

Children's attachments

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Abstract

The quality of children's attachments has profound and far-reaching implications, affecting all that should be acquired through dependency. Early foundations of attachment are particularly important in establishing children's preconceptions of relationships, in giving meaning to emotions and feelings, and for regulating stress. Unsatisfactory childhood attachment is costly, affecting long-term physical and mental health, including major causes of mortality, and is an important factor underlying intergenerational parenting problems. Attachment is relevant to symptom presentation, illness behaviour, service use, and optimal paediatric care. It is an important consideration in child protection decisions and their implementation. Enabling children to achieve adequate parental attachment is the focus of work with children in care and in adoptive homes, and is a priority for every child.

Keywords adoption; attachment; attention deficit hyperactivity disorder; attunement; autism; behaviour; children in care; parenting

Basic concepts

Definition: attachment is the enduring emotional closeness that binds families, to protect children and prepare them for independence and parenthood. Because children are dependent, the quality of their attachments affects everything that should be learned from, and mediated by parents. The length of childhood indicates the complexity of the task and the breadth of implications of dysfunctional parenting. Early attachment establishes preconceptions of the value, reliability, safety and use of relationships, with lifelong implications for the extent of emotional self-sufficiency, and for behaviour in relationships. The responses of attached parents give meaning to a child's 'inner world', and facilitate safety, stress regulation and resilience.¹

Inadequate attachment is highly costly to individuals, to public services, and to wider society. The 'adverse childhood experiences' studies indicate that physical and psychological wellbeing, including major causes of mortality, relate to dysfunctional early attachment.² Children in care, whose attachments are vulnerable, are at increased risk of:

- mental health problems
- early parenthood
- substance abuse

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- lack of qualification
- unemployment
- homelessness
- involvement in crime as victims or perpetrators.³⁻⁵

Insecure attachment contributes to sexual crime.⁶ The parents of most children adopted from care experienced inadequate early attachment as, frequently, did their own parents.⁷

Attachment affects every child's experiences in health and illness; the question is how much. It may colour use of professional services and 'illness behaviour' (bearing in mind that all 'behave' whether ill or not), or it may determine children's needs (e.g. in protecting children and substitute care). Parents' attachment experiences can be equally relevant to paediatric practice.

Foundations of attachment

Attachments form at all ages, but clinical and neurobiological evidence supports Bowlby's view that early foundations are particularly important.⁸⁻¹¹ As in a wall, the quality of foundations remains important whatever is added. Robust upper layers may partially compensate for weak foundations, but vulnerability persists, particularly under stress. Subsequent experiences build on, but do not replace, preconceptions derived from the first relationship.

Infant attachment is a two-way, mutually reinforcing process dependent on what each contributes, opportunities for closeness, attitudes of others, and wider social factors. It emerges through subtle maternal attunement to the baby's overtures, involving tone, pitch and rhythm of voice, posture, facial expression, movement and touch.¹² The baby's emotions are reflected in the mother's exaggerated responses, given meaning and regulated, moulding development of the right pre-frontal cortex.¹³ Babies learn that others recognize and respond to their needs, that their behaviour influences others, and that moderate expression of need elicits a response. Foundations are established for perceptions of the value of relationships, verbal and non-verbal communication, understanding the 'inner world' of emotions, body signals and thought, and trust.

Safety: attachment allows physical and emotional safety, and the experience that these are achievable through relationships. It is relevant to 'primitive' involuntary stress regulation and cognitive coping strategies, and may influence immunity, healing and the intestinal mucosal barrier.¹⁴⁻¹⁶

Stress regulation: infants have little capacity to regulate stress, relying on parents to do so by attuning to their needs, thereby moulding their developing self-regulatory systems. Stress regulation is important for exploration, learning, independence and effective relationships. Unregulated stress affects concentration, and 'reading' of relationships. The function of the hypothalamus-pituitary-adrenal (HPA) axis (indicated by salivary cortisol) is programmed in infancy (and probably antenatally) to suit the environment and effectiveness of parental calming. This may have lifelong implications, predisposing to:

- conduct disorder
- aggression
- attention deficit hyperactivity disorder (ADHD)

- anxiety
- depression
- post traumatic stress disorder.^{17–22}

Physical manifestations of dysregulated stress may contribute to ‘psychosomatic’ illness.²³ Ineffective attunement may cause persistently exaggerated stress responses, but serious abuse can suppress them, leading to fearlessness. Associated ‘avoidant’ infant attachment behaviour predicts future autonomic underarousal (e.g. relative bradycardia).²⁴ Neuronal plasticity, developing cognition and experience modulate stress responses during childhood around a baseline influenced by the first relationship.

‘Attachment styles’ are variably named, and describing how children use relationships is more important than labelling.

Secure attachment depends on both the baby’s ability to indicate its needs and the parent’s ability consistently to respond (Figure 1).²⁵ Relationships are experienced as valuable, reliable and safe.

‘Anxious’ attachment: if, for example, substance abuse or depression interrupt otherwise good attunement, children experience relationships as valuable but unreliable, causing anxiety to hold and regain attention. Parental stress, anxiety and fatigue affect the subtlety of attunement, with similar consequences. Children learn to use whichever strategies, desirable or undesirable, achieve attention, whether positive or negative. These range from constant smiling or overcompliance to disruptiveness, soiling, food refusal, or endangerment. They struggle with sharing attention and handling the emotional ‘separation’ of discipline. Fear of rejection colours relationships. Breaks in attunement are unreliably resolved and stress is poorly regulated.

‘Ambivalent’ attachment: variably attuned and aggressive parenting teaches children that closeness is valuable, but is unreliable and frightening. Their resulting ambivalence produces confusing behaviour. Confrontation tends to be focused on those closest to them. They may crave attention but, having achieved it, reject it. They sometimes seek and sometimes avoid

closeness. Hypervigilance to parental mood affects concentration and causes over-reading of disapproval. Fear of intimacy may persist into adult relationships.

‘Avoidant’ attachment: consistently non-attuned parenting (e.g. through poor foundations for attachment, learning difficulties) fails to teach children the benefit of closeness; parental aggression can make them fear it. They become ‘avoidant’ loners, inept at understanding non-verbal cues and the subtleties of language, often seeking control through ‘sameness’. The resulting picture resembles ‘innate’ autistic spectrum disorder. Such children may gorge to the point of vomiting, disregard ambient temperature, ignore pain, and overlook toilet needs because their ‘inner world’ lacks meaning.

‘Disorganised’ attachment: pervasive abuse can leave children disorganized and ineffective in self-sufficiency and in using relationships, lacking understanding of their own and others’ feelings. Successful independence is improbable and criminality in adulthood likely if it remains uncorrected.

Breaks in attunement: parental attunement is important, but so are imperfections. Breaks allow controlled exposure to stress, modelling of conflict resolution, and trust. The latter allows increasing distancing from parents, maintaining contact visually initially, then through language. It enables children to handle discipline, accept authority, develop self-worth and achieve safe separation during adolescence.

Secondary consequences: the more prolonged and extreme the dysfunctional parenting, the more that secondary consequences increase. Difficulties characteristically interrelate, causing vicious circles of which poor self-esteem is integral. Difficulties with peer relationships, emotional dysregulation, impulsivity and inattention are characteristic, compounded by failure at home and school.

Attachment in paediatric clinics

Attachment is relevant to all paediatric work, but particularly to problems with feeding, toileting, crying and behaviour regulation, which involve interaction.

Problems with eating and toileting relate to attachment in several ways. Children who are anxious about parental ‘availability’ are drawn to behaviour that is difficult to ignore (e.g. food refusal, soiling and wetting). Those ambivalent about the safety of close relationships may use these to ‘get at’ parents. Chaos and neglect make children take control, including through eating and toileting issues.

Over-attuned parenting encourages dependence. Children may not develop age-appropriate self-care, holding onto the security of immaturity. Insecurity after moves may prompt regression of self-help skills. Non-attuned or frightening parenting, causing avoidance of relationships, can lead to gorging to the point of vomiting, soiling or wetting because of failure to recognize body signals. Overeating may fulfil an emotional need, or represent primitive ‘clinging’ to food after deprivation. Chaotic eating, affecting the gastrocolic reflex, and absent toileting routine may accompany inadequate attachment. Toilet training may be lacking, punitive or associated with abuse. Altered gastrointestinal flora reflecting disturbed attachment²⁶ may affect bowel function, as may altered diet after moves.

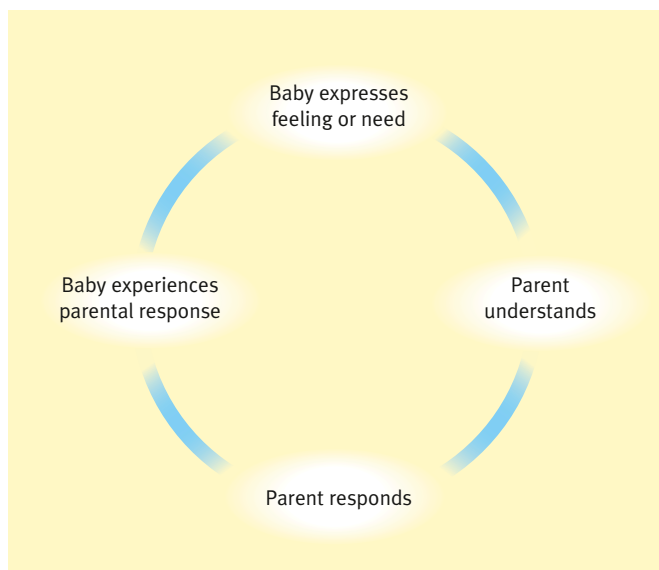


Figure 1 The attunement cycle.²⁵

Regardless of origin, eating or toileting problems in children with insecure attachment are often perpetuated as a source of attention, which is an important consideration in management.

Crying: the precise origins of infant crying may be immaterial to its management. Maternal fatigue and depression affect attunement, allowing unregulated infant stress and crying, further exacerbating parental stress.

Help includes explanation, social support, treatment of depression, calming strategies for parent and child (e.g. infant massage), and teaching attunement. Similar sequences may contribute to irritability of children whose neurological difficulties affect attunement, and contribute to parental depression and fatigue.

Attachment and ADHD

ADHD has a complex relationship to attachment difficulty, as cause and effect, through common risk factors and as comorbidity. Familial risk of ADHD is high in families experiencing multigenerational abuse. The consequences of parental ADHD may affect children's attachment. ADHD may underlie parental substance abuse or temper problems. Impulsive parents struggle to parent impulsive children safely. Antenatal exposure to drugs, alcohol and stress are risk factors for both ADHD and dysfunctional attachment. Concentration is unsafe for children experiencing unpredictable aggression. Their hypervigilance and anxiety, originally adaptive, become maladaptive in safer circumstances.

The origins of ADHD-type features cannot necessarily be determined and may be immaterial. Whether cause, effect, or both of attachment difficulty, they must be addressed because of the risk of causing escalating difficulty. Diagnostic profiles for ADHD may be atypical if attachment difficulty makes symptoms more troublesome at home than school.

Attachment to impulsive children can be difficult. In care, they are at risk of placement breakdown, and of failure to achieve stability. ADHD symptoms characteristically increase after moves, when new parents, and children, lack a safety-net of attachment. Inattention affects emotional awareness and reading of non-verbal communication, influencing all relationships. Poorly attached children lack self-esteem, and untreated ADHD compounds this. Vulnerability to rejection and hypervigilance to disapproval reduce children's resilience to the disciplinary consequences of their behaviour; success at home and school can be elusive.

Treatment: ADHD-type symptoms should be anticipated and prevention encouraged:

- calm environment
- one-to-one play without distraction
- routines to reduce anxiety
- strategies to relieve and release stress.

Decisions regarding medication in attachment-related ADHD require pragmatism founded on the:

- priority of achieving stability and adequate attachment
- likelihood of achieving change soon enough by alternative means
- cost of lack of change.

It is an adjunct to, and facilitator of, attachment-related behavioural strategies, and a means of enabling children to use opportunities for recovery. 'Slowing down' can help children's emotional awareness, enable them to achieve attention by desirable means, and encourage mutual attachment. It can help to interrupt vicious circles.

The principles of prescribing are those generally applicable to ADHD, although specific evaluation is needed of options in the context of attachment difficulty.

Autism or attachment?

Children who have learnt to avoid non-attuned or frightening parenting frequently fulfil criteria for autistic spectrum disorder. They may show:

- little eye contact
- isolated play
- poor social and communication skills
- literal interpretation of language
- poor emotional regulation
- intolerance of change
- stereotypical play
- executive function difficulties.²⁷

The question is whether the pattern of family relationships is a sufficient explanation and, if so, how the child's emotional welfare can be safeguarded. Whatever the origins, management should be broad-based, considering which contributory factors in the child, parents and environment can be changed, and how soon.

Behaviour management

Consideration of attachment is relevant to assessment and management of behaviour problems. Behaviour serves a purpose; it relates broadly to achieving perceived safety or 'success', whether physical or emotional. It usually makes sense in the context of children's preconceptions of themselves, the world, and relationships, though is coloured by sensory and cognitive ability and impulse control. It is founded in the involuntary protective responses and assumptions deriving from early attachment experiences. Children with poor foundations for attachment may revert readily to unregulated, 'immature' behaviour because of early programming of involuntary responses, often compounded by failure to learn cognitive strategies to regulate these. For some, conditioning through trauma contributes to this tendency. Difficult feelings may precipitate uncontrollable outbursts with seemingly little immediate provocation.

Assessment entails considering how the behaviour makes sense, and what purpose it achieves. For example, a child who always misbehaves when playing outside and so has to come in may have learnt this as a means of managing anxiety when separated from parents or with peers. Parents must become attuned to this and provide ways of containing the anxiety while encouraging social functioning. Because behaviour is goal-orientated, if its outcome is predictably negative, this may at some level be what the child is seeking, perhaps because it is familiar, or because any attention feels better than none.

Behaviour that was initially adaptive may cease to be so if circumstances change. This is a particular problem for children learning to live with safe relationships having honed their

behavioural strategies in response to abuse. Seemingly unreasonable reactions to 'reasonable' parenting can provoke rejection, reinforcing their already negative self-image. The extent to which children see relationships as valuable, safe and trustworthy is a key issue. Those who avoid relationships may seem, in a new home, 'easy' in their lack of demand, but carers describe difficulty and frustration in feeling 'not needed'. Those who value relationships but are insecure in their continuing availability seek and hold attention by whatever means work. Their carers can be overwhelmed by their insatiable demands. The joint parental and professional task is to teach the child how to live with safety. This often involves the professional joining the parents and child in considering the behaviour, accepting that it made sense to the child but then teaching that it is no longer the best approach.

The question is which factors in the child, parents and environment are contributory or perpetuating, and which can be

changed (Table 1). Explanation of the child's behaviour enables carers to see through the child's eyes. Minimizing parental fatigue and stress is a priority to allow sufficient stamina for effective attunement. Parents must be reassured that perfection is neither attainable nor desirable. Traumatized children frequently drive new parents to responding in less than perfect ways, causing profound guilt. Such times can be used to model repair and build the child's sense of unconditional acceptance.

Safeguarding children

Attachment should be a central consideration in safeguarding children (Table 2). It is frequently not the injury but the disturbed relationship it represents that causes greater long-term damage. An accident may be as significant as a non-accidental injury if it reflects inadequate supervision accompanying poor attachment.

Attachment-related behaviour difficulties: contributory factors and management

Factors contributing to behaviour difficulties

Child

Unregulated stress
 Limited emotional repertoire
 Need for attention
 Lack of experience of discipline
 Uncertainty regarding social 'rules'
 Need for control
 Need for 'sameness'
 Difficulty with trust/authority
 Cognitive difficulty
 Difficulty reading social cues
 Poor self-esteem
 Problems controlling temper
 Sleep disturbance
 ADHD-type symptoms
 Lack of concept of safety; fearlessness
 Depression, anxiety

Parents

Unregulated stress
 Fatigue
 Depression
 Problems controlling temper
 ADHD
 Marital difficulties
 Difficulty understanding the behaviour
 Perceived rejection by the child
 Negative feelings towards the child

Social/environmental

Lack of time with the child
 Large family
 Inadequate housing/garden

Management

Calming strategies; stress relief and release; exercise
 Attune to, reflect and amplify child's emotions
 1:1 time; attention for desired behaviour
 Consistent boundaries and consequences
 Anticipation; preparation; explanation; routine
 Simple choices acceptable to parents
 Gradually introduce flexibility while managing anxiety
 Empathy for/explanation of difficulty in trusting
 Explanation/discipline in line with developmental age
 Teach social skills/non-verbal communication through play
 Ensure success outweighs failure
 Build emotional repertoire, social skills, self-esteem
 Calm, consistent pre-bedtime routine
 Reduce anxiety (routine, explanation); minimize distraction; 1:1 time; medication
 Teach safety via play, books, discussion, role model
 Enable success/optimism

Calming/stress-release strategies (e.g. massage, exercise)
 Personal time, respite
 Encouragement; empowerment; counselling; medication
 Cognitive behaviour therapy; counselling; medication
 Clinical psychology; medication
 Relationship counselling
 Explanation to encourage empathy
 Help in understanding origins of behaviour
 Teaching regarding normal process of attachment

Family support
 Encourage 1:1 time; childcare
 Consider rehousing

ADHD: Attention deficit hyperactivity disorder.

Table 1

Considering attachment in safeguarding children and substitute care

Child protection assessment

Do the parents' childhood experiences equip them to promote attachment?
 What are the risks to attachment?
 What, despite risk factors, allows safe parenting?
 What does observed attachment behaviour suggest about home experiences?
 To whom/what is the child close?
 What factors have contributed to abuse? Which are remediable?
 What is the 'attachment context' of abuse' (e.g. scapegoat, 'parental' child, 'favoured' child)? How should this influence plans?
 What would be the purpose of foster care?
 What are the risks?
 Do the benefits of emergency placement justify the risks?
 Can risk be reduced? (e.g. can a relative, trusted adult, comforter, accompany him?)
 How can family relationships be protected? (e.g. independent parental support)

Assessing long-term placement needs

Is it *likely* that his attachment needs can be met at home?
 Which risks to attachment could be changed?
 Is adequate change likely sufficiently soon?
 What are the risks of delay?
 Is he likely to form adequate attachment away from home?
 What is needed to achieve this?
 Which relationships must be protected? How?
 What does the quality of sibling relationships mean for placement plans? What are the advantages and risks of placement together?
 What does his attachment pattern mean for choice of family?

Planning moves to foster care, adoption or back home

How is he likely to view a move?
 What are his preconceptions of adults/closeness?
 How is he likely to behave?
 What are the implications for:

- how adopters will feel
- family dynamics
- preparation and support needed for child and family?

 How can relatives/carers support the move?

Table 2

The evidence base of child abuse has been repeatedly revised,²⁸ and is arguably intrinsically insecure. Emotional abuse is particularly difficult to define. It is rarely a matter of cause and effect, but more like a jigsaw, involving putting together pieces of varying clarity and importance.

Children's attachments should be a key consideration in the timing and manner of implementing child protection decisions. Children may have important attachment to unsafe parents, and abuse may be longstanding. Protecting emotional safety may entail accepting some physical risk. The trauma of emergency removal must be balanced against the risk of delaying to allow preparation. The justification for emergency removal should be defined, and the risks realistically acknowledged, recognizing that iatrogenic harm includes emotional damage.

Substitute care

Removing children from home marks the beginning of major new professional responsibilities. The purpose should be clearly defined, and the tasks needed to achieve this identified. 'Care' is a therapeutic task that is integral to safeguarding children. Working together

is as important as when identifying risks: service structures should reflect this. Paediatricians may not technically be 'corporate parents', but effectively they are, and commitment should be commensurate with this.²⁹ Facilitating adequate parental attachment should be a professional priority (Table 2). Good physical care is essential, but adequate psychological care above all defines future wellbeing. Achieving this requires professional continuity, commitment, and pragmatism. It requires seeing beyond form filling and definable targets to the daunting reality of the greater task. When adoption offers the opportunity of stability and recovery considerable, often long-term, professional support may be needed to achieve these.

Professional services should reflect the profound vulnerability of children who lack stable relationships. Parenting without mutual attachment is difficult and frightening. Crises are inevitable and often costly. Placement breakdown is highly traumatic for all. Every move adds to the risk of a trajectory of repeated failed placements, and adult life characterized by substance abuse, unsustainable relationships, parenting problems and criminality. Cornerstones of practice are continuity, commitment, availability and rapid response. Services that do not allow these cannot meet children's needs. The cost must be balanced against that of failure to achieve stability.

Assessing attachment

	Common presentations of attachment problems	Asking about attachment	Observing attachment
0–1 year	Crying/'colic' Feeding problems Sleep problems Poor eye contact Failure to thrive Maternal depression	'Is he cuddly?' 'Does he watch you?' 'Does he calm with cuddles?' 'Does he attract attention?' 'How is he with strangers?'(from 6 months)	Does he make eye contact with, watch, 'follow' parents? Does he smile, vocalize, imitate socially Does he show stranger awareness (>6 months of age) Does the parent attune to his overtures?
1–3 years	Failure to thrive/small head Developmental delay Feeding problems Injury (accidental/non-accidental) Tantrums 'Autism'	'Does he come for cuddles?' 'Does he come to you if hurt?' 'Does he like attention...more/less than other children?' 'Can he share attention? (e.g. can you make a phone call?)' 'How is he with strangers? (Affectionate? Wary?)' 'What's it like taking him out? Does he stay with you?' 'Does he show the usual range of feelings?' 'Does he have much temper? More than usual for his age?' 'Does he know that other people have feelings?' 'Is he cautious? How high would he climb?' 'Does he cuddle toys?' 'How does he react if you go out/leave him at nursery?' 'How does he handle discipline?' 'Can he handle change in routine?'	Does he make eye contact? Does he relate preferentially to parents? Does he respond appropriately to closeness? Does he go to parents for comfort? Does he look to parents if taken from room? Does he seek affection from strangers? Does he seek attention appropriately, too little, too much? Can he share attention? Does he move away and play independently? Does he refer back to parents in play? Does he show appropriate feelings? Is he caring to dolls etc? Are his parents attuned to his needs/feelings?
3–12 years	Behaviour problems 'Autism' 'Attention deficit hyperactivity disorder' Soiling, wetting Obesity Growth delay/small head School problems (academic/social) Temper	As for 1 to 3 years and: 'Does he use words for feelings?' 'Does he understand other peoples' feelings?' 'Does he understand facial expression?' 'Does he concentrate?' 'Is he imaginative? Does he get into roles?' 'Does he recognize danger?' 'Does he know when he's hungry, eaten enough, cold?' 'How does he get on with other children?'	As for 1 to 3 years and: Does he intrude on professional conversation with parents/attract attention? How? Does he concentrate when playing? Does he play imaginatively involving feelings and roles? Does he respond to authority? Who is controlling whom?
Adolescence	Substance abuse Lawlessness Risk taking Promiscuity/pregnancy Running away Temper Mental health problems	'Who is he close to?' 'Does he confide in anyone?' 'Does he follow rules at school?' 'Does he show feelings?' 'Does he have much temper?' 'How does he deal with stress?' 'How does he sort out disagreements?'	Does he function effectively independently? Is antagonism selectively directed towards parents? Does he use family support during illness/injury? Does he show empathy? Does he trust professionals?

Table 3

Working with attachment

Risks to attachment should be identified antenatally and advice offered. Paediatricians should routinely consider attachment, recognizing that related issues come in many guises and degrees.

Understanding children's attachments involves constructing a jigsaw of pieces of varying clarity, including what is known or can be assumed about:

- parental foundations for attachment
- perinatal and postnatal risks
- the child's experiences at home, of moves and in other placements
- the current picture, assessed by questioning the carers and by observation (Table 3).

Helping attachment difficulty

Building attachment

Parental self-care, support, respite; treat depression
 Teach attunement: reflect back child's emotions verbally and non-verbally; empathy
 Calming (e.g. massage)
 Shared emotions (e.g. fun)
 1-to-1 time: shared activities allowing communication
 Use difficulties to model 'repair'/teach unconditional acceptance

Emotional safety

Routine
 Consistent boundaries/consequences
 Explanation/anticipation of change
 Structure environment to enable success

Anticipate and address secondary problems

Stranger safety
 Attention deficit hyperactivity disorder
 Temper problems
 Conflict resolution
 Social skills
 Awareness of emotion and body signals
 Non-verbal communication
 Developmental/educational problems
 Relationship education, contraception

Behaviour management

Consistent expectations and consequences
 Empathy for feelings behind behaviour
 Attention for desired behaviour
 Address control issues: ensure that parents take control (e.g. offering acceptable choices)
 Ease 'ritual': distraction, calming to reduce anxiety

Building resilience

Teach and model calming/stress release/coping strategies
 Encourage expression through creativity
 Build self-esteem (e.g. develop areas of ability)
 Mentor/trusted adult

Table 4

Consequences of attachment difficulty frequently merge with difficulties related to their cause (e.g. intrauterine exposure to drugs), and consequences of associated abuse.

Broad-based (often multidisciplinary) work is needed, addressing remediable factors in the parents, child and environment. Parents need support in promoting healthy attachment, managing behaviour; and encouraging social and communication skills, emotional awareness, stress regulation and resilience (Table 4). Paediatricians must be equipped to work to the edge of mental health services, referring children and families to more specialized services when necessary.

The multifaceted approach needed to address the complexity of relationship-related problems is potentially vulnerable if 'evidence base' becomes a rationing tool. Crucial 'outcomes' can be a generation and more away and difficult to quantify. Resource allocation should reflect the far-reaching and costly implications

of inadequate early attachment. Enabling children to achieve relationships of sufficient quality to equip them for independence, secure adult relationships and safe parenting should be a fundamental priority of paediatric practice. ◆

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