

# Attachment disorders: Disinhibited attachment behaviours and secure base distortions with special reference to adopted children

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It was in the mid 1980s, as a research-oriented academic social worker, that I first became involved with adopters and their adopted children. This was a time of falling baby adoptions and a rapid increase in the placement of older children, many of whom might otherwise have 'drifted' in the public care system. A slogan at the time was 'no child is unadoptable.' It was against this background that I was asked to describe and evaluate the work of a newly established, and pioneering post-adoption service based in London. During my exploratory interviews with the counsellors and adopted parents, I was struck by the uncanny similarity of the problem behaviours exhibited by most of the adopted children with whom parents were having difficulty. Typically, children in late childhood and early adolescence were behaving very aggressively, particularly towards their adoptive mother. Other behaviours included stealing from home, 'crazy' lying, fighting to be in control over most issues, poor eye contact, preoccupation with violent and bloody imagery, and failing to anticipate the consequences of behaviour. The majority of these children had been placed after their first birthday and often much older. Most had suffered abuse and neglect prior to being adopted (Howe 1997, 1998).

Many of the adopters had sought help from the child psychiatric and psychological services but had felt disappointed with the response which, in their eyes, seemed to concentrate on the alleged inadequacies of their parenting, ignoring the child's history and the peculiar features of their problematic behaviour. In desperation, not a few of these parents looked for help from a small number of therapists who were beginning to specialise in treating adopted children using an attachment perspective. At this time, most of these specialists were based in the States, but a steady trickle of British adopters crossed the Atlantic with their children to seek help. Of those who made the journey, most came back not only satisfied but also convinced that there existed a body of knowledge and a group of therapists who understood the nature and etiology of their children's distinctive problem behaviours. The theoretical background employed by the therapists was attachment oriented, and the label given to the children's problem behaviour was (reactive) attachment disorder.

Thus was the label 'attachment disorder' introduced into the British community of adopters and support agencies. Throughout most of their analysis, O'Connor and Zeanah define attachment disorder as the failure to show selective attachment

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behaviour, with the strong suggestion that 'the absence of a consistent caregiver and selective attachment may play a central etiological role in the development of attachment disorders' (p 224). This being the case, not surprisingly most of their examples and evidence are drawn from studies of children who have spent much, if not all of their early childhoods in institutional care before being placed for adoption. However, as a proportion of adopted children who display serious problem behaviours, children with histories of institutionalized care are very small. If the diagnosis of attachment disorder is to be reserved for children who fail to show clear, selective attachment behaviour, it begs the question what is the condition of the much larger number of adopted children who run into major relationship difficulties with their parents, particularly their adoptive mothers? The majority of these children are currently described as having an attachment disorder by the therapists and support agencies who work with them. However, their histories tend to be ones of abuse and neglect at the hands of their pre-placement parents with whom we might presume they had developed an attachment, albeit an insecure and most likely Disorganized one.

Many children who repeatedly feel helpless and frightened in relationship with their caregiver also develop one of a number of Controlling strategies. These have the effect of keeping the child disengaged from the helpless/hostile caregiver, her mind and mental representations (Solomon & George, 1999). In effect, children try to ensure their own safety and survival by not letting the carer occupy the caregiving role. In their experience, being cared for is dangerous, either because the attachment figure is frightening or frightened, or both. Nevertheless, this is a fragile strategy, one which repeatedly breaks down into a helpless, disorganized state under emotional stress (Lyons-Ruth et al., 1999).

Many adopted children with histories of abuse and neglect bring these controlling strategies to the relationship with their new carers. Children therefore remain in constant survival mode, preferring to control rather than be controlled. When safe and protective caregiving is available, they are unable either to trust or accept it. Attachment figures are recognized, but their attempts to care and protect trigger feelings of confusion and distress in the child. Distinctively, many adopted children with histories of maltreatment not only fail to experience safety and regulation in relationship with their new attachment figure, *the actual provision of safe and sensitive caregiving itself seems to generate feelings of considerable anxiety and fear, culminating in aggressive/controlling behaviours*. Whereas the experience of abusive care makes these Disorganized/Controlling behaviours adaptive and therefore understandable, the provision of sensitive caregiving by adoptive parents triggering the same defensive behaviours is maladaptive, counterproductive, and makes less sense.

On the face of it, describing these attachments as 'disordered' seems both reasonable and, certainly to many adoptive parents, evocative of the condition. If negative arousal activates attachment behaviour whose goal is care, protection, and emotional regulation, leading to the termination of attachment behaviour, then any activation of the attachment system that produces behaviours which trigger interactions with the caregiver and which fail to terminate attachment behaviour might be described as 'out of order'.

So, whereas children raised in institutions might be said to have an attachment disorder in the sense that they have failed to form a selective attachment (that is, the disorder is the absence of a subject to which attachment behaviour can be directed),

abused and neglected children who do form selective attachments fail to develop attachment behaviours that achieve their goal (that is, the disorder is the inability to organise attachment behaviour and not the absence of an attachment figure). In the first sense, there is a disorder because an attachment has not formed. In the second, there is a disorder because the attachment relationship itself activates negative arousal, the very thing it is supposed to help regulate.

To the extent adoptive mothers attempt to occupy a caregiving role, they are the most frequent targets of their children's fearfully aggressive controlling behaviours. As predicted by the work of Stovall & Dozier (1998), it is only a matter of time before many adoptive parents of 'controlling' children begin to feel helpless, and even hostile as the relationship with their adopted son or daughter feels increasingly out-of-control. Caregiving responses that normally help the child feel contained and regulated, actually seem to make matters worse. These are the children and parents most frequently seen by 'attachment therapists', and these are the children to whom the diagnosis 'attachment disorder' is most commonly applied, rightly or wrongly.

If sensitive, mind-mindedness by the carer helps bring about a secure, balanced, mentalizing, and reflective child, 'controlling' children who defend themselves by not engaging with their carer's mind, miss out on a whole range of key developmental experiences (Fonagy et al., 2002; Meins, 1999). It is this understanding of child development that 'attachment therapists' employ, using metaphors such as 'developmental arrest.' As many maltreated children placed for adoption continue to use a controlling strategy in relationship with their adoptive parents, attachment therapists see as key to therapeutic success the need to help children 'let go' in the new relationship, and feel safe when they engage with the mind of their carer.

Slightly puzzlingly given the authorship of the target paper, Zeanah and his colleagues have offered a series of papers over several years in which they identify a range of attachment disorders, one of which is described as a 'disorder of non-attachment' broadly coinciding with the definition of attachment disorder presented in the target paper (Boris & Zeanah, 1999). Although these are acknowledged in the target paper, if its preferred definition is accepted, then the other types described by Zeanah and colleagues cannot be seen as attachment disorders, including the very helpful group of 'Secure Base Distortions' defined as a:

... general type of disordered attachment [which] arose from observing patterns of clinically disturbed attachment relationships between young children and their caregivers. What distinguishes these disorders from the disorders of non-attachment is that the child with a Secure Base Distortion does have a preferred attachment figure, but the relationship with this caregiver is seriously disturbed (Zeanah et al., 2000, p. 298–99).

Zeanah et al. (2000) recognise four types of Secure Base Distortion, including 'Attachment Disorder with Role Reversal' in which children try 'to control the caregiver's behaviour, either punitively, over-solicitously, or in some other role-inappropriate manner' (p 300). This is precisely the condition of the majority of adopted children with histories of abuse and neglect who present their adoptive parents with major behavioural difficulties. And it is these children who are most likely to be described and treated by the 'attachment' therapists so combatively criticised by O'Connor and Zeanah (e.g. Hughes 1997, 1999; Keck & Kupecky 1995;

Fearnley, 2000; Levy & Orlans 1997). I acknowledge, as do O'Connor and Zeanah, that the current descriptions of these behaviours are very similar to those seen in children classified as Disorganized/Controlling. However, there is more than a suggestion from the anecdotal and clinical evidence that there is something distinctive and very recognizable about the problem behaviours displayed by many older-placed adopted children with pre-placement histories of maltreatment. In particular, the secure base distortions and the aggressive behaviour shown towards the adoptive mother, do seem worthy of the kind of concentrated attention that O'Connor and Zeanah have rightly given to the much smaller group of 'disinhibited' adopted children initially reared in institutionalised care, many of whom have failed to develop a clear-cut selective attachment.

Two options suggest themselves. First, the definitions of attachment disorder offered by DSM-IV and ICD-10, historically based on the problem behaviours and developmental difficulties displayed by institutionalized and severely deprived children, remain the touchstone. This is the position taken by O'Connor and Zeanah. It is therefore not surprising that the only group of children they feel broadly match current definitions are those who suffered early and severe deprivation in institutionalised care.

The second position suggests that DSM-IV and ICD-10 have not kept pace with developments in attachment research, theory and practice. Boris and Zeanah (1999) imply as much when they view attachment disorders as a continuum of disturbance. If this position is accepted, then the views put forward in the target paper are an excellent example of how our thinking on just one type of attachment disorder, namely 'disorders of (non) attachment with disinhibition', might be tightened. Each of the other types of disorder described by Zeanah et al. (1993, 2000) might then be subjected to equally rigorous review. Thus, my preference is to explore the idea of a more generic category of attachment disorders, recognising the more specific types of (i) disinhibited, and (ii) 'controlling' strategies under regimes of benign caregiving.

So, what O'Connor and Zeanah demand is a more rigorous, consistent, and systematically observed definition of the behaviours shown by children who had failed to form a selective attachment in their first year or so. When placed for adoption, a significant number of these children show indiscriminate social, though often superficial and shallow behaviour with strangers. In terms of clarifying the possible nature and origins of these non-attached behaviours, the target paper is timely and extremely welcome. By removing much of the noise and behavioural clutter, we are left with a tighter, more stripped down characterization of disorders of non-attachment. Thus, what the authors give us might not be a stricter definition of attachment disorders, but a much clearer and delimited characterization of just one type of attachment disorder, that which is most typical of children who have suffered early severe deprivation in large residential institutions, extreme neglect and 'serial caregiving'.

The target paper could therefore act as a useful model for thinking about and examining more systematically the behaviours shown by other problem children thought by many, though not O'Connor and Zeanah, to be an attachment disorder. In particular, the aggressive/hostile controlling secure base distortions shown by many adopted children with pre-placement histories of abuse and neglect are in need of critical review. It is this group of children who are currently most likely to be receiving the description, if not formal diagnosis of 'attachment disorder'. O'Connor

(2002, p. 783), quite reasonably, points out that it looks unhelpful to equate 'disorganized' attachment with a disorder of attachment given that the base rate of disorganized attachment is relatively high. However, what we do appear to have is a significant number of adopted children displaying very disturbed but often surprisingly similar anxious and hostile attachment behaviours in relationship with their adoptive mother, particularly when she exhibits responsive and mind-engaging caregiving behaviour.

As someone who has met, and tried to support and advise many of the parents of these adopted children, restricting the definition of attachment disorder to the behaviours shown by a relatively rare group of severely deprived and institutionally reared children who have selective attachment problems, might, once more, benight the majority of adopters and their children who are just beginning to feel recognized and understood by the professional community, if not specifically, then at least generically, as carers of children who find great difficulty in directing, organising and regulating their attachment behaviour.

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