

Attachment, aggression and holding: A cautionary tale

NEIL W. BORIS

INTRODUCTION

O'Connor and Zeanah's review of assessment strategies and treatment approaches for attachment disorders is both timely and important. There were at least two deaths in the USA in 2002 attributed to interventions designed to address the specific 'attachment problems' of children. The forensic details suggest that the treatments employed in these cases were somewhat different; however, in both instances forcible restraint (e.g., a form of holding therapy) was used in an effort to 'promote re-attachment.' Available media reports suggest that mental health professionals hired to address what were deemed attachment disorder symptoms were actively involved in shaping what appear to have been coercive physical interventions in both cases. While media attention and prosecution may force mental health providers to reconsider restraint-based interventions, it is unlikely that the number of children who experienced early disruptions of attachment and present with impulsive and aggressive behavior will diminish. In fact, the rise in adoptions of institutionalized children, the majority of whom experienced severe emotional deprivation, and the continuing problems with permanency planning in the US foster care system make it likely that children who have had early disruptions of attachment will present clinically. Furthermore, books and internet sites devoted to variants of 'holding therapies' will not disappear and, given that these deaths were not the first to be associated with restraint-based interventions, the potential for further injury of young children is clear. Still, as O'Connor and Zeanah suggest, highly symptomatic children, and the parents and foster parents who must care for them, are not currently being well served by the mainstream mental health system.

There are four pressing questions regarding children who present with aggression after early attachment disruptions. First, are these children adequately captured in the current diagnostic rubric? Second, is there a role for various forms of holding therapies in the treatment of these children? Third, can we recommend available and potentially cost-effective models for intervention? Finally, are there models for preventive intervention with children who experience early attachment disruption before aggressive symptoms become chronic?

O'Connor and Zeanah directly address the question of whether impulsive, aggressive behavior should be added to criteria for attachment disorders. Certainly, the association between aggression in childhood and disrupted early attachment is longstanding. Furthermore, groups of clinicians who publish outside the mainstream

Correspondence to: Neil W. Boris, Community Health Sciences, Suite 2301, Tulane University School of Public Health and Tropical Medicine, New Orleans, LA 70112, USA, *Email*: nboris@tulane.edu.

scientific literature have proposed revision of attachment disorder criteria to include aggression and impulse control problems as diagnostic criteria, especially in older children who have a history of early attachment disruptions (e.g. Levy & Orlans, 1988). Finally, data from a long series of primate studies confirms the link between early severe deprivation and later behavioral disturbances, including in the domains of aggression and impulse control (see Kraemer, 1992 for a helpful review with commentaries). Nevertheless, as the authors point out, there are other diagnostic categories for children with impulsive and aggressive behavior (namely oppositional-defiant disorder and conduct disorder) and adding these criteria to the current criteria for reactive attachment disorder would undermine the utility of the nosology by creating overlap among categories. No evidence has been presented that the many children with conduct disorder who have experienced early attachment disruptions are qualitatively different from those without early attachment disruptions. Amending the diagnostic criteria for reactive attachment disorder to include aggression or impulse control problems would weaken the psychiatric nosology and undermine our ability to study the genetic underpinnings, environmental triggers and natural course of various distinct disorders.

When a child presents with aggression and impulse control problems, regardless of diagnosis, these symptoms logically become the focus of intervention. O'Connor and Zeanah point out that treatments for oppositional-defiant disorder and conduct disorder already exist and carefully deconstruct the arguments in support of holding therapies. Forced holding violates key precepts of attachment theory. The fact that several children have died from forms of holding therapy is enough evidence that the risk:benefit ratio for these types of treatments is unacceptably high, especially when compared to interventions that have been more carefully researched (see Burke, Loeber, & Birmaher, 2002 for a recent review of these interventions). Still, as the authors point out, desperate parents and foster parents, many of whom feel unsupported within the current mental health system, will seek out providers with conviction, even when the interventions these providers use pose grave potential risk. As we refine our understanding of disorders of attachment through research, we must simultaneously train providers about effective interventions, while increasing our efforts on preventive intervention for groups with early attachment disruptions.

One attractive method of intervention is to combine the caregivers' frequent need for support with interventions focused on either moderating aggressive behavior or improving the caregiver-child relationship. There are two models of group-based interventions for caregivers that have been carefully researched and are effective, though longitudinal data are lacking. The first has been developed by Webster-Stratton and colleagues and targets early aggressive behavior (Webster-Stratton and Hammond, 1997). The second has been developed by Marvin and colleagues and targets the parent-child relationship using an attachment framework and relying on actual videotaped caregiver-child interactions as the source of clinical material (Marvin, Cooper, Hoffman, & Powell, 2002). We must invest our resources in studying the application of these theoretically-grounded interventions. Unlike holding therapies, there is no evidence that these interventions are potentially harmful, though they are intensive and require considerable training.

Effective interventions for both aggression and conduct disorder and disturbed or disordered attachment relationships are invaluable. On the other hand, these interventions require specialized training and are relatively high cost. Given the number of young children who have experienced attachment disruptions, it is logical

to consider preventive interventions for those who are not yet symptomatic. Here again, there is little published data on effective programs for children placed in foster care or children adopted from institutions. It is important for the field to develop a parallel line of research on preventive interventions for those young children at risk for attachment disorders and/or conduct disorder. In Louisiana, our group has developed a clinical intervention program that reports directly to child protective services and the courts on all children under age 4 placed in foster care (see Zeanah & Larrieu, 1998 for a program description). We are now collecting data on long-term follow-up of these children, including relationship-based measures and reports of behavior problems. More funding for the design, implementation and evaluation of early intervention programs aimed at moderating the effects of early trauma and attachment disruptions in order to prevent psychopathology is necessary.

REFERENCES

- Burke, J. D., Loeber, R., and Birmaher, B. (2002). Oppositional-defiant disorder and conduct disorder: A review of the past 10 years: II. *Journal of the Academy of Child and Adolescent Psychiatry, 41*, 1275-1293.
- Kraemer, G. (1992). A psychobiological theory of attachment. *Behavioral and Brain Sciences, 15*, 494-551.
- Levy, T. M., & Orlans, M. (1998). *Attachment, Trauma and Healing: Understanding and Treating Attachment Disorder in Children and Families*. Washington, DC: Child Welfare League of America.
- Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The circle of security project: Attachment-based intervention with caregiver-preschool child dyads. *Attachment and Human Development, 4*, 107-124.
- Webster-Stratton, C. & Hammond, T. (1997). Treating children with early-onset conduct problems: a comparison of child and parent training interventions. *J Consult Clin Psychology, 65*, 93-109.
- Zeanah, C. H., & Larrieu, J. A. (1998). Intensive intervention for maltreated infants and toddlers in foster care. *Child and Adolescent Psychiatric Clinics of North America, 7*, 357-371.