

Disordered attachments: Toward evidence-based clinical practice

ROBERT S. MARVIN and WILLIAM F. WHELAN

This article is timely and important, given the recent focus on international adoptions, Permanency Planning in foster and adoptive care, and the influence of and controversy over some intervention protocols purporting to be based on attachment theory. It is also timely from the perspective of academic attachment research, given the controversy over whether or not our field is at the point where we can make contributions to individual clinical 'cases,' or if we need more time and research before being able to do so. The article is rich with implications for basic and clinic research, clinical assessments of children with problematic attachments, and interventions for those children and their caregivers. This review article is best digested over a period of time and repeated readings. The review, and the accompanying rejoinders, will certainly 'set' many of the questions we must answer as we work toward integrating attachment research and clinical practice.

In this rejoinder, we focus on each of the three major areas covered by O'Connor and Zeanah: definitional problems, assessment protocols, and intervention. We draw on our experience in research on attachment, and on our nearly 10 years of gradually expanding the application of attachment research procedures in the Child-Parent Attachment Clinic at the University of Virginia. The rejoinder reflects: (a) our clinical experience that most of the children we see with disordered attachments have a complex mixture of Reactive Attachment Disorder symptoms, and also exhibit components of a Disorganized/Controlling attachment pattern; and (b) our optimism that both the procedures and knowledge developed through attachment research, *as long as they are used in a manner that is consistent with standards of clinical practice*, are very much applicable to clinical assessment and intervention.

DEFINITIONAL/DIAGNOSTIC CONCERNS

O'Connor and Zeanah appropriately warn of the need to differentiate between the DSM-IV/ICD-10 criteria for Reactive Attachment Disorder, and Disorganized, Role-Reversed Controlling, and Insecure-Other patterns of attachment-exploratory behavior. In our clinical work, we make the same distinctions, using the term Reactive Attachment Disorder if the child's behavior meets the specific DSM-IV criteria for that disorder. Whether or not that diagnosis is made, we include descriptions of the child's (often disturbed or disordered) pattern of secure base and haven of safety behavior. We include statements of secure, avoidant, and resistant patterns or

Correspondence to: Robert S. Marvin, Child-Parent Attachment Clinic, Department of Psychiatric Medicine, University of Virginia, P.O. Box 801079, USA. *Email:* rsm8j@virginia.edu

components, being clear in considering these all to be ordered or organized patterns that are 'within normal limits.' Consistent with O'Connor and Zeanah's suggestion, we use research-based terms such as Disorganized, Secure, Avoidant, etc., in our clinical work. The use of those terms, however, is completely congruent with their use in attachment research.

The point is that while the distinctions O'Connor and Zeanah make are crucial, we are convinced that if used properly, the patterns identified in attachment research can appropriately and with real benefit be used in clinical assessment and intervention. In our clinical work we need formally to recognize the complex mixture of symptoms and patterns. As Zeanah, Smyke, and Dumitrescu (2002) found in terms of mixture of subtypes in a diagnosis of Reactive Attachment Disorder, we find in our clinical work that a combination of Reactive Attachment Disorder features and those of a Disorganized, Controlling or Insecure-Other attachment classification are more common than a 'pure' version of either. Similarly, in coding the home-based separation-reunion procedure developed for preschool children adopted from Romanian orphanages (O'Connor et al., 2003), we frequently observed the same. For purposes of clinical description and design of intervention goals, the most useful approach may be to think in terms of a complex spectrum of disturbance (c.f., Zeanah et al., 2002).

In fact, we suggest that it is still too early to settle on a nosology of attachment disorders: much of the work done so far has been based on interview and (somewhat unsystematic) clinical observations. Further work is needed in *systematically observing and describing* the complex patterns of behavior, across interactive partners, contexts, and risk factors/experiences. Only as this descriptive work progresses will we be in a position to reliably and validly define the boundaries between a Reactive Attachment Disorder, Disorganized attachments, and other severely problematic attachments (see, for example, the efforts of Zeanah, Boris, and Lieberman (2000)). In the meantime, using standardized and validated descriptions of the child and caregiver's interactions in the context of a standard clinical evaluation (see below) will allow us to take clinical advantage of this area of research while minimizing definitional and diagnostic errors.

CLINICAL ASSESSMENT PROTOCOLS

The reality is that clinicians throughout much of North America, the UK, and Europe are conducting evaluations of children with problematic attachments, giving them diagnoses, designing intervention goals, and providing treatment. In fact, APA guidelines (e.g., the guidelines for custody evaluations), and the fact that the DSM-IV has a diagnosis of reactive attachment disorder, encourage clinicians to assess and treat attachment-related problems. As O'Connor and Zeanah discuss, many current approaches to each of these activities are not systematic, theoretically coherent, research-driven, or evidence-based. To that extent, these activities at least partially fail to meet the clinical standard of utilizing, as much as possible, scientifically standardized and validated procedures and findings.

Consistent with specific clinical practice guidelines and standards, what is needed are clinical protocols that simultaneously are: (a) implemented by appropriately trained and licensed clinicians; (b) as responsive as possible to referral questions regarding patterns of parent-child *interaction* and not merely child and parent personality characteristics; (c) guided by the strengths and limitations of research-

based procedures and knowledge in attachment and other areas of developmental psychology and psychopathology; and (d) consistent with standards of clinical practice, e.g., include standard clinical procedures, and rely as much as possible on convergent data from multiple procedures and sources.

A typical evaluation in our attachment clinic can be used as an illustration of one form of a clinical protocol making use of attachment research and procedures. The evaluation consists of review of records, and clinical and open-ended interviews with the child (if old enough), and the caregivers, involved professionals, etc. These are augmented by standardized questionnaires regarding the child. Standard clinical measures are also used with the parent or foster parent, and in the few cases where appropriate, personality measures such as the MMPI-2. Throughout the day of evaluation, clinical observations of interactions between the child and caregiver are conducted.

In addition to the standard clinical procedures, the child and parent are videotaped in an extended free-play episode, the Strange Situation, or other age-appropriate separation-reunion procedure. This is immediately followed by a behavior management episode in which the parent is instructed to have his or her child clean up the toys and put them away. If the child is able, he or she is administered the Doll Story Completion procedure. If the child is older than about 14 years, we often administer the Adult Attachment Interview.

To gain information that is directly relevant to the parent's caregiving behaviors, we describe and code the parent's behaviors in the Strange Situation using the Caregiver Behavior System (Marvin & Britner, 1996). Finally, we glean clinically useful information about the caregiver's internal working models of close family relationships by administering the Parent Development Interview (e.g., Aber, Slade, Cohen, & Meyer, 1989), the Adult Attachment Interview, and the Post Strange Situation Rating Scale (Whelan & Marvin, 2002). For a typical evaluation of one child and two parents, data collection takes a full working day with two clinical staff members.

A second day is spent analyzing this data, reaching our conclusions, and writing up the results and recommendations, including specific intervention goals relating to child characteristics, caregiver characteristics, and the match between the two. If appropriate, DSM-IV diagnoses are made. Standard clinical impressions are augmented by descriptive impressions resulting from the various attachment-based procedures. Each impression is based on the clinical standard of requiring corroborating evidence from multiple procedures and sources, including both standard clinical and attachment procedures. Depending on the specific referral question(s), formal attachment-based classifications are sometimes used; in most cases, however, the coding procedures for the attachment procedures are used to arrive at descriptive statements consistent with both attachment theory/research, and with standard clinical terminology, rather than research-based attachment classifications.

This protocol has many advantages over more standard clinical evaluations; it also requires, as O'Connor and Zeanah imply, subspecialty training. It may be that, at least until more clinicians are trained in them, clinical assessments of attachment may often best be performed on a 'sub-specialty,' consultation, basis. Our experience, and that of the departments of social services and therapists with whom we consult, suggest that this assessment protocol is frequently less expensive, and more productive in terms of useable intervention goals, than more traditional clinical evaluations that focus on parent-child interactions across a range of types of interaction. This increased efficiency is especially noted by the families' ongoing therapists, who evaluate their own interventions as being more focused, and as taking

less time, than would be the case without this attachment-based assessment and consultation protocol.

INTERVENTION

O'Connor and Zeanah discuss some challenges to an attachment-based intervention framework that are related to the apparent stability of a foster or adopted child's disordered attachment pattern months or even years after placement in a good home. This is challenging both in cases where a child's differential attachment is disrupted through a change in placement, and in cases (from the foster care system as well as eastern European orphanages) in which the child appears never to have formed a differential attachment. O'Connor and Zeanah think it unlikely that improving caregiver sensitivity would yield positive changes in the child-foster/adoptive parent relationship because in most cases those foster or adoptive parents would already have adequate sensitivity. They conclude that the theory underlying attachment-based interventions, i.e., increasing caregiver sensitivity to child signals, is unable to explain why so many of these children continue to exhibit a lack of differential attachments despite years of adequately sensitive caregiving. We would expand this statement to include foster and adoptive relationships in which the child does form a differential attachment, but that attachment remains disordered despite 2-5 years of placement with this presumably adequately sensitive caregiver.

This conclusion seems very compelling, *unless* we expand the theory of attachment-based interventions to include not only the caregiver, but the child as well. This expansion is based on the well-accepted idea that most parent-child relationships can be viewed as an intricate, reciprocal 'dance' composed of each partner's signals and responses to the other's signals. In the case of many children adopted from eastern European orphanages, and from the foster care system, the child's own signals may be especially complex, self-contradictory, and difficult for *anyone* to interpret. We certainly find coding these children's attachment signals in the Strange Situation to be far more difficult than with children who are Secure, Avoidant, Resistant, or even Disorganized/Controlling. We suspect their foster or adoptive parents have the same difficulty, despite the fact that they may have been adequately sensitive and successful in raising their own birth children.

Once the quality of the child's signals are included in the intervention theory, a number of new options are available. Some of these options have been formalized in an attachment-based intervention called the Circle of Security Project (Cooper, Hoffman, Marvin, & Powell, 2000; Marvin, Cooper, Hoffman, & Powell, 2002). This intervention protocol assumes that children with problematic attachments *miscue* their caregivers regarding their underlying attachment and/or exploratory needs in-the-moment. In most non-secure patterns, the child and parent miscue each other, and accept each other's miscues. For example, an avoidant child miscues his parent regarding his need for soothing by sending a cue that he wants to explore, and his parent interprets the child's signal as the latter. The more complex and severe the problematic attachment pattern, the more complex and difficult it will be to interpret the child's attachment and exploratory cues.

The Circle of Security protocol assumes that if caregivers are especially skilled at reading their child's complex cues (e.g., through programmatic coaching, or perhaps because they are 'super-sensitive' to start with), *and* if they tend not to accept the

child's miscues at face value, then they can more easily lead the child into a different parent-child 'dance.' To the extent, however, that the parent's ability to accurately read the child's cues is impaired/unsuccessful, this parent will have difficulty leading the child into a more adaptive dance.

This dyadic framework suggests that foster or adoptive parents who have mildly or moderately dismissing internal working models of caregiving may have been successful in raising their own children to have ordered (albeit perhaps Anxious-Avoidant) attachments, but may be much less successful in raising a child with a Reactive Attachment Disorder. Specifically, being dismissing of subtle attachment cues anyway, these parents may have a *very* difficult time correctly reading their foster or adopted child's *much more complex and contradictory* attachment and exploratory cues. This process may be playing *some* significant role in the continuing difficulties to which O'Connor and Zeanah refer.

This idea evolved from the work of Dozier (e.g., Dozier, Stovall, Albus, & Bates, 2001) and M. Steele (e.g., Steele, Hodges, Kaniuk, Hillman, & Henderson, in press), combined with the following information from our clinic. Over the past three years, we have conducted our clinical protocol and intervention consultations with 48 adoptive families in which either: (a) the adoptive parents report the child has never formed a strong attachment to them, despite living with them for at least 3 years; and/or (b) the parents report that the child's behavior is so difficult that the adoption is at high risk for disruption. This is obviously not a representative sample of adoptive families, but it is probably fairly representative of adoptive families seeking help because of perceived severe parent-child relationship difficulties. Approximately two-thirds of the families adopted their children from the foster care system, and one-third from foreign orphanages. Of these 48 families, 42 (88%) of the primary caregivers (and usually the parenting partner as well) exhibited a dismissing pattern in their caregiving behavior and internal working models. These results, and the large minority of British-Romanian adoptive families who continued to experience disordered attachment patterns (O'Connor et al., 2003), suggest that exploring both child and caregiver roles in the continuing problems, and in their solution, will be more informative. At the same time, we completely concur with O'Connor and Zeanah regarding the need to approach parent-focused interventions in a way that minimizes the likelihood that the parents will interpret this focus as suggesting that they are the source of the problem. Our own experience is that most of these parents, for very understandable reasons, are extremely sensitive to this potential criticism and 'rejection.'

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