

The treatment of attachment disorder in infancy and early childhood: Reflections from clinical intervention with later-adopted foster care children

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In their insightful review of assessment strategies and treatment approaches to attachment disorders, O'Connor and Zeanah (this volume) systematically elucidate the uncertainties and controversies inherent in the DSM-IV and ICD-10 diagnoses of attachment disorder. They point out that, compounding the conceptual and methodological problems of formulating a coherent diagnostic category, there are no established treatment guidelines for institutionalized children with attachment disorder who continue to show attachment disorder behavior following adoption. The authors suggest that lack of consensus about the appropriate theoretical target (Stern, 1995) for treatment is a major reason for the dearth of studies investigating effective treatments for attachment disorder. Existing attachment-based interventions focus on improving the quality of the existing relationship between parent and child when maladaptive features of the relationship are hypothesized to cause the child's disturbance. These attachment-influenced interventions are based on a concordance between theoretical assumptions and treatment strategies because the parent's pathogenic internal models of attachment and patterns of caregiving are presumed to be major etiological factors in the relationship problems and in child's disturbance. Accordingly, it is postulated that improving the parent's perception of the child and the developmental appropriateness of parental care will ameliorate the child's emotional health (Lieberman, Silverman & Pawl, 2000; McDonough, 2000). In the case of institutionalized children who are later adopted, on the other hand, the cause of the child's disturbance is presumed to precede and lie outside the adoptive parent-child relationship. O'Connor and Zeanah underscore that the persistence of attachment disorder in institutionalized children adopted by 'adequately sensitive' parents poses a challenge for attachment-influenced treatment approaches because, in their words, 'there is no intervention more radical than adoption' (p. 225).

The central argument of the present reply is that lack of trust in the reliable availability and protectiveness of the attachment figure(s) remains a core problem for institutionalized children who are later adopted, and that this persistent lack of trust has a major influence in shaping the adoptive parent's perception of the child. The

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child's mistrust originates in external circumstances – i.e., the actual absence of a consistent and predictably loving caregiver during the child's formative years –, but it becomes internalized as a conviction that the child is inherently undeserving of love (Bowlby, 1988). This self-perception is routinely expressed through a range of behaviors that, while differing in type, salience and intensity among individual children, have the common effect of creating stress in the adoptive parents, and raise the parents' concerns about their own lovability and competence as parents and/or about their adopted child's prognosis for improvement. As a result, even parents who were adequately sensitive and empathically responsive to children raised in normative family conditions may find themselves unequipped to respond to their adopted child's pervasive emotional distance, refusal to be comforted, seeming lack of appreciation and preference for them, sudden mood shifts, indiscriminate sociability, and, in many cases, defiance, non compliance, and aggression. In extreme cases, the persistent failures of emotionally satisfying reciprocity between the parents and the child can engender feelings of hopelessness and lead to failed adoptions when the parents become convinced that they are not up to the challenge of raising the child or that the child has an intrinsic and intractable inability to form healthy relationships. The failed adoption, in turn, confirms the child's lack of trust in the possibility of finding a parent figure who will be consistently available, and reinforces the child's self-perception as undeserving of love.

This perspective emphasizes that adoption, by itself, need not entail a 'happy end' for institutionalized children. Relationships affect relationships (Emde, 1989), and the child carries into the relationship with the adoptive parents the expectations, fears, and behavioral patterns developed in the course of interactions with care providers in the institution or foster care placements. The adoptive parents, in turn, bring to this new relationship with the child their own idiosyncratic hopes, fantasies, wishes, expectations, and personal vulnerabilities. The parent-child relationship is shaped by the extent to which the adopted child fits or does not fit the adoptive parents' preconceptions, and by the parent's flexibility in changing these preconceptions in response to the actual child.

It follows that attachment-influenced treatment remains relevant in conceptualizing intervention approaches for children showing attachment disorder behaviors following adoption. For children in the first four years of life, there is clinical evidence that dyadic, relationship-focused treatments such as infant-parent psychotherapy and child-parent psychotherapy can be effective in improving symptoms of attachment disorder in children adopted after foster care placement. However, important modifications need to be introduced in the treatment to respond to the specific challenges posed by young children with attachment disorder behaviors. This conclusion is based on a review of 83 clinical charts involving foster care children who were adopted between 10 months and 43 months, and whose adoptive parents sought consultation or treatment due to concerns about the child's ability to form an attachment to them. On average, the referral occurred 6 months after the child was placed with the adoptive parents; the range of time from placement to referral was between 2 months and 10 months. There was substantial variation in the severity of the referral problem, the children's age and individual characteristics, the adoptive parents' emotional and material resources, and the circumstances surrounding adoption. However, recurrent themes were found in the course of the initial assessment that supported the usefulness of an attachment-influenced approach to intervention, and these are described below.

ASSESSMENT FINDINGS

The format of the assessment typically consisted of four unstructured 1-hour sessions, with at least two of the sessions taking place in the home. The initial session involved a meeting with the parent(s) to discuss the concerns prompting the referral, the circumstances surrounding the adoption, and a brief overview of the parent's history and current family functioning. The other assessment sessions included the adopted child and involved observations of the parent(s)-child interaction and the child's behavior towards the assessor. Parental perceptions of the child and parental interpretation of the meaning of the child's behavior were elicited during these sessions. Trial interventions, including concrete developmental guidance, were offered to determine the malleability of parental and child behavior in response to intervention. When relevant, other key childcare providers as well as siblings were included in the assessment. If the child attended out-of-home care, observations in the childcare setting were added in order to obtain a range of the child's behavior with different caregivers and with peers.

Four major findings emerged. The first finding is that in every one of the cases, the adoptive parents(s) expressed at least moderate distress about the child's behavior. This distress took a variety of forms, and included: guilt about perceived failures in competence as a parent (e.g., 'if I were a better mother, she would not continue to have these problems'); anger at the child for failing to respond to the parent's loving care (e.g., 'he is quite unfeeling; he could not care less about what we do for him'); worry about the child's genetic predispositions (e.g., 'do you think he inherited his parents' mental health illness?'); ambivalence about the child (e.g., 'sometimes I adore her, and other times I just want to send her away'); and regret about the adoption (e.g., 'maybe we made a mistake in not waiting for a younger child to adopt').

The second finding was that parents tended to overlook or minimize the child's expressions of anxiety or need for care. Parents often missed signs that the child responded preferentially to them. For example, a 15-month-old girl looked momentarily worried when the father left the room, and smiled imperceptibly on his return. He remarked: 'she did not notice I was gone, did she?'. Admittedly, the child's signals were often very subtle, and the ability to detect them called for considerable observation skills and knowledge of young children's emotional cues. Parents also misinterpreted temper tantrums, defiance and non-compliance as signs that the child did not care for them, instead of seeing them as age-appropriate expressions of anxiety and fear of loss.

The third and related finding is that parents often 'missed the mark' in responding to the child's attachment cues. Specifically, they often responded with disciplinary measures when they perceived the child's behavior as inappropriate, instead of responding with firm but comforting behavior that would have reassured the child about the parent's ongoing availability. Limit-setting often included the use of 'time out', which reinforced the child's fear of not being wanted. Finally, the fourth finding is that adoptive parents were not, as a rule, appropriately prepared by the adoption agencies for the challenges of raising a foster care child. Even parents who were reasonably knowledgeable about child development were not sufficiently aware of the special needs of children who had been deprived of a primary attachment figure.

IMPLICATIONS FOR INTERVENTION

The findings from the assessments have clear implications for intervention. Educating adoptive parents about the predictable psychological and behavioral problems of children who were deprived of a consistent attachment figure must be an essential cornerstone of the adoption process. This information needs to be supplemented with emotionally supportive, child-focused developmental guidance, which allows the parent to become more receptive to the child's often overlooked or misunderstood efforts to obtain reassurance. Children profit from the parents' ability to tell a story of what happened, to speak to the child's fear of loss, and to reassure the child that the parent 'is here to stay'. For non-verbal children, games such as peek-a-boo and hide-and-seek can serve as vehicles for this message. Finally, ordinary sensitivity is usually insufficient to give emotionally deprived children a feeling of predictability and continuity. Parents need to over-emphasize their response to the child's muted signs of need, marking separations with unambiguous demonstrations of sadness and assurances of a prompt reunion, and underlining reunions with clear demonstrations of joy (Lieberman & Pawl, 1988). For children who have not known love, learning that they are wanted does not come automatically: it calls for conscious and deliberate teaching on the parent's part. 'Good enough' parenting is often not good enough for an emotionally disturbed child. In this sense, adoption is a radical intervention only if the adoptive parents become adept intervenors, able to decode and respond appropriately to the child's psychological needs.

The assessment findings and treatment principles outlined above were derived from interventions with infants, toddlers and preschoolers. Their relevance to older children with attachment disorder remains to be explored, as is their applicability with a larger sample in clinical trials. However, the need to belong and the fear of loss are the building blocks of human relationships, and clinical intervention with children of all ages must incorporate attention to these needs.

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