

# Dyadic Developmental Practice (DDP): A framework for therapeutic intervention and parenting

Geraldine Casswell, Kim S. Golding, Edwina Grant,  
Julie Hudson & Pam Tower

---

*Dyadic developmental practice (DDP) provides a framework for supporting looked after and adopted children to recover from trauma through the parenting and support they receive, supplemented by therapy when appropriate.*

*Based on theories of attachment and intersubjectivity, DDP aims to help family members to feel safe and connected through the development of healthy patterns of relating and communicating. Of central importance is supporting parents to manage challenging behaviour whilst also staying emotionally connected with the children. This is achieved by helping parents with day-to-day parenting based on principles of playfulness, acceptance, curiosity and empathy (PACE), as well as through therapeutic sessions.*

*The model is briefly described before discussing the range of ways that DDP is influencing practice in the UK. Case studies will illustrate this and the developing evidence base is described.*

*Note: We use the word 'parent' to include anyone in the parenting role whether in foster, kinship, adoptive or residential homes.*

**C**HILDREN AND YOUNG PEOPLE who have experienced early adversity necessitating alternative care often struggle to get appropriate help. A survey investigating placement stability for looked after children revealed high levels of concern from local authorities and independent agencies about the availability of mental health services (Holland et al., 2005). This is also noted in a Scottish study (Minnis et al., 2006) and in Tarren-Sweeney's review (2011); this latter concluding 'that sizeable proportions of children in public care who manifest mental health problems do not receive adequate clinical assessment or access to mental health services'. This is acknowledged within key publications: *Every Child Matters* (DfES, 2004), *Care Matters* (DCSF 2007), *Promoting the Health and Well-being of Looked After Children* (DCSF, 2009) and *Promoting the Quality of Life of Looked After Children and Young People* (NICE/SCIE, 2010).

Despite this identified need therapeutic interventions developed and researched with this population of children are limited.

Reliance on traditional cognitive behavioural interventions is problematic. Howe (2005) suggests that traditional therapies do not take enough account of the different physiology of the children's traumatised brains. Similarly, Perry (2006) places importance on 'bottom-up' therapeutic interventions which provide regulatory support and more reflective support when emotional regulation is improved. Interventions are needed, informed by attachment and trauma theories.

Dyadic developmental psychotherapy was developed by Dan Hughes as a therapy for children and young people who had been exposed to interfamilial abuse, neglect and loss (Hughes, 2007, 2011). The term dyadic developmental practice acknowledges that DDP has developed to encompass a framework for helping children through the parenting and support they receive as well as therapy.

This paper will consider the range of ways that the DDP model is currently being applied within the UK in collaboration with practitioners from across the world.

### **Dyadic Developmental Psychotherapy: Attachment informed therapeutic intervention**

DDP as a therapy has a central treatment goal to facilitate attachment security between the child and parents. This is achieved by using here and now intersubjective experiences in the therapy room to discover positive qualities in the child, provide emotional regulation, and facilitate a new understanding of why the child has needed to use distrustful, defensive and controlling behaviours in order to keep safe (Hughes, 2011).

The therapist seeks to understand the child in the moment and to communicate that understanding back to him. As the child experiences his inner world being understood, the therapist helps him to remain emotionally regulated (co-regulation) whilst exploring and finding meaning in experience past or present (co-construction of meaning). The therapist additionally helps the child to communicate with the parents so that co-regulation and co-construction become a shared process between parents, child and therapist. In this way, the child is helped to feel more secure with parents, so that he can reduce the need to control the relationship and can seek comfort in a straightforward way.

#### ***Harry's story***

Harry, aged 17 years, has learning difficulties and Asperger's syndrome, the symptoms of which have become increasingly distinct and incapacitating. He and his brothers were removed from their birth mother when Harry was 7 and placed with Helga and Jan, who later adopted them. Harry suffered severe neglect and emotional and physical abuse, and was exposed to domestic violence as a young child. He had no speech until he was 10. Two days after he was told contact with his birth mother was stopped, Helga heard him talking in sentences in the toilet.

Helga and Jan encompassed the DDP model within their parenting. Harry responded well, forming a clear attachment

to them, particularly Helga. The attachment was, however, insecure as Harry worried intensely if Helga was away from him for more than a few minutes. Furthermore, Harry continued to have a compelling need to please his adopters, was repeatedly bullied by his brothers and peers, and had little confidence or ability to assert himself. As his Asperger's symptoms developed, Harry withdrew further, becoming almost a recluse.

Harry, Helga and Jan underwent 12 sessions of dyadic developmental psychotherapy. When first seen, Harry seemed to have little sense of self or understanding of his feelings. The intersubjective dialogue, although slow to establish, was essential in helping Harry explore his inner world. Harry had precise memories of early traumatic events and his behavioural responses to these. He remembered his birth mother shouting, calling him names and hitting him with a stick. His response was to 'go away', withdrawing into himself. Helga, Jan and the therapist's emotional reactions to Harry's story gave him the safety to start to 'feel', and later to name and understand his sensations. Through this process, Harry understood that he still experienced extreme fear when people called him names linked to feelings of rejection by and fear of his birth mother. He remembered an intense 'need' to keep his birth mother happy and how sad, helpless and frightened he was when he could not do that. He described how 'empty' he felt when his birth mother actively ignored him.

In contrast, Harry 'felt' the warmth of the love that his adopters had for him. He 'felt' the delight of them and the therapist. He 'felt' the comfort and validation of his adopters and therapist experiencing sadness and fear with him when describing intense traumatic events. He was shocked that his adopters could be angry with his birth mother for hurting him so much.

As the sessions progressed Harry's emotions became integrated with his memories and he started to understand his narrative and why he did the things he did.

He became more expressive of his feelings and asserted himself with his brothers and peers. His compulsion to 'please' Helga reduced and he developed a more secure attachment alongside a developing sense of 'self'.

The therapist asked Harry to write down things he wanted to say to his birth mother at the beginning and end of therapy. Initially, Harry tried to please his birth mother and was overly concerned about her feelings. The only reference he made to himself was to wonder if she was proud of him because he could talk. Latterly, he listed 28 questions for his birth mother: the two most telling of which were, 'Why didn't you want me to speak?', and 'Why did you treat me like a non-person?'

**Dyadic developmental practice:  
Attachment informed parenting support**

As the DDP model has evolved, the value of preparing parents to extend the same principles used in the therapy room to the day-to-day tasks of parenting has become ever clearer. Children with emotional difficulties experience more insecurity or disorganisation of attachment and distrust of relationships. Parenting needs to extend beyond a behavioural approach, with more attention to connection with the children's emotional experience. The children experience an unconditional relationship with a parent who is attuned to their emotional experience whilst able to provide containment for their behaviour. Without this connection children can be left with pervasive feelings of shame and a conviction that they will lose these parents just as parents have been lost to them in the past.

The attitude of PACE (denoting qualities of [P]layful parenting, [A]cceptance of the child's inner world, [C]uriosity about the meaning underneath the behaviour and [E]mpathy for the child's emotional state) is central within DDP. It helps parents to offer this enhanced connection within their day-to-day parenting (Hughes, 2009; Golding & Hughes, 2013). This attitude requires a level

of mentalisation skill so that parents can be mind-minded towards their children; understanding, without judging, their inner experience of thoughts, feelings, beliefs, worries, fears and wishes.

Part of parenting support involves helping parents explore their own attachment history; linking this to their experience of parenting the child. Parents become more aware of potential triggers which can cause them to lose empathy and interfere with their capacity to be mind-minded. A process of exploring hopes and dreams, fears and doubts, current experience and attachment history can lead the parent to a greater self-understanding and increased capacity to stay present for the child even in the heat of parenting.

*Janet's attachment history*

Janet is aunt and now parent to Jack and Andrew. The boys came to live with her when they were 3- and 5-years-old respectively. Their early experience included neglect, exposure to domestic violence and extensive instability. Janet is now struggling to cope with the behavioural legacy of this early experience. The boys are constantly fighting as each competes for the attention which they believe is in short supply. This, coupled with lying, stealing and regular meltdowns has brought Janet to the edge of despair. Her therapist helps her to explore her attachment history as part of the parenting support she has requested. Having had a chance to talk about her current frustrations Janet shares the hopes and dreams she had when the boys came to live with her. This reminds her of her good motivations and she remembers that she is a good person trying to do the best she can. The conversation turns to her fears and doubts. Janet is readily able to reflect on her fears for the boys' future and her doubts in her own parenting abilities. She anticipates criticism from others. The therapist asks her when she finds it hardest to feel empathy for the boys. After some thought Janet thinks it is when the boys are fighting; she worries that others will see her

as out of control. The therapist wonders about this fear of being judged, leading into an exploration of Janet's conflictual relationship with her own mother. Janet is helped to see the link between her current frustrations and her experience of being not good enough whilst growing up. This self-reflection is helpful for Janet in understanding her responses to the boys. She notices how hard it is to focus on their experience when her past experience continues to erode her confidence.

Parenting support based upon the DDP model recognises the level of stress that parents can experience when parenting developmentally traumatised children. At the extreme, parents can lose their capacity to provide empathic, attuned caregiving in what Hughes and Baylin (2012) have described as blocked care. The relationship-based focus of DDP can provide the emotional support and connection to an attuned other that is necessary to help these parents become unblocked again, reducing their stress and recovering their empathy.

Group support can be helpful. *The Nurturing Attachments Training Resource* (based upon the Fostering Attachments Group; Golding & Picken, 2004; Golding, 2008) helps parents to develop their parenting skills in line with DDP principles (Golding, 2014). This three module, 18 session programme has PACE and mind-mindedness at its core, informing the house model of parenting. Participants are taught about attachment theory, relationship development and the impact of trauma on children's development and security. This provides the theoretical basis for developing parenting skills matched to the emotional, developmental and behavioural needs of the children. Whilst parents are helped to manage behaviour, this is within the context of building trust and security with the children.

### **A DDP informed model for providing wrap around support to adoptive families**

Increasing the numbers of children placed for adoption is government priority. However, the importance of including a model and funding for the provision of adoption support is often omitted.

One support service for adoptive families from matching onwards has proved successful (Hudson, 2006, Chapter 8). Dyadic developmental practice was integrated into all service levels. This included regular parental and network consultation, therapy and parenting programmes. Therapists worked closely with all agencies including senior managers in social care and commissioners. The latter enabled multi-agency adoption support protocols to be in place between social care, CAMHS, and paediatric services.

Whilst positive new behaviours are known to develop in adoptive families during the first year, the challenging behaviours also remain (Steele et al., 2003). A strength of this service was that psychological intervention was provided early in the process of adoption and could then be targeted appropriately throughout the adoption journey. This made good use of scarce resources. Key principles were:

1. Psychological input into adopter preparation courses.
2. Intervention informed by detailed analysis of psychologically relevant historical and current information about the children and the prospective adoptive parents.
3. Normalisation, providing a context of adoption support where 'having some difficulties' is anticipated and seen as normal.
4. Timely intervention, from matching onwards, throughout childhood.
5. Regular multi-agency parent training.
6. Multi-agency parental consultation. This proactive model enabled key themes to be identified, and addressed positively as they arose, before potentially unhelpful

parent-child interactions become established. Themes included:

- Recognition of the impact of the child's persistent need to control on parents, and on the child's emotional development.
- An increase in the child's verbal and physical expression of aggression towards a parent, often the mother.
- New information from the child about the child's past, such as sexual abuse.
- Troubles at school for children who are academically able but who have emotional difficulties. They are not yet ready to manage the complexities of a school environment without a safe adult figure nearby to help them translate the world.
- Children being perceived as splitting parents into one good and one bad.
- Parental worries about not feeling able to like a child.

Additionally, this consultation provided a flexible, responsive and non-stigmatising assessment as to which families require and will benefit from additional interventions.

7. The provision of dyadic developmental psychotherapy for some children and their adoptive parents.
8. Rather than taking a 'wait and see' approach families could access support from known professionals as needed, supported by long-term pro-active follow-up.
9. Seeing adolescence as a key developmental time to revisit earlier themes and consolidate.

This adoption support model therefore provided a flexible combination of consultation, parent training and relationship focused therapy, supported by routine appointments every six months. Consistent use of the service principles enabled children to integrate past trauma, allowed children and their parents to develop a shared and flexible coherent narrative about their lives together and apart, and minimised the risk of parents developing 'blocked care' (Hughes & Baylin, 2012).

### **Applying DDP principles to residential settings**

Understanding and education are key to using dyadic developmental practice effectively in residential settings. Professionals in qualifying courses in social work, health and education have had little teaching in attachment theory, developmental trauma or neuroscience (see, for example, the Scottish Government-commissioned *Attachment Mapping Exercise* (Furnivall et al., 2012)). Providing in-service training in dyadic developmental practice aids understanding of why the children behave as they do, and creates a robust framework for managers and staff to work together with a common purpose. This reduces their experience of oppositional behaviours as a personal 'attack' and reduces conflict about ways of working with and caring for the child.

Residential settings need an articulated and practised mission statement. DDP values emphasise the intentional building of safe, positive and genuine relationships with the children, with families and between staff. The philosophy and work is about alliance not compliance, and acceptance not judgement. Distressed children and teenagers need to learn that adults can be safe and fun to be with. Keeping the child close builds trust, allows appropriate independence and aids the teaching of new skills. This offers the child a secure platform from which to develop. The clear message given by staff needs to be: 'I can take care of you, I will take care of you, and I want to take care of you.'

Residential care is a complex emotional and social environment. Individuals in and between staff teams will, at times, disagree with each other about ways of supporting children and how to provide boundaries and consequences. Accepting that this is part of residential child care, and modelling emotionally regulated ways of conflict resolution and repairing relationships is the DDP way. However, the challenges in this way of working cannot be underestimated. An awareness of this in the recruiting,

induction, training and ongoing support of staff in all roles from cook to senior manager is essential. A core quality is the capacity to be curious about self. Much skills practice in PACE, patience and perseverance will be needed.

Understanding the need to maintain a core attitude of PACE is one thing, 'being' and maintaining this attitude on a day-to-day basis with children who are relationally resistant, is quite another; it is professionally and personally challenging. Developmentally traumatised children and young people are highly reactive to being or feeling unsafe and become emotionally dysregulated quickly and often unpredictably. Powerful and 'big' feelings predominate, that when working relationally, are easily awakened in staff. In short, it is very difficult for a staff member to remain emotionally regulated and cognitively connected/reflective when a child offers little acceptance of care but a continuous onslaught of verbal and physical abuse. Staff are at risk to experience habitual 'blocked care' just as are parents who are raising children who do not respond to their care (Hughes & Baylin, 2012).

Holistic containment through regular individual supervision and team meetings is essential (Ruch, 2008). The ethos and core attitude of support with and amongst staff is Acceptance, Curiosity and Empathy, with an emphasis on reflective practice and accountability. Staff are encouraged to be curious about themselves and with each other. There is acknowledgement that there are times when they will feel angry, stressed and anxious: it's a challenging job and they will need proactive support.

Structure and predictability are essential. Daily routines are adhered to and change prepared for. Rituals for celebrating success, birthdays and anniversaries are in place and take account of the children's capacity to manage excitement and achievement. Opportunities to share positive experiences and have fun are in place. The children and young people experience seeking and accepting adult soothing and comfort,

rather than aggression as the best ways of dealing with anxiety and stress. It is safe to ask for what they need, whether support with homework, washing their hair or playing a game. Staff will help them whilst supporting appropriate independence. Positive touch through cuddling, massage and playing is encouraged and celebrated. When children have 'fallen out' or behaved dangerously with staff or with each other, safety and relationship repair are at the forefront of consequences. New, prosocial ways of behaving are practised and celebrated.

Residential establishments need robust systems of admission, assessment, recording, reporting, reviewing, rotas, key working and supervision. The DDP model ensures the systems will be congruent with attachment-focused work. This aims at supporting every child's uniqueness and ability to achieve at their own pace. Children experience pride in their forward steps that can be shared with their families, sometimes for the first time.

When children move on from the establishment continued contact with staff members is planned for and regarded positively, not, as so often the case, regarded with suspicion. The children need continuity of relationships, to know that staff are minded of them, whether or not they are present, and to be supported through change and loss.

### **Evidence base for DDP**

DDP is both theoretically grounded and with a developing research base. The DDP framework provides interventions which are congruent with attachment theory, with its emphasis on security to support exploration. It fits well with Bowlby's advice for the therapist to be 'reliable, attentive and sympathetically responsive... to see and feel the world through his patient's eyes, namely to be empathic' (Bowlby, 1988, p.140). Similarly, aims of DDP fit with Bowlby's suggestion that we should enable the 'patient' to construct or reconstruct working models of self and attachment figures. In this way, Bowlby suggests '...he becomes less under the spell

of forgotten miseries and better able to recognise companions in the present for what they are' (Bowly, 1988, p.137).

In addition to attachment security, children need to experience reciprocal relationships; the capacity to influence and be influenced within relationships. This is the intersubjective relationship described by Trevarthen and Aitken (2001). Congruent with this theory DDP has a particular focus on helping families regain and enjoy intersubjective relationships.

There is a broad consensus within a special psychotherapy taskforce of the American Psychological Association that the therapeutic relationship is central in achieving progress in all schools of therapy to the extent that 'efforts to promulgate best practices or evidence-based practices without including the relationship are seriously incomplete and potentially misleading' (Norcross & Wampold, 2011). This taskforce concluded that the core components of such a relationship are the therapeutic alliance and empathy, along with secondary factors of collaboration and positive regard, and promising factors of congruence/genuineness, relationship repair and managing the therapist's own relationship 'triggers'. The therapeutic relationship including these factors are central in the practice of DDP, as well as in the training and supervision provided to those becoming accredited in the use of DDP.

DDP provides an innovative treatment model which is deserving of attention by researchers and commissioners:

*Although progress has been made in identifying evidence-based models of intervention for maltreated children, much work remains and it is important that the field does not prematurely restrict research funding or service reimbursement only to evidence-based models of intervention. Although we should not fund what has been determined to be ineffective, we must continue to support the innovative development of new models of intervention.* (Toth & Cicchetti, 2013, p.136)

Whilst still a relatively new approach there is a developing research evidence base for DDP.

A trial was carried out in the US which demonstrates the efficacy of DDP compared to treatment as usual with groups of children matched on demographic and clinical measures (Becker-Weidman, 2006a). Improvements were sustained in the DDP group at four year follow-up. (Becker-Weidman, 2006b). In the UK, a scoping study of DDP has been carried out (Minnis, personal communication). This is the first part of a bid to carry out a UK-based randomised controlled trial.

The DDP informed adoption support service described earlier worked with 125 children between 2002 and 2010. Research predicts some disruption within this cohort. For example, Alan Rushton (2004) in a study with 108 families of late adopted children aged 5- to 11-years-old found that approximately 50 per cent settled, 25 per cent had difficulties, and 25 per cent disrupted. In the service there were no adoption breakdowns, providing confidence that the model was beneficial, and only 18 per cent of children required the more intensive support. The adoptive parents reported benefits from early advice: opportunities to consider how personal issues link to difficulties accepting the internal experience underlying their child's behaviour and help to stay calm in the face of frustrations. In addition, parents appreciated input at a local and strategic level to mental health and education services about specific needs, including extra resources required for children with primary emotional difficulties.

A range of small-scale, service-based evaluations have demonstrated the efficacy of the Fostering Attachments groupwork programme. These have revealed high levels of participant satisfaction, with carers rating their understanding and confidence as higher and the difficulty of the children as lower following group attendance. Participant stress and Strengths and Difficulties Questionnaire scores have improved in some

studies (Golding & Picken, 2004; Green, 2011; Gurney-Smith et al., 2010; Laybourne et al., 2008). One randomised control trial utilising a waiting list control found the carers' sense of competence and confidence significantly improved immediately and eight months following intervention. Sense of self-efficacy improved at the eight months follow-up. These changes were not observed during the waiting period. Whilst there were no group differences in carer stress levels or ability to remain mind-minded, individual carers did show reliable positive change in these areas. This suggests the intervention may have been especially effective for some families (Wassall, 2011). This evaluation informed the revision of the programme, (*Nurturing Attachments Training Resource*, Golding, 2014). Preliminary analysis of an evaluation of this revision suggests that the group has been positive for the participants (Tipper, 2013, personal communication).

## References

- Becker-Weidman, A. (2006a). Treatment for children with trauma-attachment disorders: Dyadic developmental psychotherapy. *Child and Adolescent Social Work Journal*, 23(2), 147–171.
- Becker-Weidman, A. (2006b). Dyadic developmental psychotherapy: A multi-year follow-up. In S.M. Sturt (Ed.), *New Developments in Child Abuse Research*. Nova Science Publishers.
- Bowlby J (1988/1998). *A secure base: Clinical applications of attachment theory*. London: Routledge.
- Department for Education and Skills (2004). *Every Child Matters: Change for children*. London: The Stationery Office.
- Department for Children Schools and Families (2007). *Care Matters: Time for change*. London: The Stationery Office
- Department for Children Schools and Families & Department of Health (2009). *Promoting the Health and Well-being of Looked After Children: Revised statutory guidance*. London: The Stationery Office.
- Furnivall, J., McKenna, M., McFarlane, S. & Grant, E. (2012). *Attachment Matters for All: An attachment mapping exercise for children's services in Scotland*. Edinburgh: Scottish Government & Scottish Attachment in Action.
- Golding K.S. (2008). *Nurturing Attachments: Supporting children who are fostered or adopted*. London: Jessica Kingsley Publishers.
- Golding, K.S. & Hughes, D.A. (2012). *Creating Loving Attachments: Parenting with PACE to nurture confidence and security in the troubled child*. London: Jessica Kingsley Publishers.
- Golding, K. & Picken, W. (2004). *Group Work for Foster Carers Caring for Children with Complex Problems*. Adoption & Fostering, 28(1), 25–37.
- Golding, K.S. (2014). *Nurturing Attachments Training Resource: Running groups for adoptive parents and carers of children who have experienced early trauma and attachment difficulties*. London: Jessica Kingsley Publishers.
- Green, H. (2011). *Fostering Attachments: Improving placement stability in a local authority, Windsor & Maidenhead*. Centre for Excellence and Outcomes in Children and Young People's Services.
- Gurney-Smith, B., Granger, C., Randle A. & Fletcher, J. (2010). 'In time and in tune' – The Fostering Attachments Group: Capturing sustained change in both caregiver and child. *Adoption & Fostering*, 34(4), 50–60.
- Holland, S., Faulkner, A., Perez-del-Aguila, R. (2005). Promoting stability and continuity of care for looked after children: A survey and critical review. *Child & Family Social Work*, 10, 29–41.
- Howe D. (2005). *Child Abuse and Neglect: Attachment, development and intervention*. Hampshire: Palgrave Macmillan.

## Conclusion

DDP is a framework for intervention that is rapidly growing and developing within the UK. Its broad range of applications tailored to children who have experienced developmental trauma and are living in substitute homes makes it an attractive treatment for clinicians. Researchers have been slower to consider the efficacy of this approach, but it is hoped that the evidence base will grow over the next few years.

## The Authors

**Geraldine Casswell, Kim S. Golding, Edwina Grant, Julie Hudson & Pam Tower**

The authors are all Chartered/Registered Psychologists, Therapists and Dyadic Developmental Practitioners who work either in NHS or independent practice.

For more information about DDP Practice, please go to [www.dyadicdevelopmentalpsychotherapy.org](http://www.dyadicdevelopmentalpsychotherapy.org).

- Hudson, J. (2006). Being adopted: Psychological services for adopting families. In K.S. Golding, H.R. Dent, R. Nissim & E. Stott (Eds.), *Thinking Psychologically About Children Who Are Looked After and Adopted. Space for reflection*. Chichester: John Wiley & Sons Ltd.
- Hughes, D.A. (2007). *Attachment-Focused Family Therapy*. New York: W.W. Norton.
- Hughes, D.A. (2009). *Attachment-Focused Parenting*. New York: W.W.Norton.
- Hughes, D.A. (2011). *Attachment-Focused Family Therapy: The workbook*. New York: W.W. Norton.
- Hughes, D.A. & Baylin, J. (2012). *Brain-Based Parenting: The neuroscience of caregiving for healthy attachment*. New York: W.W. Norton.
- Laybourne, G., Andersen, J. & Sands J. (2008). Fostering attachments in looked after children: Further insight into the group-based programme for foster carers. *Adoption & Fostering*, 32(4), 64–76.
- Minnis, H., Everett, K., Pelosi, J. et al. (2006). Children in foster care: Mental health, service use and costs. *European Child Adolescent Psychiatry*, 15(63), 63–70.
- National Institute for Health and Clinical Excellence/ Social Care Institute for Excellence (2010). *Promoting the Quality of Life of Looked After Children and Young People*. London: National Institute for Health and Clinical Excellence.
- Norcross, J.C. & Wampold, B.E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, 48, 98–102.
- Perry, B.D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatised children: The neurosequential model of therapeutics. In N.B. Webb (Ed.) *Working with Traumatised Youth in Child Welfare* (pp.27–52). New York: Guilford Press.
- Ruch, G. (2008). Developing ‘containing contexts’ for the promotion of effective work: The challenge for organisations. In B. Luckock & M. Lefevre (Eds.), *Direct Work: Social work with children and young people in care*. London: British Association for Adoption and Fostering.
- Rushton A. (2004). A scoping and scanning review of research on the adoption of children placed from public care. *Clinical Child Psychology and Psychiatry*, 9(1), 89–106.
- Steele M., Hodges J., Kanuik J., Hillman S. & Henderson K. (2003). Attachment representations and adoption: Associations between maternal states of mind and emotion narratives in previously maltreated children. *Journal of Child Psychotherapy*, 29(2), 187–205.
- Tarren-Sweeney, M. (2011). Concordance of mental health impairment and service utilisation among children in care. *Clinical Child Psychology and Psychiatry* 15(4), 481–495.
- Toth, S.L. & Cicchetti, D. (2013). A developmental psychopathology perspective on child maltreatment. *Child Maltreatment*, 18(3), 135–139.
- Trevarthen, C. & Aitken, K.J. (2001). Infant intersubjectivity: Research, theory, and clinical applications. *Journal of Child Psychology and Psychiatry*, 42, 3–48.
- Wassall, S. (2011). *Evaluation of an Attachment Theory Based Parenting Programme for Adoptive Parents and Foster Carers*. Unpublished ClinPsyD thesis, University of Birmingham.