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# Controversial attachments: The indirect treatment of fostered and adopted children via Parent Co-Therapy

ANGIE HART and HELEN THOMAS

**ABSTRACT** Fostered and adopted children often show a large array of psychosocial problems and are conceptualized as having attachment disorders. It can be necessary to engage such children in direct mental health treatment, in addition to interventions set up to deal with their problems through agencies such as Education and Social Services. In order to protect children from a multitude of treating professionals, thereby potentially further weakening the emerging parental attachments, a model is proposed of indirect treatment of children, with the adoptive parents as co-therapists. This elevates the status of parents and is controversial in child mental health work as it challenges traditional hierarchies. We refer to this model, based on a single case study, as Parent Co-Therapy (PCT). It is proposed that this may be a suitable treatment model for fostered and adopted children, particularly in the early years of placement. The model has the potential to strengthen the children's attachments to the parents and vice versa, with a concomitant reduction in symptomatology.

**KEYWORDS:** attachment – adoption – fostering – co-therapy – user-involvement – child mental health

## INTRODUCTION

Child mental health interventions are increasingly predicated on attachment theories. Secure attachments are heralded as the central cause of positive outcomes for families (Ainsworth, Blehar, Waters, & Wall, 1978; Chase Stovall & Dozier, 1998; Howe, 1998; Howe, Brandon, Hinings, & Schofield, 1999;

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Svanberg, 1998). In the case of fostering and adoption, this is seen to be of particular importance (Barth & Berry, 1988; Chase Stovall & Dozier, 1998; Fahlberg, 1994; Groze, 1996; Howe, 1996; Howe, 1998). However, there is only sparse discussion in the literature of precisely how the specific role of the professional in practice impinges on the achievement of secure attachments between these family members (see Byng-Hall, 1991). Thus this article explores the operational relevance of the principles, which have hitherto only been implicit, in debates concerning theories of attachment in the fostering and adoption field.

The operational relevance of attachment theory is, indirectly, part of a wider debate within the caring professions regarding the merits of continuity of care and continuity of carer; for example, in general practice (De Maeseneer, Hjortdahl, & Starfield, 2000) and within the maternity services (Hart, 1997). Although our discussion focuses on the issue of professional involvement in adoptive and foster families, it also has implications for other treatment contexts in which a high level of involvement from different professionals is proposed, and in which attachment issues are paramount. For example, Schofield and Brown (1999) discuss the operational relevance of attachment theory to social work practice with adolescent girls in a residential setting. The practitioners built an awareness of the effects of insecure attachments into their work and treatment programme. This awareness was also fundamental to the focus of interventions with disadvantaged mothers in the NEWPIN experiment (Pound, 1990).

We propose a treatment model that is fundamentally grounded in the notion that in cases where attachment issues are paramount, indirect work with parents may be more effective than direct work with children in the early years of treatment.

The paper contributes to the debate on the care-giving system which influences the attachments of children (George & Solomon, 1999). It explores complex attachments involving five individuals, extending attachment research beyond its traditional focus on the mother-child dyad (Chase Stovall & Dozier, 1998).

The analysis presented in this article is based on a case study of an intervention in which a therapist undertook therapeutic work in collaboration with adoptive parents and explicitly eschewed undertaking direct work with the children. The therapist acted as an advocate and a communication channel between the parents, children and other practitioners to ensure the minimum exposure of the children to professionals. We argue that such practice was effective in this case study, although this model certainly challenges custom and practice within child mental health. This case study suggests that in certain contexts, operationalizing the principles implicit in debates concerning theories of attachment into child mental health practice has positive repercussions for children.

## Attachment theory

Drawing on Bowlby's seminal work, Fonagy and Target suggest that a secure attachment is central to a child's social competence (1997). This, they argue, will provide a growing child with resilience, trust in the caregiver and skills to regulate his or her emotional responses and to develop self-reflective capacities. On the other hand, children who grow up having experienced disorganized, ambivalent or avoidant attachments can be characterized by one of the following: angry, anxious or non-engaging patterns of interaction (Cline, 1992; Howe, 1998). Such children find social interaction difficult and are extraordinarily hard to care for. In adulthood they have difficulty forming close relationships, demonstrate a lack of resilience, and often display severely antisocial behaviour (Howe, 1998).

Many of the suggested therapeutic implications from work undertaken in relation to attachment do not recognize the differences between parents with biological children and those with fostered or adopted children. For example, Svanberg's (1998) comprehensive review of the implications of attachment theory to primary health care follows a developmental model from pre-birth to adolescence and it implicitly assumes that children reside with their biological parents. Advice to professionals according to this model does not recognize that some families in the care of primary health care teams will have experienced multiple placements and insecure attachments with a multitude of caregivers. Linear models such as those suggested by Svanberg (1998) are not applicable in such circumstances. Commentators within the field of adoption and fostering have developed theories of attachment which do not assume a linear model (Howe, 1998; Howe *et al.*, 1999).

Work on children's attachments has led to the diagnostic categories of reactive and disinhibited attachment disorders (Boris & Zeanah, 1999; World Health Organisation, 1992). Accordingly, reactive attachment disorder starts in the first five years of life and is characterized by persistent abnormalities in the child's pattern of social relationships (for example, fearfulness, hypervigilance, poor social interaction with peers, aggression towards self and others, misery and growth failure in some cases). These are associated with emotional disturbances and the syndrome probably occurs as a result of severe parental neglect, abuse or serious mishandling. The disinhibited attachment disorder of childhood is characterized by a particular pattern of abnormal social functions, which arise during the first five years of life and which tend to persist despite marked changes in environmental circumstances. Such behaviours include diffuse, non-selectively focused attachment behaviour, attention-seeking and indiscriminately friendly behaviour, and poorly modulated peer interactions. Depending on the circumstances there may also be associated emotional or behavioural disturbances.

It has been well documented that looked-after children and those being placed for adoption often exhibit severe social, emotional and behavioural problems (e.g. O'Connor, Bredenkamp, Rutter, *et al.*, 1999). These problems

are related to profound attachment difficulties (Beek, 1999; Chase Stovall & Dozier, 1998; Gibbons, Gallagher, Bell, & Gordon, 1995; Howe, 1996; Howe, 1998; Thoburn & Rowe, 1991). Work to date within the adoption field seems largely only to report on the global diagnosis of reactive attachment disorder (Hughes, 1997; Nadelman, 1997). However, in many cases, the behaviour of fostered and adopted children may be categorized according to either the reactive or the disinhibited disorders outlined above (Albus & Dozier, 1999). Other commentators refer to disorganized attachment or the generic term attachment disorder (Chase Stovall & Dozier, 1998). Attachment problems arise as a result of a combination of widely recognized factors including early abuse, removal from the biological family and being subjected to multiple placements in the care of the state while an adoptive family is being sought.

However, a further issue, which is not so widely acknowledged, may also have an impact in this regard; the extent to which looked-after children are brought into contact with a multitude of practitioners. We contend that excessive child-professional contact, particularly in the absence of a secure parental base, has the potential to impede children's primary attachments.

### Case history

Three children, a biologically related sibling group (aged 6, 4 and nearly 2), were referred to the Child and Adolescent Mental Health Service (CAMHS) by the adoptive parents in November 1996 after they had been in their adoptive placement for three months. At this time, no adoption or residence order had been made and attachments were new and insecure. Table 1 outlines the children's background and summarizes the difficulties with which they were presenting.

Research in the field of adoption emphasizes that it is considerably more difficult to intergrate older, special needs children into families than it is to integrate young babies (Brodzinsky, Smith, & Brodzinsky, 1998; Chase Stovall & Dozier, 1998; Groze, 1996; Yarrow & Goodwin, 1973). In this case study, the adoptive parents, who had had no prior parenting experience, were, as is frequently the case in relation to the early stages of parenting such traumatized children, overwhelmed by the children's challenging behaviour and emotional needs (Beek, 1999; Chase Stovall & Dozier, 1998; Groze, 1996; Hughes, 1997; Pinderhughes, 1996). At the time of self-referral to CAMHS, they had no formal support mechanisms in place, with the exception of an occasional visit from their support social worker. Furthermore, because of the children's histories and their developmental problems, a large array of professionals were involved in their care. As seems to be the case for many parents of children with special needs (for example, Close, 1999), it fell to the adoptive parents to co-ordinate appointments and implement treatment regimes. Managing the involvement of professionals was, right from the start, as much of a burden for the parents as managing the behaviour and emotional

*Table 1* The children's histories

| <i>Pseudonym</i> | <i>Age</i> | <i>Context prior to adoption</i>   | <i>Behaviour/difficulties</i>  |
|------------------|------------|--|--|
| Allan            | 6          | <ul style="list-style-type: none"> <li>• Neglect and physical abuse by biological parents</li> <li>• Removed from biological parents aged 4</li> <li>• Two foster placements</li> <li>• Placement in two different schools</li> <li>• In separate foster placement from siblings</li> </ul>  | <ul style="list-style-type: none"> <li>• Extreme concentration difficulties</li> <li>• Hyperactivity</li> <li>• Persistent attention-seeking</li> <li>• Obsession with negative events</li> <li>• Persistent questioning</li> <li>• Aggression towards other children at school</li> <li>• Extreme anxiety if left in room alone</li> <li>• Moderate and specific learning difficulties</li> <li>• Hearing impairment</li> <li>• Speech and language delay</li> <li>• Bed-wetting</li> </ul>   |
| Joseph           | 4          | <ul style="list-style-type: none"> <li>• Neglect and physical abuse by biological parents</li> <li>• Removed from biological parents aged 18 months</li> <li>• Two foster placements</li> <li>• Death of foster father following degenerative illness</li> <li>• In separate foster placement from siblings</li> <li>• In nursery 9 a.m.–5 p.m. in foster home</li> <li>• Went to respite care every weekend from foster home</li> </ul> | <ul style="list-style-type: none"> <li>• Persistent night terrors</li> <li>• Ignoring primary carers</li> <li>• Passivity with primary carers</li> <li>• Extreme aggression in play</li> <li>• Indiscriminate affection</li> <li>• Hearing impairment</li> <li>• Speech and language delay</li> <li>• Learning difficulties</li> <li>• Poor saliva control</li> <li>• Smearing of faeces and urinating on walls</li> <li>• Bed-wetting</li> <li>• Extreme regressive behaviour (crawling, bottle-feeding, talking in baby language, etc.)</li> </ul> |
| Jane             | 22 months  | <ul style="list-style-type: none"> <li>• Neglect and physical abuse by biological parents</li> <li>• Removed from biological parents aged 12 weeks</li> <li>• Hospitalized at 12 weeks for two months – severe failure to thrive</li> <li>• One foster placement</li> <li>• In separate foster placement from siblings</li> </ul>  | <ul style="list-style-type: none"> <li>• Lack of interest in the world around her</li> <li>• Passivity with primary carers</li> <li>• Anxious when left alone</li> <li>• Severe global developmental delay</li> <li>• Hearing impairment</li> <li>• Severe speech and language delay</li> <li>• Severe constipation</li> </ul>   |

needs of the children. More importantly, the constant involvement of professionals potentially thwarted the aim of securing the children's attachment to their adoptive parents. The fact that the newly placed children were bombarded with new people to meet from within the family and friendship circles of the adoptive parents was a further issue of relevance here.

Table 2 gives an indication of the professionals the children had contact with from the point at which they first became introduced into the adoptive home. Only those professionals have been documented who were involved over and above those involved with most children. Included are professionals such as a judge and a Guardian *ad litem* who, while not directly involved with the children's care, nevertheless had power and symbolic significance in the children's lives. Furthermore, because the children moved between a number of placements, and were subject to myriad assessments, they were treated by many more 'mainstream' professionals (such as general practitioners, health visitors, dentists and teachers) than most children would be. Such professionals have been included in the tables. We have not documented those professionals who were involved with the children prior to the children's being placed for adoption. As the children were placed in a different town from the one in which they were in foster care, they also had interventions from a vast range of different professionals prior to their adoptive placement.

## DESIGN OF TREATMENT

It is well documented that even within positive and stable adoptive families, the behaviour of fostered and adopted children is not static and significant events in their lives can trigger adverse reactions (Groze, 1996; Howe, 1996; Howe, 1998). These may be related to prominent times in a child's development such as adolescence, or to events such as contact with birth parents, moving home, etc. Such events often trigger complex feelings concerned with issues of attachment and loss. These feelings can lead to challenging behaviour, which may occur many years after the children have been adopted or gone into long-term foster care. Thus right from the initial point of contact, the design of treatment incorporated the potential necessity for long-term involvement with the therapist or another appropriate professional within CAMHS.

Taking into account the implications of attachment theory, a central strategy adopted by the therapist and the parents involved aiming to reduce the number of unnecessary contacts the children had with adults in the professional world. A further, and related, aim was strengthening the attachment between the adoptive parents and the children and offering a secure base for the adopters to explore issues. This complemented other support systems for the caregivers including an adoptive parents' group and a voluntary organization offering post-adoption support and training.



Table 2 Professionals involved with the children

| <i>Name</i> | <i>Professionals involved with child</i>  |
|-------------|---|
| Allan       | Placement and follow-up social worker (× 2)<br>Judge<br>Solicitor<br>Guardian <i>ad litem</i><br>A number of family centre sessional workers<br>Speech therapist<br>Eneuretic nurse<br>Ear, nose and throat doctors, nurses and audiologists<br>Sensory needs educational support worker<br>Paediatrician<br>Respite carers (× 2)<br>Post-adoption centre workers (× 2)<br>New GP, new dentist, new teachers  |
| Joseph      | Placement and follow-up social worker (× 2)<br>Judge<br>Solicitor<br>Guardian <i>ad litem</i><br>A number of family centre sessional workers<br>Special educational needs co-ordinator<br>Special educational needs assistant<br>Speech therapist<br>Educational psychologist<br>Ear, nose and throat doctors, nurses and audiologists<br>Respite carers (× 2)<br>Sensory needs educational support worker<br>Paediatrician<br>Portage worker<br>Special needs health visitor<br>Post-adoption centre workers (× 2)<br>New GP, new dentist, new teachers, new health visitors (× 3) |
| Jane        | Placement and follow-up social worker (× 2)<br>Judge<br>Solicitor<br>Guardian <i>ad litem</i><br>A number of family centre sessional workers<br>Speech therapist (× 2)<br>Pre-school child development centre play worker (× 2)<br>Pre-school teacher for children with special needs<br>Pre-school child assessment centre teachers and teaching assistants (× 6)<br>Educational psychologist<br>Ear, nose and throat doctors, nurses and audiologists<br>Sensory needs educational support worker<br>Paediatrician  |

*Table 2 Continued**Name Professionals involved with child*


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|  |
|--|
| Special needs health visitor                                 |
| Portage worker   |
| Physiotherapist  |
| Respite carers (× 2)   |
| Post-adoption centre workers (× 2)                           |
| New GP, new dentist, new teachers, new health visitors (× 3) |

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**Treatment models rejected**

As is usual in an assessment, a number of different treatment models were explored. After an initial consultation with the parents, at this stage of the engagement individual therapy for the children was rejected while the parents and therapist addressed the priority needs for a more secure base. It was felt that this, in itself, would facilitate positive outcomes should individual therapy take place in the future. Thus, the therapist and the parents agreed that the children's attachment to their parents was too new and insecure for two or three individual therapists to be introduced at this time. Although it was clear that the children were in need of urgent therapeutic intervention, direct work with them would have probably exacerbated the very problem for which they needed treatment. A resource issue is also of relevance here. Individual therapy in most CAMHS takes time to set up and the family had self-referred in a time of crisis. In view of this, it would have been difficult to set up individual therapy immediately.

The possibility of instigating family therapy was also considered. Although family therapy would have constituted more diffuse contact for the children with a professional than individual therapy, it was nevertheless also rejected on the grounds that the children needed to be protected from further intrusion from professionals. Furthermore, it was clear in this case that the basic criteria for employing family therapy were not met. It is generally recognized that two conditions should exist before family therapy is recommended. These are evidence of a non-functioning group and evidence that the family dysfunction is related to the problem for which help is being sought (Barker, 1998, p. 103). In the case under discussion, the adoptive parents were not implicated in the children's attachment disorders. On the contrary, although the parents were at first overwhelmed by the behaviour and obviously in need of some targeted professional help, it was clear that they had the capacity to support the children in a therapeutic manner. As Chase Stovall and Dozier argue, 'Because foster children enter the dyad with problematic care-giving histories we suspect that foster parents need to be not only sensitive but "therapeutic" as well' (1998, p. 80).

Therefore in this complex situation no single treatment model was appropriate. A combination of different models that allowed the parents to play

explicitly a dual role of client and expert was proposed. We have called this model Parent Co-Therapy (PCT).

### Treatment model developed: Parent Co-Therapy

PCT is the attachment of parents to one key professional (lead therapist) who can help mediate with myriad other professionals, mirroring a key parenting role in regulating the interface between the children and their outside worlds. PCT has much in common with recent postmodernist treatment epistemologies within the family therapy field (Gergen, 1994; Hoffman, 1997) elevating the status of parents and challenging orthodox treatment methods. It shares elements of the social-ecological model of multi-systemic family therapy, which has been developed in the United States (Cunningham & Henggeler, 1999). PCT also contributes to a growing paradigm of treatment models in which indirect work is conducted with children via parents and carers (e.g. Glazer & Kottman 1994; VanFleet, 1994). Table 3 summarizes the different elements of the model that were operationalized in this case study.

The parents were able to consider analytically the behaviour and emotional state of the children and the lead therapist trusted them to reflect honestly on the children's behaviour. Furthermore their analytic capacity was complemented by the existence of the potential for a positive therapeutic relationship between therapist, parents and children. According to Rogers, the therapist's personality and the extent to which she or he is interested and involved are key factors. Empathy, warmth and genuineness are thought to be characteristics that predispose to favourable outcomes in non-directive therapy (Rogers, 1962). These factors are relevant in some degree to all types of therapy, and have certainly been highlighted as important factors in the success of multi-systemic family therapy (Cunningham & Henggeler, 1999).

What matters in particular is how well the lead therapist and parent co-therapists work together. In conventional therapy this can often be assessed at a first interview by:

- the degree of emotional contact or rapport that is made between them
- the feelings that the patient/client expresses
- the therapist's own counter-transference responses.

Rapport was established between the lead therapist and the parent co-therapists. The parents had similar positive relationships with the children. A cyclical model emerged in which the parents were consistently mirroring with the children the emotional contact and analytic framework embedded within the therapeutic work undertaken between the adults. Bowlby (1977) has spoken of the provision of a secure base (a temporary attachment figure) from which the patient/client can explore self and relationships. Attachment behaviour reaches a peak between 9 months and 3 years (Bowlby, 1975). In terms of the therapeutic intervention discussed here, three years was the

*Table 3* Summary of the different elements of the model

| <i>Elements of the model</i>   | <i>Characteristics of these elements</i>   |
|--------------------------------|--|
| Co-therapy                     | <ul style="list-style-type: none"> <li>• Recognition of parent(s) as co-expert(s) in terms of accurate reporting and analysis of children's behaviour</li> <li>• Ability to engage therapeutically with the children at home.</li> <li>• Increasing parity in the relationship between lead therapist and parents.</li> <li>• Therapeutic alliance and rapport between lead and parent co-therapists.</li> </ul>   |
| Indirect treatment of children | <ul style="list-style-type: none"> <li>• Only parent co-therapists directly treat the children.</li> <li>• Lead therapist and parent co-therapists collaborate to reduce the exposure of the children to other professionals.</li> </ul>   |
| Open-ended treatment model     | <ul style="list-style-type: none"> <li>• Parent co-therapists and lead therapist collaborate in arranging breaks in treatment and the ending.</li> </ul>   |
| Psycho-dynamic approaches      | <ul style="list-style-type: none"> <li>• The work between lead and co-therapists is conducted within a therapeutic space.</li> <li>• Lead therapist explicitly sets the boundaries.</li> <li>• Use of transference and counter-transference.</li> <li>• Lead therapist becomes an attachment figure offering containing long-term commitment to parents, which provides a secure base for exploration of children's internal and external worlds.</li> </ul> |
| Behavioural interventions      | <ul style="list-style-type: none"> <li>• The lead therapist and the co-therapists explore behavioural modification processes.</li> </ul>   |
| Multi-systemic approach        | <ul style="list-style-type: none"> <li>• The impact of bureaucratic structures, procedures and resources is explored.</li> <li>• Consideration of biological family system, adoptive family and friendship systems, and professional systems to aid integration.</li> </ul>  |
| Education                      | <ul style="list-style-type: none"> <li>• Lead therapist teaches. This leads to interpretative and behavioural skills in the parents, further strengthening their co-therapy role.</li> </ul>   |
| Advocacy                       | <ul style="list-style-type: none"> <li>• Lead therapist liaises with other professionals.</li> <li>• Reports on the children are jointly compiled by lead therapist and parent co-therapists.</li> </ul>   |

initial phase of the treatment model. This intersubjective sharing of affect between the therapists and then in turn between the parents and the children is broadly modelled on the ideas of theorists such as Stern, Bowlby, Ainsworth and Winnicott. They contend that such 'attunement' is central to a growing infant's psychological development (Stern, 1985, p. 141).

It seems that successful therapy institutes a process of learning that develops its own momentum (Brown & Peddar, 1979). This is founded on the

relationship between therapist and client, the crux of all dynamic therapy, whether at the outer levels of support and counselling or the deeper levels of explanation and analysis (Brown & Peddar, 1979). Such a learning process was certainly evident in the treatment process under discussion and culminated, after two years of treatment, in one of the parent co-therapists (PCTs) teaching multi-disciplinary/multi-agency therapists who were engaged in adoption and fostering work. This educational process was, as Bond & Burns (1998, p. 496) suggest, helpful for individuals (in this case the PCTs) to expand their own 'developmental capacities'. Chase Stovall and Dozier suggest that foster parents need to reinterpret children's behaviour and to be helped to develop alternative behavioural responses. They suggest this may be best done in a psychoeducational format led by an experienced foster parent (1998, p. 81).

A further issue that underlies the design of treatment was the recognition that parenting three children with multiple emotional, behavioural, cognitive and developmental difficulties was extremely difficult, and a potential strain on the parents' relationship. Such adoptions have a high disruption rate, particularly among middle-class parents (Brodzinsky *et al.*, 1998; Rosenthal & Groze, 1992, p. 6). Thus the model employed encompassed the goal of assisting the parents to develop resilience as a couple in the face of difficult behaviour.

One of the responsibilities of the therapist is to create and maintain the therapeutic setting (Brown & Peddar, 1979, p. 47). Employing an open-ended model of practice, the lead therapist met with the parent co-therapists once a fortnight for 50 minutes during school term-times at one of the lead therapist's consulting rooms. This low level of contact time was administered with assurances that if they needed it, at specific times of crisis, more time could be offered. During the treatment period this was deemed appropriate, and although they often faced considerable difficulties between sessions, the parents were largely able to deal with issues in between this time themselves, drawing on some of the principles and strategies they learnt from the lead therapist. This model of intervention develops resilience in the parents within safe and predictable limits. It also takes account of attachment theory, in some senses mirroring the desired attachments between children and adoptive parents. In this form of treatment, the parent co-therapists are given the opportunity to form a long-term attachment to a lead therapist, within specific boundaries.

At different points in the treatment cycle, different elements were more prominent, although the central tenet of indirectly treating the children was always present. Thus at times of crisis, when the children's behaviour challenged the parents' coping ability, the psycho-dynamic, educational and behavioural components of the model were more evident. In some sessions, different topics were explored within all frameworks of the model. Problem-solving, crisis intervention as well as insight and reflection were employed.

In setting up the intervention, both therapist and the parents were careful

to avoid further pathologizing the children. Throughout the work, the emphasis was on normalization. The lead therapist acknowledged at the design stage that the parents did not have any prior parenting experience. Treatment therefore involved helping them to distinguish between common and unusual behaviour in children and exploring the application of Winnicott's idea of the good enough mother and maternal preoccupation in this parenting context (Brown & Peddar, 1979, p. 58).

During the sessions, the lead therapist discussed the children's behaviour with the PCTs and offered strategies, drawing again on Winnicott in the context of his work on delinquent behaviour as an expression of hope (1958). In particular, the lead therapist interpreted an intensive period of stealing and destructive behaviour by Joseph in this light. The adoptive parents were then able to use this conceptual framework as a tool to help Joseph's teacher reframe his actions in a more positive light.

The lead therapist also assisted the children by acting as an advocate for them in situations in which the parents had difficulties dealing with other professionals; for example negotiating statements of special education need, adoption allowances, respite care, etc.

Each of the treatment strategies employed can be conceptualized as falling within one or more of the following areas: instigating behavioural change; facilitating emotional containment; increasing parental attunement with the children; validating the parents' intuitive actions; maintaining parents' confidence and resilience. The following are specific examples of treatment implemented.

During the first year of placement Joseph's disinhibited attachment behaviour was severe. It threatened his personal safety, affected his interaction with his adoptive parents and sometimes made other people feel uncomfortable. Outside the house he would hone in on complete strangers and attempt to befriend them, often initiating close physical contact. At home, whenever adult visitors came, he would invariably attempt to sit on their laps. Some adults interpreted this behaviour as Joseph being friendly and affectionate, and they encouraged it further. Others found it disturbing and were at a loss as to how to deal with it.

Pooling their knowledge of dealing with attachment issues, the lead therapist and the co-therapists devised a method for dealing with his disinhibited attachment behaviour as follows.

- 1 Consciously reflect on past situations in which Joseph's disinhibited attachment behaviour was most pronounced.
- 2 Make efforts to minimize Joseph's exposure to these types of situations involving new people.
- 3 In unavoidable situations, verbalize the process of Joseph's behaviour. When Joseph initiates physical contact with a stranger, say: 'At the moment Joseph needs to sit on the laps of people he doesn't know. We're trying to help him not to do this because it's best if he sits with us. We're his family

and he is beginning to trust us. Joseph, you can sit on [the stranger's] lap for five minutes and then it's time to come back to us.' After five minutes say firmly: 'It's time to come back now.' Physically remove the child from the stranger's lap and put him on the adoptive parent's lap. If he attempts to return, take him away and hold him in a positive manner.

- 4 Whenever possible, inform family and friends of this strategy so that they can co-operate with it.
- 5 Make explicit adoptive parents' feelings and behaviours in relation to Joseph's behaviour. Explore in the clinical setting how these differ between the parents and how they relate to issues in the adoptive parents' past.

Regression was a prominent feature of the behaviour of all three children. The lead therapist helped the parents by highlighting their own intuitive practices in this regard. For example, she encouraged them to bottle-feed the children if it seemed appropriate, and to allow Joseph, wherever practical, to satisfy his overwhelming need to take on the identity of a cat, crawling rather than walking, purring rather than talking. This validation from the lead therapist was important since some of these practices implemented by the parents were controversial and led to adverse comments. At the beginning of the treatment cycle in particular, the adoptive parents needed positive reassurance that their actions were helpful to the children, regardless of what others might think. Furthermore, the parents were able to relay advice from the therapist to teachers and other professionals involved with the children. This increased multi-disciplinary knowledge and understanding of attachment issues. It also led to a co-ordinated team approach to the manner in which the parents and professionals such as teachers dealt with their behaviour.

At the age of 4½, Jane could still not be in a room alone without screaming in terror. The fact that Allan and Joseph were both symptomatic in their own ways meant that the adoptive parents did not think about the brothers' taking responsibility for Jane; instead they themselves were left having to be constantly in her presence. Rather than taking all the responsibility for Jane themselves, the lead therapist suggested that the adoptive parents use her brothers to give her security. This then became rewarding for all three children.

Six-year-old Allan's negative attention-seeking behaviour meant that he persistently asked questions to which he already knew the answer. He would present with a stream of questions such as 'Am I sitting in the back of the car?' when he was sitting in the back of the car, 'Is it raining' when it was pouring with rain, etc. The lead therapist suggested the adoptive parents put a time-limit on this activity, saying: 'Allan, you seem to need to ask questions you already know the answer to, you can ask questions for five minutes now and then we'll have ten minutes quiet time.'

Another behaviour exhibited by Allan was a frequent inability to converse without demanding food, activities, etc., from the adoptive parents. It was often as though he could not interact without having something tangible to

show for it. The lead therapist suggested that in these situations the adoptive parents should sit with Allan, stroke him and tell him that he seemed a bit worried and needed soothing. As they stroked him, whenever he opened his mouth to demand something or to ask a question he already knew the answer to, the adoptive parents were to put a finger to their mouths and suggest he 'shhh' in the manner a parent would to a small baby. Although at first resistant to this, Allan soon settled into enjoying this positive attention. Eventually it seemed that he internalized this more positive pattern himself, sometimes saying when he became agitated, 'Oh here I go, I'm in a tizzy, there, there, there!'

For the first 18 months of placement Joseph woke three or four times each night screaming intensely. Despite his being inconsolable, the adoptive parents would patiently sit with him and cuddle him, in their attempts to get him to go back to sleep. After 18 months, one night, in the middle of a loud bout of screaming, one of the adoptive parents lost her temper as a result of the cumulative and compounding effects of the children's behaviour. Joseph's night terrors diminished considerably after this. Following this event, in a reflective session, the actions of the adoptive parents were validated and explored in-depth. Feelings of reaching breaking point as a parent were also examined, together with intensive emotional interactions and surprising positive outcomes from seemingly negative events. There was acceptance that parents can reach the end of their tether and that both parent and child can survive.

## OUTCOMES

The problem of assessing outcomes in therapy remains an important challenge. Studies undertaken by sociologists suggest that the lack of supportive relationships contributes to the development of the depressive state (Andrews & Brown, 1995; Brown & Harris, 1978; Brown, Harris, & Hepworth, 1995; Oakley, Rajan, & Grant, 1990). Such evidence supports the value of therapeutic input. Recent debates concerning the impact of social capital on children's well-being also have much relevance here (Morrow, 1999). Within the field of fostering and adoption, Barth and Berry (1988) argue that the provision of post-placement support reduces the risk of disruption.

No formal evaluation of the children's psychological state has been conducted. Indeed, the model of treatment that was employed would not readily embrace such an evaluation, since one of its central aims was to reduce contact with professionals rather than increase them.

After three years of therapeutic input, outcomes can be summarized as follows:

- 1 more secure attachments achieved;



- 2 concomitant reduction in the children's extreme symptomatology arising from attachments to adoptive parents;
- 3 increased parental confidence and enjoyment of the children leading to rewarding mutual interaction.

Reports from school and from the parents show that while most of the children's symptoms have not disappeared completely, after the three-year treatment period they are less prominent. In particular, the more extreme behaviours such as smearing of faeces, regression to the point of not walking, prolonged night terrors, the persistent seeking of physical affection from total strangers, etc., have almost disappeared. Less extreme behaviours persist, such as inability to concentrate, enuresis, persistent attention-seeking behavior, immaturity and the inability to be alone. However, the adoptive parents have been furnished with a range of strategies to deal with specific behaviours and are also protected by the knowledge that the intervention has the potential to be long-term if this is necessary. This is an important fall-back since the dynamics of the children's behaviour has changed and will change in response to external events. For example, a burglary two and a half years after the children were first placed resulted in extremely regressive behaviour from Allan for a two-month period.

The children see the parents as effective agents in their increasingly pleasurable interactions. These relationships are not diluted in any way by outside therapeutic relationships. The rewardingness of interactions and sense of competence are important factors in promoting resilience in the parents and children. Rutter's ideas on the development of resilience (1987, 1995, 1996) expands on this theme. His work explores the notion that 'turning-point' experiences occur in families, thereby strengthening attachments (1998).

The children's early years' experiences, their learning difficulties and their hearing impairments continue to affect how they experience the world and have implications for their relationships with their adoptive parents, with friends and with the extended family, and also for their education. It is therefore important to note that in the case of adoptive children with such complex genetic and social backgrounds, short-term interventions are unlikely to succeed. The long-term, open-ended nature of the intervention allowed for this.

## DISCUSSION

The PCT model stresses that adopters and foster carers are not causally connected with the children's genetic and psycho/social vulnerability. Thus, in terms of their relationship with both the children and the therapist, they will always fall somewhere between parent and professional. This is clearly not a static relationship, and it must be acknowledged that adoptive parents and foster carers are not themselves *tabulae rasae* (Hughes, 1997, p. 44). The

impact of issues such as infertility, although not applicable in this case study, is thought by commentators to be particularly pertinent in this regard (Blum, 1983; Brodzinsky *et al.*, 1998). The intervention recognizes that as the children become more enmeshed in a relationship with the adoptive parents, the adoptive parents become more embedded in the production of their feelings and behaviour. This is clearly a complex issue and one that presents challenges to the lead therapist. A balance must be achieved between acknowledging the effects of past trauma and dealing with relationships in the present. The model is different from mainstream therapeutic interventions, which may be predicated on the parents being implicated in the symptoms with which the children are presenting (Bond & Burns, 1998). Nevertheless, different elements of the model can be implemented to a greater or lesser extent depending on the particular issues with which the parents present.

Despite the rhetoric of parental empowerment and the increased employment of peer-led interventions (Bond & Burns, 1998), many programmes that target parents are concerned with ameliorating poor skills and changing negative family dynamics (see Bond & Burns, 1998; Edwards, 1995; Kosterman, Hawkins, Spoth, Haggerty, & Zhu, 1997). It is becoming increasingly recognized that interventions giving importance to lay as well as professional perspectives are more successful. This is witnessed by the increase in peer-led initiatives (Cunningham & Henggeler, 1999; Rogers & Pilgrim, 1997). However, for professionals trained within a paradigm that has historically pathologized parental lay knowledge, it is challenging to adjust to working in a context in which parents are not wholly implicated in the children's pathology. Such families will require a different way of working, as is evidenced by the exploration of the work undertaken in this case study. Of course it is not suggested here that adoptive parents have no influence on their children. But perhaps responses to such families should be considered in relation to work with children and their carers in residential care. Adoptive and foster families are not biological families within which straightforward developmental models can be applied, nor are they therapeutic communities in institutional settings. They represent a position on a continuum and work with them should reflect this. Such parents should be viewed as an important part of the multi-disciplinary and multi-agency team; user involvement rather than tokenism.

These kinds of co-therapy relationship present complex challenges to conventional therapeutic boundaries (Wosket, 1999). Issues such as power, conflict and enmeshment between the lead and co-therapists need to be explicitly addressed in order that the indirect work with the children is not threatened by complications in the adult system. Such co-therapy relationships clearly have the potential to be controversial, although others who have drawn on similar principles have not raised the challenging issues that may arise in attempts to instigate a more egalitarian therapeutic model between therapists and parents (for example, Hughes 1997). Hughes (1997) contends that parental participation should be a central feature of the treatment of fostered

and adopted children. In his model parents are active co-therapists with the lead therapist, although the children are present in the therapeutic setting.

It is widely documented that foster and adoptive parents often feel blamed by professionals for the behavior of children which, it is increasingly being recognized, has its origins in events that preceded the child's arrival in the adoptive home (see Beek, 1999; Perry & Pollard, 1998). Treatment models such as PCT allow for the fact that parents are not implicated in the child's pathology, whilst recognizing that coping and dealing with the repercussions of early trauma require therapeutic assistance.

The involvement of users in service design, treatment and provision is a growing paradigm that fits in with government-led policy on client/patient participation (Pilgrim & Waldron, 1998). This is also the case in relation to direct work undertaken with children; for example, in relation to life-story/preparation for adoption, etc. (Triseliotis, Shireman, & Hundleby, 1997). However, this case study advocates children's being protected from direct user involvement and possibly from undertaking short-term life-story work directly with practitioners, particularly in the early few years of the attachment process.

Services are increasingly being asked to talk to children as 'users' in the spirit of consultation with clients (Horgan, 1998). In the case of newly fostered or adopted children, this may not be in their interests. Professionals need to know when it is appropriate to consult with children. It is argued here that keeping away from children, i.e. working with them indirectly, might be more in their interests. In this case study, over time the adoptive parents have learnt to share the children in a protective way in many different contexts. This is analogous to a mother's gradual separation from her growing infant. Such conceptualization is controversial since it challenges the current philosophy of providing extensive, direct multi-disciplinary and multi-agency input to looked-after and adopted children.

Pilgrim & Waldron (1998) identify the lack of parity in the relationship between user and professional in the mental health context. Sometimes in this case study the consequences of such power relations were relatively unproblematic. However, on other occasions rather than being perceived to be protecting the children, the actions of the parents appeared to be interpreted as hiding the children. This practice had the inverse effect of making professionals even keener to meet the children. While some individual practitioners did have some sympathy for this indirect working, and tried to accommodate this wish of working through the lead therapist and/or PCTs, they were themselves often impeded by bureaucratic procedures and structures related to child protection and resource allocation. The surveillance orientation of public services, which has been extensively documented (Leonard, 1994; Thompson, 1998), coupled with the practice of the privileging of professional knowledge over parental knowledge, was not conducive to PCT.

The PCT model relies on the lead therapist fully trusting that the adoptive

parent co-therapists will bring to the session an interpretation of reality that has a robust correlation with the behaviour of the children. On the part of the adoptive parents, this is perhaps reliant on some ability to self-reflect in a learning context, and to have some insight into the children's behaviour. However, given that in public services professional knowledge is often given higher status than parental knowledge, it can be difficult when the lead therapist is asked for advice on the children from other agencies. The fact that the therapist does not actually treat the children directly can be seen in some way as diluting the evidence. In some professional circles, to see a child is to know a child, or at least to have a professional opinion on him or her (unless you are the parent). Also, from the adoptive parents' point of view, the fact that the children do not attend therapy can mean other professionals who are aware of this stigmatize the parents as needing therapy. This is an illustration of the subtle discrimination that can occur when people are using mental health services.

Multi-agency and interdisciplinary work is currently enjoying great credence with central government. While such working practices are often appropriate, this case study shows that for fostered and adopted children, the involvement of multiple professionals may bring unnecessary short-term exposure to adults, as well as an over-emphasis on assessment and task duplication. PCT has the potential to cut down these practices, with its emphasis on appropriate containment and holding.

## CONCLUSION

It is usual in the mental health field for overwhelming cases to be shared between a number of different professional disciplines. In this model the treatment was shared between the adopters and lead therapist for the crucial first three years of the placement, when symptomatically the children were at their most disturbed.

This case study suggests that indirect work with children is highly beneficial in cases in which attachment difficulties are pre-eminent. In such work, the lead therapist and PCTs take a central role in co-ordinating and supporting all issues concerned with health, education and social welfare of children. For some adoptive parents with single adoptions and/or children without such complex needs, this may be more of a health promotion service, helping them through the early years of attachment, but with the option of returning to the lead therapist during times of crisis in the child's development, e.g. adolescence.

Secure attachment of the children to adoptive parents is one of the goals of therapy leading quite naturally, it is argued here, to a diminution of symptomatology. This is a single case study, but we suggest the model could be implemented in work with other looked-after and adopted children.

In a climate of increasing recognition that foster and adoptive families need

considerable post-placement support (Barth & Berry, 1988; Beek, 1999), as well as providing significant therapeutic benefits, PCT also has the potential to be a cost-effective vehicle for the provision of such support. Parent-Co-Therapy at 50 minutes once a fortnight, term-time only, for three years is a relatively small input (£1,000 per year, including indirect costs) compared to the adoption breakdown of three children with special needs.

In this article we have explored the paradox that the very children who need the least confusion regarding those to whom they should attach are exposed to myriad professionals, each armed with good justification for his or her involvement. Minimizing unnecessary attachments and moving adoptive parents into a central position therapeutically, have been the main tenets of this paper.

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