Description, History, and Critique of Corrective Attachment Therapy

Matthew L. Speltz, PhD
University of Washington School of Medicine

Procedural Distinctions

Prescribed physical contact between parents and children, and between therapists and children, is not uncommon in mental health treatments. Parents are often asked to initiate affectionate physical contact with their problem children (sometimes contingent on the child's positive behavior). It is also sometimes necessary for a parent or mental health specialist to escort a child physically to a time-out situation as part of a planned behavior program.

A parent or clinician may be asked to physically restrain violent or self-injurious children for safety reasons, releasing them when they regain control. However, the holding therapies included in "corrective" attachment therapy do not address safety needs. They differ in that a therapist or parent *initiates* the holding process for the purpose of *provoking* strong, negative emotions in the child (e.g., fear, anger), and the child's release is typically contingent upon his or her compliance with the therapist's clinical agenda.

History

Today's holding therapies trace their roots to the controversial techniques developed by Robert Zaslow in the 1970s for autistic individuals. Zaslow believed that inducing rage by holding autistic individuals—often against their will— would lead to a breakdown in the person's defense mechanisms, making the individual more receptive to and cooperative with others (Zaslow & Menta, 1975). These ideas have been dispelled by research on the genetic/biologic causes of autism. Unlike Zaslow's techniques, interventions based on behavioral principles have proven effective with autistic children.

A decade later, Martha Welsh (1984, 1989) described a technique for children with attachment problems called holding time. Mothers were instructed to take hold of their defiant child at these times, holding them tightly to the point of inducing anger. Mothers were told to expect that the child may spit, scream, swear, attempt to get free, bite, and try to cause alarm by saying that he is in pain, cannot breathe, will vomit, is going to die, or needs to urinate. In this approach, parents were encouraged to accept these behaviors calmly and silently. Welsh described a subsequent stage (marked by the child's weeping and wailing) in which parents were encouraged to resist the temptation to feel sorry for the child or to feel guilty about what they are doing. Mothers were told that if they could successfully resist these temptations, the child would enter an acceptance stage in which the child would fight less and become relaxed and tired. The mother was then instructed to loosen her hold on the child, at which point a bonding process was believed to begin, in which the child would find comfort from the mother in this relaxed state. To my knowledge, no evidence for the efficacy of this method has ever been provided.

Foster Cline (1991) and associates at the Attachment Center at Evergreen, Inc. (Evergreen, Colorado) began to promote the use of the same or similar holding techniques with adopted, maltreated children who were said to have an attachment disorder (not to be confused with DSM-IV's reactive attachment disorder). For several reasons, maltreated children and their adoptive parents were ideal recipients for this innovative but risky intervention. That is, maltreated children are difficult to change and adoptive parents (mostly from middle-socioeconomic backgrounds) tend to have high expectations for good child deportment. In addition, many adoptive parents are desperate for any intervention that promises rapid change (within days instead of months or years), and a relatively high percentage of adoptive parents have the resources to pay privately for mental health services not traditionally covered by traditional payor mechanisms. Most important, the Evergreen model offered a conceptualization that placed the cause of child mental health problems squarely on the child rather than on the quality of the family environment.

Description

(The following is a description of attachment therapy used by a treatment center in the Pacific Northwest, referred to as The Center. Quotations are taken from this center's published material.)

The Center's protocol appears to be a replication of the Evergreen Attachment Center model and is very similar to the Welsh methods described above, except that a therapist replaces the parent, at least in the initial stages of therapy. As stated in The Center's therapeutic protocol (from which the quotations below are taken unless otherwise noted), the therapist seeks to provide a "corrective emotional experience" in a 10-day intensive therapy program. Like Welsh (1984, 1989), The Center induces rage by physically restraining the child and forcing eye contact with the therapist (the child must lie across the laps of two therapists, looking up at one of them).

In a workshop handout prepared by two therapists at The Center, the following sequence of events is described: (1) therapist "forces control" by holding (which produces child "rage"); (2) rage leads to child "capitulation" to the therapist, as indicated by the child breaking down emotionally ("sobbing"); (3) the therapist takes advantage of the child's capitulation by showing nurturance and warmth; (4) nurturance at this juncture is believed to produce greater "trust" in the child; and (4) this new trust allows the child to accept "control" by the therapist and eventually the parent.

According to The Center's treatment protocol, if the child "shuts down" (i.e., refuses to comply), he or she may be threatened with detainment for the day at the clinic or forced placement in a temporary foster home; this is explained to the child as a consequence of not choosing to be a "family boy or girl." If the child is actually placed in foster care, the child is then required to "earn the way back to therapy" and a chance to resume living with the adoptive family.

Children who comply with the holding procedure go on to "practice a new way of being with Mom and Dad" (including adoptive parents' use of "in arms holding") and a procedure in which the child is required to forgive and say good-bye to his or her birth mother. This is a staged scenario or psychodrama in which the therapist plays the role of the child's birth mother for about 10 minutes. Children are expected to tell their birth mother "what they've always wanted to say" and then to say good-bye. At this point the adoptive mother is prompted to enter the room to provide "comfort and closeness." If the child does not seem ready to say good-bye to the birth mother, the therapist can facilitate the process by

getting the child to remember or acknowledge certain negative characteristics about the birth mother. For example, this might include the therapist reminding the child about the birth mother's history of drug use and prostitution.

Other techniques that are used during the 10-day intensive therapy include a confession procedure, in which children are asked to write down all the "negative, mean things" they have done (called the "clean slate list") and to make "amends" by doing something nice for a family member as a consequence for a previous mean behavior. As a follow-up measure at home, adoptive parents are encouraged to use "natural consequences" for undesired child behaviors. For example, in one case first seen at The Center and then seen subsequently in the Attachment Clinic at Seattle Children's Hospital, parents described to me a procedure in which they were encouraged to make their preschool child use a toothbrush to clean the grout on the family's back patio. This was deemed appropriate punishment for misbehavior involving spilling something in the house.

In my reviews of the literature on various attachment holding therapies, I have found limited variation in the degree of coercion employed. For example, Hughes (1997) prepares the child for holding beforehand (with discussion and demonstration), and he states that he would discontinue the holding if the child showed "terror" or "strong fear." Although not explicitly stated, it does not appear that Hughes (1997) uses punishment contingencies (such as not returning home when the child is noncompliant), as is done in The Center's procedure. Hughes also states that he would respect an adolescent's refusal to be held, as this would require other adults to help restrain the adolescent (presumably, however, younger children are not given this option).

Relation of Attachment Therapy to Other Coercive Methods for Behavior Change

Intensive attachment therapy bears remarkable similarity to other programs that use coercive persuasion to change human behavior—the comparison is helpful, I believe, in understanding the theoretical context and potential risks and benefits of intensive attachment therapy.

Sociologists have studied thought reform programs that rely on intense interpersonal and psychological methods to "destabilize" an individual's sense of self in order to promote compliance with an ideology or organization (Borgatta & Borgatta, 2000). The targets of such procedures are typically adults who participate voluntarily in the process, at least initially. Well-known examples include the recruitment strategies employed by some religious organizations and social movements (e.g., a notable historical example is the Rev. Moon's Unification Church), fringe rehabilitation programs (e.g., Synanon, a now obsolete and ineffective drug rehabilitation program), some police and military interrogation methods, and quasi-therapeutic programs such as those popular in the human potential movement of the 1970s and 1980s.

According to Borgatta and Borgatta, all of these programs share the following three components: (1) a staged and intense interpersonal experience in which the individual's psychological defenses are taken away and the individual is flooded with powerful emotions; (2) an opportunity for the targeted individual to escape further destabilization procedures by (a) accepting the proffered ideology, (b) rejecting previously held beliefs, or (c) confessing previous undesired acts; (3) a final stage in which there is organized social approval for the individual's compliance with the goals of the program and rejection of competing ideas.

With respect to the efficacy of these procedures, Borgatta and Borgatta report that in most applications there have been only transient alterations in behavior that were limited to the environment in which the coercive persuasion was applied. Borgatta and Borgatta note that such programs have produced high rates of what are termed "psychological injuries" to participants including anxiety/panic, manic episodes, and psychiatric disturbances.

In my opinion, intensive attachment therapy contains elements of all three of the stages described above: (1) the child is subjected to an intense interpersonal experience that is explicitly designed to induce powerful emotions (e.g. rage and sobbing); (2) while in this vulnerable state, the child is given the opportunity to terminate the procedure by complying with the wishes of the therapist and adoptive parent, and/or by choosing his adoptive parents over memories of birth parents; and (3) the child's verbalized acceptance of the adoptive family and rejection of the birth family are strongly reinforced by the therapists and adoptive parents. However, unlike the adults who typically volunteer to participate in these procedures (who, with the exception of prisoners, are free to leave), the child recipients of intensive attachment therapy are given no choice in the matter and may be threatened with expulsion from their family if they do not comply. For them, the consequences of noncompliance with this version of thought reform are potentially life changing, (e.g., the adoption being reversed, placement in residential treatment facilities).

Critique

1)Diagnostic Formulations

There is currently no reliable diagnosis of attachment problems with proven validity including the DSM-IV reactive attachment disorder (RAD). One of the country's leading researchers of RAD, Charles Zeanah, MD, of Tulane University School of Medicine, has recently reported that evidence can be found in support of only some RAD criteria. He also notes the significant "discrepancy between popular accounts of RAD and more formal definitions in the scientific literature" (Zeanah, 2000, p. 230). It is anticipated that the next version of DSM will contain a substantially revised version of RAD.

In my experience with therapists in the Pacific Northwest, this diagnosis tends to be made whenever maltreatment is known or suspected in the history of a child referred for psychiatric problems, although this event is only one of several criteria required for diagnosis. Consequently, there is likely to be significant over diagnosis of RAD. The implication of this is that many children believed to have unique and highly specialized needs because of their RAD diagnosis may in fact have other, better-understood diagnoses that suggest different and potentially more effective treatment plans. It is important to understand that adoptive parents tend to support a diagnosis of RAD because it implies that the child's problems are due almost exclusively to the birth parents, and that resulting psychopathology is "within the child," rather than a broader reflection of the child's adoptive family and other interpersonal relationships. However, almost all research in developmental psychopathology indicates that children's disruptive behavior problems result from complex interactions between genetic factors and past and current environmental (e.g., family, interpersonal) factors.

As noted, Foster Cline (1979) is an important figure in the attachment therapy movement. He has described an attachment disorder that is based solely on child characteristics (e.g., antisocial behavior, disordered eating, counterfeit emotionality, toileting problems) and differs considerably from the DSM-IV version. To my knowledge, this diagnosis has not been empirically validated, but its clinical "face validity" is reasonably strong (i.e., it seems to capture many of the characteristics commonly seen in maltreated children, for example, mood regulation problems, obsessive tendencies, compulsive behaviors, hoarding, counterfeit emotionality, toileting problems). This may explain why many adoptive parents are attracted to the promise of intensive attachment therapies; they make the understandable assumption that a therapist who can so accurately *describe* (diagnose) their child should be able to effectively *treat* the child as well.

2) Theoretical Linkage

Although recent writings by therapists at the Evergreen Attachment Center and elsewhere (e.g., *Handbook of Attachment Interventions*, edited by Terry Levy, PhD, 2000) have increasingly emphasized the link between their methods and the considerable scientific literature on human attachment, there is very little connection between the two. Rather, as suggested above, the theoretical origins of holding therapies can be traced more directly to the work of Zaslow and Menta (1975), Welsh (1984, 1989), and the thought reform methods employed by trainers in the human potential movement. In my opinion, the recent integration of holding therapies with mainstream scientific work largely represents a post hoc effort to legitimize highly controversial methods that would otherwise remain on the fringe of mental health treatment.

The writings of intensive attachment therapists are inconsistent with mainstream attachment theory and research in ways too numerous and technical to detail here (e.g., intensive attachment therapists often talk about the "unattached child," a theoretical unlikely possibility from the perspective of John Bowlby and others, and one that is inconsistent with research on the attachment behaviors of institutionalized, severely maltreated orphans). Furthermore, interventions that have been legitimately based on the scientific study of attachment and related theories and hypotheses (e.g., Erickson, et al., 1992; Van den Boom, 1994; Speltz, 1990) contain goals and procedures that are diametrically opposed to those utilized by intensive attachment therapists. The goals of the former are to *enhance* the sensitivity of the caregiver, to provide the child with *more* control rather than less, to *reduce* caregivers' expectations for rapid change (and encourage *acceptance* of the child's basic temperament and personality), to *unlink* contingencies between the child's behavior and his or her perceived permanency within the family, and to *emphasize* reinforcement and positive exchanges of affection (when the child wants it) rather than punitive consequences that tend to erode the quality of family relationships.

3) Potential Risks

a. Psychological risks

Because of the traumatic nature of the abusive encounters, many children who have been physically or sexually abused experience extreme anxiety or panic when forced into close contact with others. For this reason, forced or intimate physical contact with unfamiliar caregivers can further traumatize the child as well as maintain or exacerbate anxiety-spectrum symptoms.

In our clinical work, we have found that some adoptive families are simply too intrusive with newly adopted children. For example, some parents may expect their child to quickly engage in discussions of their emotional and psychological status or to respond favorably to physical affection within weeks or months of adoption. In one case with which I'm familiar, the parents wanted their adoptive child to change her last name to theirs within a few months of the adoption; they interpreted her resistance to this idea as an attachment problem. In such cases, we would advise parental patience and a desensitization approach, in which intimacy on various levels is approached slowly in a step-wise fashion with the child given maximum control.

I would also anticipate harmful psychological effects of procedures that make "nurturing" (love) contingent upon the child's submission to authority. In my opinion, this recapitulates the interactions that many abused children have experienced earlier in their lives (e.g., sexually abused children may be given extraordinary nurturance for submitting to demands for sexual favors).

Similarly, the procedure of responding to child noncompliance with threats of expulsion from the adoptive family (in many cases, a family with whom the child has lived for many years) can significantly exacerbate a child's fear of abandonment. (I know of no other legalized situation in which individuals can be removed immediately from their family if they do not comply with a procedure from which they seek escape.) This procedure also reinforces the notion that the child is acceptable to the adoptive family only if the child, in essence, becomes a different person. In our clinical work, we have found that antisocial maltreated children tend to improve (i.e., stop testing their caregivers' commitment with increasing levels of disruptive behavior) when they consistently hear the message that they are permanent members of the family, *regardless of how they behave* (replicating the circumstances naturally experienced by most children in their biological families).

The procedure of requiring children to say good-bye to their birth parents and facilitating the process by emphasizing the birth parents' negative characteristics is potentially harmful to the child's self-perception (i.e., derogation of one's birth parent requires implicit derogation of one's self, at least in part). This practice is inconsistent with theory and clinical experience suggesting that many adopted children retain positive fantasies about their biological parents that are helpful to their development, especially during the adolescent years (when many nonadoptive adolescents fantasize about life with a better parent).

The challenge for adoptive parents is to develop the ego strength or resilience to encourage the adopted child's *acceptance* of birth parents, to see the *good* in birth parents, and perhaps eventually (as an adult) to come to understand the difficult circumstances that may have forced the birth parents to give up the child. If the adoptive parent criticizes birth parents, the adopted child experiences loyalty conflicts that can lead to the child feeling misunderstood and criticized. For the younger child, it may be better to hold a somewhat idealized or romanticized version of the birth parent than one that is harshly objective.

Finally, there is a striking manipulative quality to the behavior of the therapists and adoptive parents in this staged psychological intervention that has the potential to reduce the child's already fragile security and trust in the behavior of adults. Children are not likely

to trust an adult who only minutes before deliberately provoked intense anger and fear. Although many children may portend acceptance of the procedure in order to end it as soon as possible, in my opinion most will leave with an enduring suspicion of therapists and caregivers (e.g., a 12-year-old girl referred to our clinic, who had previously been subjected to attachment therapy, reported a deep mistrust of adults as a result of her previous experience).

b. Physical risks

The probability of physical harm to the child is increased by the physical confrontation that defines the holding method. Children have been known to hit, bite, scratch, and do anything they can to release themselves from a therapist's grip. Holding therapists tend to regard the child's complaints of discomfort as manipulative strategies, and these protests are therefore typically ignored. This perspective may have been the precipitant of death for 10-year-old Candace Newmaker by an Evergreen, Colorado, psychotherapist during an extreme version of holding therapy, called "rebirthing" (the child's complaints of being unable to breathe while wrapped in a rug were apparently ignored). To my knowledge, therapists at The Center do not use such extreme measures, and the probability of serious injury or death is relatively low in my opinion; however, the risk of mild to moderate injuries cannot be discounted in a therapy situation that requires physical restraint of children who may panic when forcibly held against their will.

It is also important to understand the tremendous emotional stress that is placed upon the *therapist* during the holding encounter. Imagine the difficulty of trying to restrain a 10-year-old who is hitting, biting, swearing, and yelling "I hate you" repeatedly. Few clinicians can regulate their emotions and remain objective throughout such an encounter, and we have no information about the type of training, preparation, or oversight that would allow a therapist to manage such a risky and volatile procedure.

4)Potential Benefits

In my opinion, there are no potential benefits to the child as a result of participation in intensive attachment therapy. There may be a dramatic, but very short-term change in child behavior that is desired by the therapists and/or adoptive parents as a result of the child's overt submission (e.g., increased compliance to parental directives). However, as suggested by the results of research on thought reform programs, such changes are likely to be transient and shown primarily in the presence of the adoptive family, with very limited generalization to school, peer group, and other settings.

Unfortunately, there has been no empirical study of holding therapy using scientifically rigorous methods. Almost all that is known about the effects of this therapy are testimonials and other anecdotal information. Most of it is found on Internet sites promoting the use of this approach or a related product (e.g., see the 40 plus consumer reviews of Welsh's *Holding Time* on Amazon.com).

In my review of the literature in preparation for this article, I located a single journal publication, conducted as part of a student's dissertation project (Myeroff, Mertlich, & Gross, 1999). A quasi-experimental design was used to examine the pre- and posttreatment effects of holding therapy conducted at the Attachment Center at Evergreen. Data analyses showed a significant decrease in adoptive parent reports of specific aggressive behaviors as measured by the Child Behavior Checklist (Achenbach, 1991). However, there was no effective control group, no randomized assignment of children to treatment conditions, and no subjective measures of child status and well-being. Ascertainment methods were questionable. These methodological limitations are so significant that it becomes impossible to interpret the data from this single study.

a. Risk versus scientific evidence

The Center for Evidence-Based Medicine at Oxford University has developed standards for evaluating the risks and benefits of new treatments and determining whether such treatments meet criteria for acceptable scientific scrutiny. In this system, five levels of scientific evidence are described as follows, from most to least rigorous: 1) randomized clinical trial, 2) prospective cohort study, 3) case-control study, 4) case-series studies, and 5) expert opinion. Treatments that involve relatively higher levels of risk (e.g., endanger the safety of patients or carry high probability of iatrogenic effects) are required to meet higher levels of scientific evidence. Similarly, the American Psychological Association has established criteria for what it terms "empirically supported treatment" (Chambless & Holton, 1998).

In my opinion, (a) intensive attachment therapy carries a high risk of psychological injury to the child that requires the highest levels of evidence in support of its benefits (#1 or #2 above), and (b) the current support for this treatment (primarily personal testimony) does not meet criteria for any of the five levels listed above or any of the criteria listed by Chambless and Holton (1998). Until a randomized clinical trial of a well-specified coercive attachment or holding therapy is conducted and replicated, it is both unethical and dangerous to involve a child in this form of treatment. Other researchers and clinicians also believe this treatment is unethical and dangerous and have stated so in published papers or books (e.g., Hanson & Spratt, 2000; Hoyle, 1995; Miller, 1997).

5) Alternative Treatments

It is important to understand the limitations of current technology in psychology, psychiatry, and education because adults' expectations for children's behavior change often far exceed what is currently possible. For example, there is no known technology that can change a child's basic temperament or personality or one that can completely eliminate or reverse the effects of maltreatment in early life. There *are* effective technologies for stabilizing, managing, and containing children's antisocial and violent behavior, reducing family conflict, improving children's social skills and their ability to regulate emotion, improving school adjustment and achievement and peer relationships, and reducing anxiety and fear in children who have been traumatized by early experiences.

There are many alternatives to intensive attachment therapy for adoptive children with histories of maltreatment that have been empirically supported in studies with nonadoptive high-risk and/or severely disordered children (see Greenberg, Domitrovich, & Bumbarger, 2001, for examples). Empirically supported treatments for aggressive/disruptive behavior, anxiety, sleep disorders, and toileting problems (commonly found in foster/adopt populations) are described in a recent book (*Treatments That Work With Children: Empirically Supported Strategies for Managing Childhood Problems*) by Christophersen and Mortweet (2001), published by the American Psychological Association.

DESCRIPTION Cont'd

These treatments include parent and family interventions, cognitive-behavior therapy for children's emotion regulation and social skills, and specialized behavior programs for home and school. Maltreated children with behavior problems typically need a combination of such services as well as intensive in-home, parental support. To my knowledge, none of these strategies has been specifically studied in samples of adopted children with severe behavior problems. However, in my opinion, these treatments are likely to be effective when applied by therapists with specific expertise and experience in child maltreatment and issues germane to foster and/or adoptive parents.

I would agree with holding therapists that traditional "supportive counseling" (or "talk therapy") for the individual child is rarely effective, especially when used as a solitary intervention. When individual treatment is the sole intervention, the child's problems once again are not viewed from an attachment-perspective, but rather are seen to reside solely in the child.

It is important to note that the effective treatment of maltreated children does not necessarily require a focus on attachment processes, although therapist knowledge of attachment theory and related interventions is in my opinion likely to enhance the probability of a positive outcome. Most children and adolescents are incapable of resolving (or "working through") their "abandonment, grief, and loss," either by talking about it or through brief, staged interventions like holding therapy. In my clinical experience, these issues are more productively addressed (if needed) when maltreated individuals reach late adolescence or early adulthood. Perspective can emerge with age, and it is as a young adult that the issues of maltreatment and subsequent loss of family can eventually be resolved. Most children and adolescents are overwhelmed and confused by discussions of their early experiences of maltreatment. It is more appropriate to focus on stabilization of the child's behavior, coping skills, attainment of critical developmental milestones, and the quality of the adoptive parent-child/adolescent relationship.

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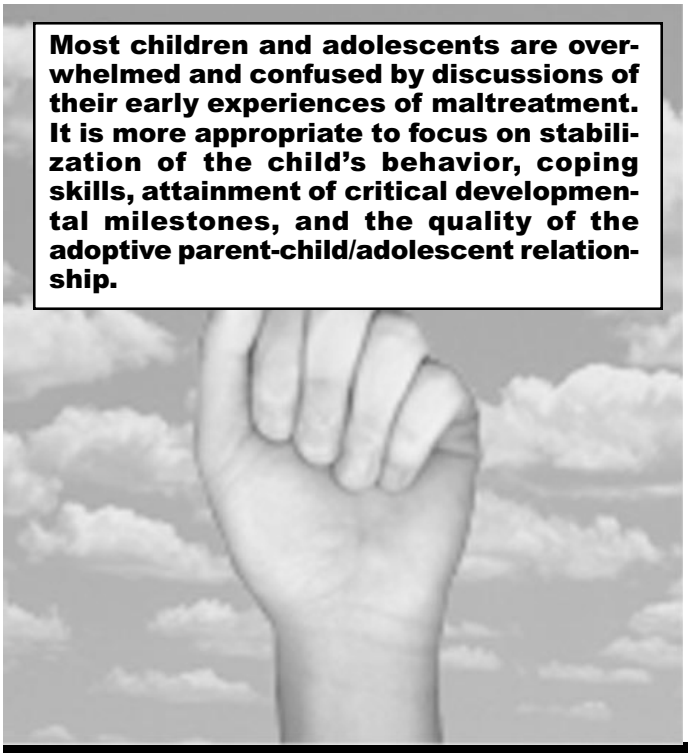

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