Children with the worst early experiences present a considerable challenge for those helping them. Fostering is a vital resource in the care of these children. However, as **Kim Golding** argues in this paper, to be successful, fostering services need to be developed, supported and resourced to provide stable and therapeutic care. The extent of the difficulties experienced by the children needs to be recognised and services developed which can provide turning points in their development. Therapeutic options can be used that emphasise the role of the carer in the intervention, with a particular emphasis on the facilitation of secure attachment. Research and practice developments are urgently needed to explore interventions stemming from attachment theory for foster carers and the children they look after. The usefulness of attachment theory for guiding interventions with foster carers is explored, based on the experience of a specialist project set up to support carers of children ‘looked after’.

**Introduction**
Children who live in foster care have typically experienced several years of extremely poor parenting where they were subject to various forms of abuse or neglect (Quinton *et al.*, 1998). Schofield *et al* (2000), in a study of 58 children in long-term foster care, found that 81 per cent had experienced three or more types of abuse or neglect. Only ten per cent had no such history.

Children who have been abused and neglected are at high risk of developing insecure attachments to their primary carer (Bowlby, 1988). Crittenden (1988, cited in Hughes, 1997) found that only 5–13 per cent of children who had experienced abuse or neglect had formed a secure attachment to their carer. Thirty-six per cent of children experiencing more marginal inadequate parenting formed secure attachments. Since Mary Main focused attention on to the development of a disorganised category of attachment (Main and Solomon, 1986), many studies have shown that children living in high-risk families (including abuse, neglect, domestic violence, poverty, substance abuse, parental history of abuse, depression and other psychological difficulties) are at increased risk of developing attachment disorders (Solomon and George, 1999). In particular, disorganised attachment patterns are more likely in infancy. Studies have shown that between 55 per cent and 82 per cent of abused infants have such patterns (Lyons-Ruth and Jacobvitz, 1999). Following abuse or neglect, therefore, children will be left with multiple problems including difficulties in regulating emotions, developing attachment relationships, development of the self system, forming peer relationships and adapting to the demands of school (Cicchetti and Toth, 1995).

These children are at high risk of developing mental health problems. Arcelus *et al* (1999) reviewed a range of studies to conclude that up to a third of children who are looked after have clinically significant problems of mental health. The disruption of parenting within their families of origin, moves within the care system and the subsequent need to break and re-make attachments all have a profound effect on the development of the children (Rosenfeld *et al.*, 1997).

These children find living in foster care difficult. They find it hard to trust and often appear to invite carers to reject them. They can be anxious and afraid but this is hidden beneath a veneer of angry, aggressive and controlling behaviours. Children who have difficulty giving and receiving love and affection, who constantly defy parental rules and authority...
and who are physically and emotionally abusive to family members place a severe strain on the foster family (Levy and Orlans, 1998).

This paper describes the work of the Primary Care and Support Project, set up to provide support to carers of looked after children. In particular the usefulness of attachment theory to guide this support is explored.

**The Primary Care and Support Project**
The Primary Care and Support Project is an inter-agency project based in Worcestershire. It involves social workers, educators and clinical psychologists working together to provide support and training for carers of children and young people within the looked after system. The project has been set up to help carers feel more supported, to help them to understand and manage the children optimally and to increase their knowledge about local services and how to access them. The majority of support offered involves working with carers and thus indirectly helping the children. However, a small amount of project time is spent exploring ways of working directly with the children.

**Indirect work: supporting foster carers**

**Consultation**
Access to support from the project is initially via a consultation service. Consultation with foster carers is beginning to be developed within the practice literature. Nissim (1993) has reported the successful development of a consultation service for carers together with social workers, but success has not been systematically researched. From her experience, she suggests that benefits occur when time is provided to discuss issues and consider different perspectives. Similarly, a number of practitioners have commented on the usefulness of consultancy for working with the multiple systems and complex networks found within foster care (Lindsey, 1985; Sprince, 2000).

Within the project, consultation broadly follows the consultee-centred case consultation model developed by Caplan (1970). This focuses on the consultee’s management of the client or clients with the aim of increasing the skill of the consultee. The model is adapted to include other relevant professionals at the consultation meeting. Thus a range of people are invited to attend including the child’s social worker, the family placement social worker, school staff and relevant health professionals. The focus of the consultation remains with the foster carer and current issues impacting on the care of the child, but the network of people involved are invited to discuss the issues and support the carer. Within this model a collaborative approach is adopted. The consultants work in partnership with the consultees to explore problems and find potential solutions. The psychological expertise brought to this process is the unique responsibility of the psychologist, but the use of this expertise becomes a collaborative process. This type of consultation is similar to process consultation as described by Schein (1988, cited in Cowburn, 2000).

Typically these consultations last for two hours. They begin with an opportunity for the carer or carers to talk about how they are feeling about the placement, what their concerns are and what progress they have made. Sufficient time is allowed for them to feel listened to. Following this the other consultees provide their own perceptions of the child and/or the placement. There is some exploration of the child’s background. The psychologist will then bring a psychological perspective to the discussion. A formulation of the child’s difficulties is presented and issues are highlighted for further consideration. This input guides the remaining discussion leading to reassurance for the carer and specific ideas for helping the child. Finally, plans for further support are made.

The psychologist helps the consultees increase their understanding of the young person, and make sense of the often-perplexing behaviour they present. Attachment theory is often drawn upon to do this. Foster carers are encouraged to consider the apparently maladaptive behaviour of the child as an adaptive response to their early environment. The child continues to display behaviours that helped to maintain a feeling of security and safety when living within an adverse
environment. Building upon attachment theory, Crittenden has suggested a dynamic-maturational model in which children who are not safe are seen to behave in ways that will increase their feeling of safety. This may take the form of eliciting adult protection or reducing the possibility of adult threat (Crittenden et al., 2001). The attachment style of the child supplies important clues as to how their behaviour has developed to increase their feelings of safety (see Howe et al., 1999). The consultation provides a reflective space in which carers and the related network can explore patterns of attachment and how these might have been adaptive within the child's early environments. The impact of these formerly adaptive behaviours on the current placement can then be looked at, leading to increased understanding of the child. With this increased understanding comes a reduction in feelings of failure or of the placement not being right for the child. We have found that carers perceive the foster child as having more severe and chronic problems following consultation (Golding, 2002). The consultation process alters the foster carers' perception of the children, as they become more aware of the extent of difficulty in the child's early history. The discussion helps the carer to see that slow progress and the challenge the child presents stem from the complexity and extent of their difficulties, rather than from the adequacy of the fostering being provided. For carers already feeling confident this provides validation for their own practice. For less assured carers it can dramatically increase their confidence. Carers have reported that consultation has helped them to continue a placement that was on the verge of ending.

Consultation therefore helps the carer understand the reasons for difficulties displayed, leading to a different view of the child and the relationship between them. In turn, this different perception helps them to feel less victimised by the child, and to reduce their expectations of her or him. The result is increased confidence in their ability to foster and more realistic goals for the placement.

The following case study provides an example of one consultation. It illustrates how one intensive meeting can make a significant impact on the carer and provide indirect help to the child, in this case by increasing placement stability. The focus of the consultation was Sam. One of six children, his early life experiences were abusive and traumatic. They included domestic violence and substance misuse by his parents, physical abuse and the death of a significant adult. Sam was received into the looked after system aged seven years, and proceeded to experience multiple placements.

At the time of referral Sam was ten and had lived with his current carers for two years. His behaviour was extremely challenging: the carers described every day as a battle. Sam could be dangerous and unpredictable. The carers were concerned about his mental health and about their capacity to continue the placement. They had high expectations of what they should be able to achieve, and doubted their fostering ability. The consultation provided the carers with an opportunity to reframe their understanding of Sam and of what they could achieve. They were helped to view his behaviour as a manifestation of an attachment disorder, and given ideas about how to manage this. The insight provided by the consultation enabled these carers to reduce their expectations of the progress they would make and renewed their confidence in themselves. They could acknowledge that Sam wasn’t what they had initially wanted in a foster child, but also that they wished to continue with the placement. Following the consultation they reported:

Having had no real direction or diagnosis of Sam it was difficult to understand why no progress or anything seemed to make a difference to Sam's behaviour, which seemed to be deteriorating. Having talked to Kim things fell into place, and we had less personal views of the reasons why Sam was so abusive and violent.

Two years later Sam remains in placement with them. He is still extremely difficult but the family have also had moments of real progress.

An evaluation of the experience of 104
foster carers, 44 of whom had received a consultation and 26 of whom were awaiting one, revealed that carers do feel more supported through the increased access to psychological advice and support made possible by consultation (Golding, 2002). The greatest satisfaction and feeling of being supported arose when consultation was followed by a support intervention. This could be in the form of individual or group work.

### Individual support interventions with foster carers

Following consultation a decision can be made to offer further, more intensive support to the foster carer. The need for indirect interventions with carers is being identified within the practice literature. For example, Hart and Thomas (2000) suggest that direct interventions with a child can compromise primary attachments where the child has an attachment difficulty. They describe parent co-therapy as a model of treatment that can strengthen attachments of the child to the carer. Within the Primary Care and Support Project we have developed a similar model of working with the carers. This consists of regular meetings to explore with them their fostering skills and how these may be adapted to the individual needs of the child they are caring for. Promoting attachments from the child to the foster carer is generally central within these. The family placement worker is also invited to attend these sessions to ensure that they understand and can support the approach the foster carer is taking.

Practitioners have developed ways of working with foster children based on attachment theory. These have guided our interventions with foster carers. Fahlberg (1996) suggests that the foster carer use the arousal–relaxation cycle. This cycle, apparent in the first year of life and seen as pivotal in allowing the child to develop trust and feelings of security, can be used with older children who are experiencing relationship difficulties. Carers respond to the needs expressed by often distressed and difficult behaviour, and use the period of relaxation following an outburst to get closer to the child. Similarly the positive interaction cycle, in which the carer initiates and responds to positive social interactions and claiming behaviours to help increase the child’s sense of belonging, can further facilitate the development of secure attachments.

Hughes (1997) suggests a comprehensive approach for children traumatised by their past and who find living in a family difficult. He advocates the provision within the foster placement of a therapeutic environment. The children experience a high degree of affection and empathy, alongside clear and comprehensive behavioural expectations and consequences.

These and similar ideas are explored with the foster carers. The therapist and carer work together to plan how the ideas might be implemented within their home and fitted to their own existing style. The carers are helped to recognise and respond to the attachment needs of the children, to spot when they are being drawn into confrontation and to side-step this, and provide clear and firm boundaries in an atmosphere of empathy and low irritation. Always the aim is to facilitate the development of a positive emotional atmosphere within which the child can experience safety, being valued and being cared for. It is recognised that this approach to fostering is not easy and the therapist and family placement worker work closely together to support the carer. Telephone support is offered between sessions and when the period of intervention has ended. Time is also given to exploring the feelings and reactions the carer has to the child. At times their own early experience may be relevant to this.

The relationship between the carer and psychologist is an important element of this intervention. This approach works best when carers are interested in ideas about attachment and want to adapt their fostering to promote secure attachment. This may be more than some carers want. Trust and respect are needed on both sides, with the needs of the carer taken into account.

The successful use of such an intervention is illustrated by the case of Natalie. She is a single child. Her mother has mental health difficulties and parenting was neglectful and physically abusive.
At the time of referral Natalie was two years old and had been in placement for a few weeks. The foster carer was exhausted and concerned about the impact of Natalie on her own family. She was close to ending the placement. The initial consultation was used to explore with the carer Natalie’s behaviour and its link to the early trauma experienced. Natalie was preoccupied with the availability of the carer, fearing abandonment. When negative emotion overwhelmed her, she engaged in severe tantrums and self-harming behaviours. Her difficulty in trusting and feeling secure with the carer was explained as stemming from an experience of carers as unreliable and frightening. She was more at ease with confrontation than with nurturing. Further support was offered to the carer and family placement worker. Home visits by the psychologist helped the carer to develop her fostering skills tailored to Natalie’s needs. In particular a cycle of emotional attunement, calm, non-hostile discipline and interactive repair and re-attunement were fostered. Six months later there are fewer and less violent tantrums, and the self-harming has ceased. Natalie is able to use the carer as a secure base and can tolerate being left in a room while the carer moves into another room. Natalie can use her carer to co-regulate emotions and is beginning to develop self-regulation skills. The carer takes great pleasure in Natalie’s achievements and reports finding her a very rewarding child to care for.

Overall carers in a number of families have found this approach useful and supportive. However, the impact on the child has been mixed. For some this intervention has been a turning point allowing the development of a more secure attachment. For others it has led to a moderation in their behaviour and to the development of some emotional warmth with their carers. Occasionally the child’s behaviour has continued to be extremely troubling, often resulting in the breakdown of the placement. Research is needed to explore factors both within the carers and the children that can lead to success or failure. We have found that the extent to which the carers are able to develop a reflective stance is important. This allows them to collaborate with the therapist to understand and develop successful interventions. The approach appears to work best for pre-school children or for those who are still seeking some degree of security from their carers. For older children who appear to have given up on adults and have become strongly self-reliant, our impression is that the interventions are less successful.

**Group interventions with carers**

Individual intervention with foster carers is expensive in time and resources. Within a small project the numbers of foster carers who can be supported this way is inevitably limited. In addition foster carers can be left isolated, with little contact with other carers who are also managing children with attachment difficulties. We have therefore also explored group interventions. These aim to provide foster carers with an opportunity to meet other carers and to reflect together on the difficulties being presented by the children they are caring for. They can gain support and further develop their fostering skills. In doing this they draw upon ideas from each other as well as from the therapists. Group interventions with foster carers elsewhere have been shown to provide a positive experience. Participants report a growth in confidence and self-efficacy (Pallett et al., 2002) and an increased ability to communicate with their foster children (Minnis et al., 1999; Minnis and Devine, 2001). There is also some evidence that these improvements have a positive impact on the child (Pallett et al., 2002). We initially explored the usefulness of parent management training for foster carers. Our starting point was the early years parent-training programme as described by Webster-Stratton and Hancock (1998). Therapists and carers work collaboratively as partners to consider parenting techniques and how they might be adapted and used in different situations. Expertise is viewed as being within both the therapist and the carer and it is the combining of this expertise that leads to solutions. A combination of teaching, discussion and role play is used to allow foster carers to
reflect on and practise different ways of managing the child. The programme introduces social learning theory and techniques organised around a parenting pyramid. The first part of the programme focuses on building positive relationships. Effective parenting is viewed as one that has at its foundation a positive base. A positive foundation promotes feelings of confidence and self-worth in the child. This helps the child to feel loved, fostering a secure base for ongoing emotional development, and promoting feelings of attachment and warmth between the child and the carer. The programme therefore begins with building this positive base. Non-aggressive disciplinary techniques such as time out, and logical and natural consequences can then be used to build upon this foundation of positive parenting skills.

The parenting pyramid provided a framework for our group but was extended and adapted to explore matters of relevance to caring for looked after children. Issues were allowed to emerge naturally and the discussion used to consider these in relation to the behaviour management techniques being discussed. This group was run very successfully four times. Pre- and post-questionnaires revealed that carers felt they had increased understanding and a better relationship with the child following the group work. The child was perceived as less difficult and fewer conduct problems were reported on the Strengths and Difficulties Questionnaire (Goodman, 1997).

Each time we ran the group we found that a substantial amount of time was spent on the issues of trauma and attachment. We therefore decided to explore the same group approach but with a specific focus on attachment theory and intervention. A manual was written (Golding, 2001) based on the ideas of a number of authors (Fahlberg, 1996; Hughes, 1997; Delaney, 1998; Howe et al, 1999). This manual provides the content of the sessions, but the group participants set the pace. The group is open ended, with carers encouraged to continue attending for as long as they find it useful. The group begins with a four-week course explaining attachment theory and the development of different attachment patterns. We then meet on a monthly basis exploring different ways of working with children that have been suggested by attachment theory. We help carers to focus on how to provide a positive family atmosphere and how to avoid being drawn into a re-enactment of the child’s early experience. Carers are encouraged to control the emotional rhythm of the house. In this way they foster a secure base within which the child can learn emotional regulation and the ability to be reflective. Carers learn to build attachments through attunement and empathy, and we explore ways to manage difficult behaviours. Special attention is given to the difficult but common behaviours of lying and stealing, managing children who are angry and coping when a child is regressing emotionally. While much of the group discussion focuses on looking after the child, some attention is also given to carers looking after themselves, which includes considering their own experience of being parented and how this impacts on their fostering.

In recognition that children with attachment difficulties only change slowly, we wanted to work with the carers over a longer time period than is usual for a group intervention. Foster carers can try out ideas with their child and bring these attempts back for further discussion in later groups. Thus they develop their fostering skills tailored to the individual children they are caring for. Our initial attachment group has now been meeting for one year. It began with 13 foster carers and five family placement workers, of whom nine carers and all the family placement workers are still attending. One couple stopped coming because of problems with babysitting. The female carer is now going to a daytime group instead. A further two carers decided to stop attending when their current placements broke down. We have not yet formally evaluated the group, but initial feedback suggests that the carers find the group extremely helpful for increasing their understanding, offering ideas for them to try, and providing time to recharge their batteries. The facilitators
have found the opportunity to explore material at the group’s pace useful. An idea can be explored in depth and ideas discussed at one meeting can be picked up again in a subsequent meeting. We anticipate that this extended process will aid the application of ideas into practice, not only with the current child but also with future children being fostered. We do recognise that at times the group discussion can have significant impact on the carers. We encourage the potentially painful exploration of the damage that is created by early adverse environments, the difficulty in enabling children to recover from this, and sometimes the impact of the carers’ own early histories on their fostering. For example, one carer reported:

*I felt reassured that other people feel so frustrated at times. It was a session that provoked sadness in me and I felt quite low at the end.*

Another carer was profoundly moved by a discussion of the avoidant attachment pattern and talked afterwards of his own early experience and the impact this has on his fostering. The fact that these carers continue to attend despite this painful exploration provides an indication of the supportive nature of such group work.

An example from one of the group sessions illustrates how a carer can feel supported by other participants, helping her to cope with a difficult period in her fostering career. The carer was looking after Andrew, a ten-year-old boy with early experience of neglect and domestic violence. At the time of the group session described he had been in placement 18 months. The carers found it very difficult to build a relationship with Andrew. He was self-reliant, using hostile, confrontational behaviour to keep carers at a distance.

The sixth monthly meeting of the attachment group was focused on avoiding getting angry with the children. Anger was explored as disrupting the development of secure attachment, allowing the child rather than the carer to set the emotional rhythm of the house. A role play was used to facilitate group discussion of the topic. This led Andrew’s foster carer to explore with the group the difficulties of sustaining the recommended approach over a longer period. Carers shared ideas for maintaining their calm and for coping with periods where they felt hopeless and became indifferent to the child. Andrew’s carer was reassured that her feelings were shared and encouraged to find ways of looking after herself. She subsequently arranged to have more time for herself and again felt engaged in the task of fostering this difficult child.

**Direct work with children**

While offering support to carers is successful, we have found in a number of cases that the child continues to be difficult, sometimes to breaking point for the placement. He or she has not been able to start to trust or obtain security from within the placement. At times the breakdown appears to have stemmed from initial success. For example, Jo is a self-reliant and controlling 12-year-old girl who had experienced a series of abandonment in her early life, and a number of unsuccessful placements thereafter. She began to feel some security and trust in her female carer. Jo experienced her emotional needs being met, perhaps for the first time ever. However, the carer became overwhelmed by the neediness that was opening up. Jo’s increasingly demanding behaviour and inability to tolerate any attention from the carer to her partner or the other child living with them led to the carer feeling exhausted, and concerned for the effects on the rest of the family. The child sensed some withdrawal from the carer, and feared further abandonment, so resumed her challenging behaviour to the point where the placement had to be ended. She rejected before she could be rejected. This example highlighted for us the importance of working with the whole family, and in particular ensuring that the partner is understanding the approach being taken. It also led us to question whether more needs to be done directly with some children. Could therapeutic work with the child increase resilience and thus further strengthen the placement?

Children with attachment difficulties
can do less well initially with traditional therapies. This has led some authors to suggest the need for therapies that are specifically guided by attachment theory (Delaney, 1998). Such therapies are being developed, both for parents of origin (Marvin et al., 2002) and for foster and adoptive carers (Hughes, 1997; Howe and Fearnley, 1999; Crittenden et al., 2001). These therapies can focus on the attachment relationship specifically. Secure attachments can only be established in the context of a nurturing relationship (Levy and Orlans, 1998). When the child has developed sufficient security in their relationship with their carers they are more able to address issues without being overwhelmed (James, 1994). Then traditional psychotherapy may be more successful (see Hunter, 2001, for a discussion of the use of psychotherapy with looked after children).

We have started to explore whether further therapeutic work involving both the child and carer can benefit some of the placements. We are identifying children where there is little change within the child despite individual or group intervention with the carer. Based on the Hughes model (Hughes, 1997), the therapist works with the child and carer together. The therapist directing the sessions facilitates the development of a relationship between the child and carer whereby they communicate emotionally and the child is able to experience recurring sequences of attachment, affective union, separation and reunion. This provides the child with a feeling of containment and security, allowing them to experience trust and to use this trust to begin to explore issues of attachment, abuse and neglect.

Sometimes such communication between the child and carer can be used to explore issues that are of current relevance. This form of direct work creates an opportunity to help the child experience his or her fears being understood and supported. For example, Alex is a seven-year-old boy. At the time of referral he had lived in a short-term placement for 18 months while an adoptive family was sought. He had no contact with his mother who had severe mental health problems. Alex had formed an insecure attachment to his carers. He desperate wanted to belong to a family and experienced anger at expected rejections from others. The foster carers received regular visits from the psychologist, which they found helpful. Alex, however, remained hostile, convinced that he was ‘bad child’ and that carers were unreliable. At the time of the intervention with Alex the carers were concerned about needing to use a respite placement so that they could fulfil a family commitment. The therapeutic sessions were used to help Alex express his feelings and to experience these as supported by his foster mother. Over the course of three sessions he was enabled to express his anger at his carer for planning to go away and to experience her empathy for these feelings and his underlying sadness. They planned together how they would both cope with the separation. Alex did cope well with the respite placement and returned easily to his foster carers upon their return. At the same time, he continues to experience difficulty in trusting them and will need continued help with current and future carers.

While this approach has not been systematically researched, practitioners report success with this ‘hard-to-treat’ group (Hughes, 1997). Studies exploring research-based evidence are currently being set up (Hughes, personal communication). These will provide important guidance for using and developing these interventions further.

Our project has been set up principally to support carers and therefore has only limited opportunities to work directly with children. However, with a number of children we have found that the intervention has enabled the child to emotionally communicate with the carer and consequently to develop a closer relationship. Long-term outcome studies will be important to determine whether such changes ultimately benefit the child and, in particular, whether it improves their ability to sustain adult and parenting relationships themselves.
Conclusion
The Primary Care and Support Project has been set up to provide support to foster carers. In developing this service we have found an attachment framework to be useful in guiding the development of successful interventions. Consultations, individual and group interventions with the foster carers and direct interventions with the children have all been guided by attachment theory and practice. All those involved with the service have reported high levels of satisfaction (Burgess and Smith, 2002). Carers feel more supported following intervention from the project, in particular benefiting from the increased access to psychological advice and support (Golding, 2002).

Children for whom adoption or return home is not an option can benefit from establishing long-term secure attachments with foster carers. Attention needs to be given to the therapeutic needs of these foster placements, and for recruiting and training foster carers who can meet these needs. Foster carers need to be able to provide long-term support to children who may have a range of difficulties stemming from their early unsatisfactory relationships. In order to do this successfully carers will require support and guidance. While this is a growing field of practice, establishing an evidence base of suitable interventions for carers is more difficult. Satisfaction with support services is typically high, as witnessed by the evaluation of our project (Burgess and Smith, 2002). Demonstrating measurable developmental benefits for the children is more difficult. There is an urgent need to adapt mental health approaches to the special needs of foster children. The long-term nature of this work should be recognised. There is also a need for therapists with specific knowledge about the special task of fostering very troubled children and the impact attachment difficulties have on this task. They must be able to work collaboratively with foster carers. Fostering offers an opportunity to provide comprehensive treatment and care for the most difficult of children. It will only be a successful resource if the therapeutic needs of the children are recognised and foster carers are supported to meet these needs.

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