. Elder (1998) states that:

...early transitions can have enduring consequences by affecting subsequent transitions, even after many years and decades have passed. They do so, in part, through behavioural consequences that set in motion 'cumulative advantages and disadvantages'. (p. 7)

Through the transition to a strong family setting, children have the opportunity to accumulate advantages with the potential to affect lifelong outcomes. It is critical that interventions target these windows of opportunity in a manner that is developmentally sensitive and appropriate to the context and culture of the family.

CONCLUSION: TOWARDS MORE EVIDENCE-BASED APPROACHES TO HELPING TROUBLED ADOPTIVE AND FOSTER FAMILIES

Interventions with children experiencing conduct disorders have matured substantially during the last decade, and a variety of US federal and state governmental 'blueprints' and scientific papers (e.g. Weisz *et al.* 2005) have identified a core group with the highest levels of scientific support. Most of this work is with biological families and, as yet, the evidence of efficacy with children who have experienced maltreatment is limited. These interventions are The Incredible Years (Webster-Stratton & Hammond 1997), Parent Management Training (Reid & Kavanagh 1985), Multisystemic Therapy (Henggeller *et al.* 1998), Parent Child Interaction Therapy (Eyberg *et al.* 2001; Chaffin *et al.* 2004) and Functional Family Therapy (Alexander & Parsons 1997). Other parent intervention programmes with substantial use and some empirical evidence include Parenting Wisely (Gordon

& Stanar 2003) and Common Sense Parenting (Thompson *et al.* 1996; Barnes & York 2001). The evidence base for treating children with a variety of different conditions is developing in the research world (see for example the work of Judith Cohen, John Weisz, David Kolko, and Scott Henggeller). In the UK, psychologists, psychiatrists and social workers are involved in the development of evidence-based treatments (for example, Stephen Scott and William Yule). There is a risk that adoption workers will miss out on these developments because of their immersion in attachment language and concepts. This appears to be excluding them, and their clients, from benefiting from a wider range of theories and approaches to treatment.

Greater awareness is needed that other promising interventions exist and are being vigorously tested for their ability to enhance parent-child relationships among maltreated children (Barth *et al.* 2005). Whereas these interventions may not, ultimately, be quite as successful with the full spectrum of children having withdrawn or rejecting temperaments, the paradigm for developing such interventions is available (Dozier *et al.* 2002; Chamberlain 2003). Satisfactory parent-child social relationships depend on many factors and may require a broad family and school-focused response. Interventions that have addressed these issues for children developing or showing conduct disorders should be adaptable to interventions with adoptive and foster families.

Professionals who approach their work from the paradigm of attachment theories may incorporate ideas from earlier work to integrate an understanding of the attachment between family members and behavioural interventions that help to modify parent-child relationships (Greenberg & Speltz 1988; Speltz 1990; Scott 2003). More recently, a rigorous clinical trial has been implemented in the USA to assess the effectiveness of the integration of attachment-focused interventions and social learning theory for caregivers and young children in foster care (Dozier *et al.* 2002). This innovation offers promise for the development of science-based interventions that address children's social behaviour and parents' concerns. Ross Thompson, a leading scholar in the area of attachment and development, and colleagues (Thompson 2000; Thompson & Raikes 2003) conclude that understanding children's working models of attachment security can be useful but that cognizance of a broader set of influences on children's social relationships is also critical. These include strategies for negotiating conflict and establishing cooperation. The field needs

to recognize the elements of security that parents and professionals have found in attachment theory and therapies, but also be cognizant of the importance of engendering a broader set of evidence-based interventions to help adoptive and foster families in distress.

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REFERENCES

- Ainsworth, M.D.S. (1989) Attachments beyond infancy. *American Psychologist*, **44**, 709–716.
- Alexander, J. & Parsons, B. (1997) *Functional Family Therapy*. Brookes-Cole, Monterey, CA.
- American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders*, 4th edn. American Psychiatric Association, Washington, DC.
- Arredondo, D. & Edwards, L.P. (2000) Attachment, bonding and reciprocal connectedness: limitations of attachment theory in juvenile and family court. *Journal of the Center for Families, Children, and the Court*, **2**, 109–127.
- ATTACH, Inc. (2004) *About Attachment: The Importance of Attachment*. Retrieved 24 June 2004 from http://www.attach.org/about_attach.htm.
- Barnes, B.A. & York, S.M. (2001) *Common Sense Parenting of Toddlers and Preschoolers*. Boys Town Press, Boys Town, NE.
- Barth, R.P. (2002) Outcomes of adoption and what they tell us about designing adoption services. *Adoption Quarterly*, **6**, 45–60.
- Barth, R.P. & Berry, M. (1988) *Adoption and Disruption: Rates, Risks and Resources*. Aldine, New York.
- Barth, R.P., Landsverk, J., Chamberlain, P., Reid, J., Rolls, J., Hurlburt, M. & Kohl, P. (2005) Parent training in child welfare services: planning for a more evidence based approach to serving biological parents. *Research on Social Work Practice*, **15**, 353–371.
- Barth, R.P. & Miller, J. (2001) Building effective post-adoption services: What are the empirical foundations? *Family Relations*, **49**, 447–455.
- Beek, M. & Schofield, G. (2004) *Providing a Secure Base in Long-Term Foster Care*. British Agencies for Adoption and Fostering, London.
- Bettleheim, B. (1967) *The Empty Fortress: Infantile Autism and the Birth of Self*. Free Press, New York.
- Boris, N.W. (2003) Attachment, aggression and holding: a cautionary tale. *Attachment and Human Development*, **5**, 245–247.
- Bowlby, J. (1951) *Maternal Care and Mental Health*. World Health Organization, Geneva.
- Bowlby, J. (1953) *Child Care and the Growth of Love*. Penguin, London.
- Cairns, K. (2002) *Attachment, Trauma and Resilience: Therapeutic Caring for Children*. BAAF, London.
- Chaffin, M., Silovsky, J.F., Funderburk, B., Valle, L.A., Brestan, E.V. & Balachova, T. (2004) Parent–child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, **72**, 500–510.
- Chamberlain, P. (2003) Multidimensional treatment foster care program components and principles of practice. In: *Treating Chronic Juvenile Offenders: Advances made through the Oregon Multidimensional Treatment Foster Care Model* (ed. P. Chamberlain). American Psychological Association, Washington, DC.
- Cline, F.W. (1979) *Understanding and Treating the Severely Disturbed Child*. Evergreen Consultants, Evergreen, CO.
- Crawford, S., Haworth, F. & Sclare, I. (1986) Holding therapy. *Adoption and Fostering*, **10**, 43–46.
- Dozier, M. (2003) Attachment-based treatment for vulnerable children. *Attachment and Human Development*, **5**, 253–257.
- Dozier, M., Albus, K., Fisher, P.A. & Sepulveda, S. (2002) Interventions for foster parents: implications for developmental theory. *Development and Psychopathology*, **14**, 843–860.
- Elder, G.H. Jr (1996) Human lives in changing societies: life course and developmental insights. In: *Developmental Science* (eds R.B. Cairns, G.H. Elder Jr & E.J. Costello), pp. 31–62. Cambridge University Press, New York.
- Elder, G.H. Jr (1998) The life course as developmental theory. *Child Development*, **69**, 1–12.
- Eyberg, S.M., Funderburk, B.W., Hembree-Kigin, T.L., McNeil, C.B., Querido, J.G. & Hood, K.K. (2001) Parent–child interaction therapy with behavior problem children: one and two year maintenance of treatment effects in the family. *Child and Family Behavior Therapy*, **23**, 1–20.
- Fahlberg, V.I. (1991) A developmental approach to separation/loss. In: *Adoption: International Perspectives* (ed. E.D. Hibbs), pp. 27–33. International Universities Press, Madison, CT.
- Feigelman, W. (1997) Adopted results: comparisons with persons raised in conventional families. *Marriage and Family Review*, **25**, 199–223.
- Fisher, P.A., Gunnar, M.R., Chamberlain, P. & Reid, J.B. (2000) Preventive intervention for maltreated preschool children: impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child and Adolescent Psychiatry*, **39**, 1356–1364.
- Gauld, J. (1993) *Character First: The Hyde School Challenge*. Institute for Contemporary Studies, San Francisco, CA.
- Goldfarb, W. (1943) The effects of early institutional care on adolescent personality. *Journal of Experimental Education*, **12**, 106–129.
- Goldfarb, W. (1945) Effects of psychological deprivation in infancy and subsequent stimulation. *American Journal of Psychiatry*, **102**, 18–33.
- Gordon, D.A. & Stanar, C.R. (2003) Lessons learned from the dissemination of Parenting Wisely, a parent training program. *Cognitive Behavior and Practice*, **10**, 312–323.

- Green, J. (2003) Are attachment disorders best seen as social impairment syndromes? *Attachment and Human Development*, **5**, 259–264.
- Greenberg, M.T. & Speltz, M.L. (1988) Attachment and the ontogeny of conduct problems. In: *Clinical Implications of Attachment* (eds J. Belsky & T. Nezworski), pp. 177–218. Lawrence Erlbaum Associates, Hillsdale, NJ.
- Haight, W.L., Kagle, J.D. & Black, J.E. (2003) Understanding and supporting parent–child relationships during foster care visits: attachment theory and research. *Social Work*, **48**, 195–207.
- Harris, J. (1999) *The Nurture Assumption: Why Children Turn Out the Way They Do*. Free Press, New York.
- Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D. & Cunningham, P.B. (1998) *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. Guilford Press, New York.
- Hill, M., Lambert, L., Triseliotis, J. & Buist, M. (1992) Making judgments about parenting: the example of freeing for adoption. *British Journal of Social Work*, **22**, 373–389.
- Hjern, A. & Vinnerljung, B. (2002) Healthcare for children in foster and residential care. *Acta Paediatrica*, **91**, 1153–1154.
- Hoksbergen, R. & ter Laak, J. (2000) Adult foreign adoptees: Reactive Attachment Disorder may grow into psychic homelessness. *Journal of Social Distress and the Homeless*, **9**, 291–308.
- Howe, D. (1996) *Adopters on Adoption*. British Agencies for Adoption and Fostering, London.
- Howe, D. (1997) Parent-reported problems in 211 adopted children. *Journal of Child Psychology and Psychiatry*, **38**, 401–411.
- Juffer, F. & Rosenboom, L.G. (1997) Infant–mother attachment of internationally adopted children in the Netherlands. *International Journal of Behavioral Development*, **20**, 93–107.
- Kolko, D.J. & Swenson, C.C. (2002) *Assessing and Treating Physically Abused Children and Their Families: A Cognitive-Behavioral Approach*. Sage Publications, Thousand Oaks, CA.
- Kurtz, Z., Thornes, R. & Wolkind, S. (1996) *Services for the Mental Health of Children and Young People in England: Assessment of Needs and Unmet Need*. South West Thames Region Health Authority, London.
- Laibow, R.E. (1988) Towards a developmental nosology based on attachment theory. *Journal of Prenatal and Perinatal Psychology and Health*, **3**, 5–24.
- Levy, D. (1937) Primary affect hunger. *American Journal of Psychiatry*, **94**, 643–652.
- Levy, T.D. & Orlans, M. (1998) *Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families*. Child Welfare League of America, Washington, DC.
- Lieberman, A. (2003) The treatment of attachment disorder in infancy and early childhood: reflections from clinical intervention with later-adopted foster care children. *Attachment and Human Development*, **5**, 279–282.
- Lindblad, F., Hjern, A. & Vinnerljung, B. (2003) Intercountry adopted children as young adults: a Swedish cohort study. *American Journal of Orthopsychiatry*, **72**, 190–202.
- Main, M. & Hesse, E. (1992) The Adult Attachment Interview: some speculations regarding the future. *International Journal of Psychology*, **27**, 210.
- Maldonado-Duran, M., Helmig, L., Moody, C., Fonagy, P., Fulz, J. & Lartigue, T. (2003) The zero-to-three diagnostic classification in an infant mental health clinic: its usefulness and challenges. *Infant Mental Health Journal*, **24**, 378–397.
- Meltzer, H., Corbin, T., Gatward, R., Goodman, R. & Ford, T. (2003) *The Mental Health of Young People Looked After by Local Authorities in England*. Office of National Statistics, London.
- Mercer, J. (2001) Warning: Are you aware of ‘holding therapy’? *Pediatrics*, **107**, 1498.
- Mercer, J., Sarner, L. & Rosa, L. (2003) *Attachment Therapy on Trial: The Torture and Death of Candace Newmaker*. Prager, Westport, CT.
- Myeroff, R., Mertlich, G. & Gross, J. (1999) Comparative effectiveness of holding therapy with aggressive children. *Child Psychiatry and Human Development*, **29**, 303–313.
- O'Connor, T.G. & Rutter, M. (2000) Attachment disorder behavior following early severe deprivation: extension and longitudinal follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, **39**, 703–712.
- O'Connor, T.G. & Zeanah, C.H. (2003) Attachment disorders: assessment strategies and treatment approaches. *Attachment and Human Development*, **5**, 223–244.
- Pallett, C., Scott, S., Blackeby, K., Yule, W. & Weissman, R. (2002) Fostering changes: a cognitive-behavioural approach to help foster carers manage children. *Adoption and Fostering*, **26**, 39–48.
- Patterson, G.R., Reid, J.B. & Eddy, M.J. (2002) A brief history of the Oregon model. In: *Antisocial Behavior in Children and Adolescents: A Developmental Analysis and Model for Intervention* (eds J.B. Reid, G.R. Patterson & J. Snyder). American Psychological Association, Washington, DC.
- Reid, J.B. & Kavanagh, K. (1985) A social interactional approach to child abuse: risk, prevention, and treatment. In: *Anger and Hostility in Cardiovascular and Behavioral Disorders* (eds M.A. Chesney & R.H. Rosenman). Hemisphere Publishing, Washington, DC.
- Richardson, J. & Joughin, C. (2002) *The Mental Health Needs of Looked After Children*. The Royal College of Psychiatrists, London.
- Roisman, G.I., Padron, E., Sroufe, L.A. & Egeland, B. (2002) Earned-secure attachment status in retrospect and prospect. *Child Development*, **73**, 1204–1219.
- Rutter, M. (1996) Clinical implications of attachment concepts: retrospect and prospect. *Annual Progress in Child Psychiatry and Child Development*, 127–156.
- Saunders, B.E., Berliner, L. & Hanson, R.F. (2003) *Child Physical and Sexual Abuse: Guidelines for Treatment (Final Report, 15 January 2003)*. National Crime Victims Research and Treatment Center, Charleston, SC.
- Scott, S. (2003) Integrating attachment theory with other approaches to developmental psychopathology. *Attachment and Human Development*, **5**, 307–311.

- Sinclair, I., Gibbs, I. & Wilson, K. (2004a) *Foster Carers: Why They Stay and Why They Leave*. Jessica Kingsley Publishers, London.
- Sinclair, I., Wilson, K. & Gibbs, I. (2004b) *Foster Placements: Why They Succeed and Why They Fail*. Jessica Kingsley Publishers, London.
- Singer, L.M., Brodzinsky, D.M., Ramsay, D., Steir, M. & Waters, E. (1985) Mother–infant attachment in adoptive families. *Child Development*, **56**, 1543–1551.
- Smith, S.L. & Howard, J.A. (1999) *Promoting Successful Adoptions: Practice with Troubled Families*. Sage Publications, Thousand Oaks, CA.
- Speltz, M.L. (1990) The treatment of preschool conduct problems: an integration of behavioral and attachment concepts. In: *Attachment in the Preschool Years: Theory, Research, and Intervention* (eds M.T. Greenberg & D. Cicchetti), pp. 399–426. University of Chicago Press, Chicago, IL.
- Spitz, R. (1946) Anaclitic depression: an inquiry into the genesis of psychiatric conditions in early childhood. *Psychoanalytic Study of the Child*, **1**, 53–74.
- Sroufe, L.A. (1983) Infant–caregiver attachment and patterns of adaptation in preschool: the roots of maladaptation and competence. *Minnesota Symposia on Child Psychology*, **16**, 41–83.
- Sroufe, L.A., Carlson, E.A., Levy, A.K. & Egeland, B. (1999) Implications of attachment theory for developmental psychopathology. *Development and Psychopathology*, **11**, 1–13.
- Steele, H. (2003) Holding therapy is not attachment therapy: Editor's introduction to this invited Special Issue. *Attachment and Human Development*, **5**, 219–220.
- Thoburn, J., Norford, L. & Rashid, S. (2000) *Permanent Family Placement for Children of Minority Ethnic Origin*. Jessica Kingsley Publishers, London.
- Thomas, N. (1997) *When Love is Not Enough: A Guide to Parenting Children with RAD – Reactive Attachment Disorder*. Families By Design, Glenwood Springs, CO.
- Thompson, R.A. (2000) The legacy of early attachments. *Child Development*, **71**, 145–152.
- Thompson, R.A. & Raikes, H.A. (2003) Towards the next quarter-century: conceptual and methodological challenges for attachment theory. *Development and Psychopathology*, **15**, 691–718.
- Thompson, R.W., Ruma, P.R., Schuchmann, L.F. & Burke, R.V. (1996) A cost-effectiveness evaluation of parent training. *Journal of Child and Family Studies*, **5**, 415–429.
- Torrey, W.C., Finnerty, M., Evans, A. & Wyzik, P. (2003) Strategies for leading the implementation of evidence-based practices. *Psychiatric Clinics of North America*, **26**, 883–889.
- Webster-Stratton, C. & Hammond, M. (1997) Treating children with early-onset conduct problems: a comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology*, **65**, 93–99.
- Weinfeld, N.S., Sroufe, L.A. & Egeland, B. (2000) Attachment from infancy to early adulthood in a high-risk sample: continuity, discontinuity, and their correlates. *Child Development*, **71**, 695–702.
- Weisz, J.R., Doss, A.J. & Hawley, K.M. (2005) Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, **56**, 337–363.
- Weisz, J.R., Weiss, B., Alicke, M.D. & Klotz, M.L. (1987) Effectiveness of psychotherapy with children and adolescents: a metaanalysis for clinicians. *Journal of Consulting and Clinical Psychology*, **55**, 542–549.
- Welch, M.G. (1989) Towards prevention of developmental disorders. *Journal of Prenatal and Perinatal Psychology and Health*, **3**, 319–328.
- Werner-Wilson, R.J. & Davenport, B.R. (2003) Distinguishing between conceptualizations of attachment: clinical implications in marriage and family therapy. *Contemporary Family Therapy*, **25**, 179–193.
- World Health Organization (1992) *The Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (ICD-10)*. World Health Organization, Geneva.
- Zeanah, C.H. (1996) Beyond insecurity: a reconceptualization of attachment disorders of infancy. *Journal of Consulting and Clinical Psychology*, **64**, 42–52.
- Zeanah, C.H. & Fox, N.A. (2004) Temperament and attachment disorders. *Journal of Clinical Child and Adolescent Psychology*, **33**, 32–41.

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