

# Integrating attachment theory with other approaches to developmental psychopathology

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## INTRODUCTION

O'Connor and Zeanah (2003) identify two different strands of thinking in attachment problems. The first comprises descriptions of *clinical attachment disorders* of seriously impaired children and adolescents, while the second provides a way of conceptualizing and measuring *insecure attachment patterns* displayed by infants who have a regular caregiver. Boris and Zeanah (1999) helpfully propose that these two classificatory systems might be drawn together in a spectrum with insecure response patterns at the milder end, and attachment disorders at the severe end. O'Connor and Zeanah (2003) also call for descriptive studies of attachment disorder that do not presume any cause. This article suggests that there may be a number of subtypes of attachment disorder, and that the difficulties children with attachment problems face require more than exclusively an attachment framework to meet their needs.

## PRESENTATION AND MANAGEMENT OF CLINICAL ATTACHMENT DISORDERS

In clinical practice there appear to be several types of attachment disorder. For example, there are the children who suffered severe global deprivation, as in Romania. They exhibit indiscriminate friendliness, but also show general social skills deficits, failing to pick up subtle social cues and know 'what is going on' in social situations (O'Connor, Rutter, & the English and Romanian Adoptees Study Team, 2000). Then there are children who have been brought up with adequate nutrition and stimulation but no consistent carer. They are indiscriminately friendly, but in other respects seem to understand the rules of social exchanges – they can often hold their own in conversations and larger social gatherings. In the third instance, there are older children who have had some early attachment figures but have been subjected to longstanding abuse, and then had a series of foster carers whom they have had to leave because of disruptive behaviour. Such youths give the impression of having had intact mechanisms, but to have understandably lost faith in any close relationships; their social understanding seems good. In the fourth instance, there are adolescents with

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organic brain disorders such as frontal lobe damage or hypomania who also exhibit inappropriate friendliness and are disinhibited. Research is needed on all these presentations, looking at the pattern of all the children's relationship difficulties, their social understanding using theory of mind tests, and their neural processing deficits using functional magnetic resonance imaging.

### PRESENTATION AND MANAGEMENT OF INSECURE ATTACHMENT PATTERNS

The presentation of secure and insecure attachment patterns in *infancy* is reasonably well worked out. If required, there are a number of empirically supported interventions. The recent metanalysis of over 70 treatment studies with infants by Bakermans-Kranenburg, van Ijzendoorn and Juffer (2003) found interventions that offered behaviourally-based direct coaching of the mother's skills with her infant were best at increasing maternal sensitive responding, and infant attachment security. Attempts to alter parents' internal working models (IWMs) were less effective. This is perhaps a hopeful message, insofar as it suggests that individuals who grew up to become adults with insecure attachment patterns and IWMs are not doomed to impose their effects on the next generation. So long as their behaviour with their child is adequately sensitive, it may not matter that their IWM is not secure.

Assessment of insecure attachment patterns *beyond infancy* (say over 3 years of age) poses difficulties in clinical practice. There is no agreed observational test of older children's attachment behaviour, nor any standardized interview with proven reliability and validity: these need to be developed. Story stem techniques may elicit representations that fit infant behaviour patterns, but however they are assessed, how much childhood attachment patterns predict later psychosocial functioning is unclear. Where current impairment is slight, an insecure attachment pattern may not require treatment. In contrast, the same children may have many other problems missed by an attachment framework for which there are effective treatments, as discussed below.

Where pervasive impairment is present in children who have insecure attachment patterns, if the attachment response is appropriate, then 'fixing' the child with some sort of therapy may overwhelm their healthy coping strategies and defence mechanisms, and cause damage by forcing them into an inappropriately close relationship with abusive parents. As noted by O'Connor and Zeanah (2003), there are some regrettably abusive so-called 'attachment therapies' along these lines. Instead of trying to treat the child, *if* other child disorders are not present and the parenting style is demonstrably inadequate, then it is the parenting that should be treated. To achieve this may require a wider set of concepts than traditionally espoused by attachment theory.

### THE NEED TO INTEGRATE ATTACHMENT THEORY WITH OTHER APPROACHES

Research studies attest that the outcomes of children exposed to inappropriate parenting go beyond insecure attachment patterns, and that the relevant dimensions

of the parent-child relationship go beyond those postulated by attachment theory to be central, such as insensitive responding or a dismissive style. Attachment theory has greatly enriched the understanding of child development, but it is time the findings from the rest of developmental psychopathology were integrated. This will allow a wider range of the phenomena presented by children with attachment problems to be explained, and offer improved treatments to meet their needs. Using an attachment lens to examine many psychopathological problems could also bring benefits. Three examples are discussed: the consequences of abusive parenting, child antisocial behaviour, and multiple foster care placements.

### Consequences of abusive parenting

A wide range of problems is seen in abused children, with a greatly increased incidence of emotional disorders, such as Post Traumatic Stress Disorder (PTSD), anxiety and phobias, and disruptive disorders, such as ADHD and conduct problems (Cicchetti & Toth, 1995). It is important not to overlook the fact that, although these problems may have arisen in the context of disturbed attachment relationships, effective interventions are available that do not rely on attachment theory. Thus cognitive-behavioural approaches are successful for PTSD (Yule, 2002), and behavioural management and medication are effective in ADHD (Schachar & Tannock, 2002). These treatment models are sometimes viewed as competing with attachment research-based interventions; however, instead they should be viewed as complementary. Attempts to integrate these alternative treatment approaches will likely be mutually informative.

### Children with persistent antisocial behaviour

Antisocial behaviour and aggression are features of some insecure attachment patterns, notably ambivalent and disorganized (Greenberg, Speltz & DeKleyn, 1993), but there is an enormous amount of knowledge about this behaviour from developmental psychopathology outside attachment theory that is relevant. The parenting pattern that gives rise to pervasive antisocial behaviour (also classified as oppositional defiant and conduct disorder) has repeatedly been characterized as low on warmth, stimulation and encouragement, and high on criticism and hostility. Discipline is harsh and inconsistent, and there is poor monitoring and supervision. Social learning theory approaches have shown that children are parented in such a way that the child's prosocial overtures are ignored (Gardner, 1989), and antisocial strategies inadvertently rewarded (Patterson, 1982). Such parenting is probably also insensitive and dismissive, and likely to give rise to attachment problems.

The most successful and widely applied interventions for antisocial behaviour are parenting programmes derived from social learning theory (SLT) (McMahon & Forehand, 2002; Webster-Stratton, Reid, & Hammond, 2002). They involve the coaching of here and now skills rather than changing parental beliefs or internal working models, although some include processing of parental emotions and a strong element of changing attitudes to the parenting task (Webster-Stratton et al., 2002). Sessions cover attending and praise for desired behaviours, setting clear limits, and swift consequences for rule breaking. A generally warm atmosphere is promoted so the child will want to please the parent and comply with requests. Even in seriously

disturbed, multiply comorbid populations, such programmes can be very effective, with effect sizes of over 1 sd on antisocial behaviour (Scott, Spender, Doolan, Jacobs, & Aspland, 2001).

Interestingly, although developed independently of attachment concepts, most programmes start off with coaching the parent to play with the child in a way that follows the child's lead, including commenting on what they are doing. This could be construed as a form of sensitive responding, albeit outside the context of stress and distress.

SLT derived parenting interventions may also add information as to *how* to improve relationships, as well as informing what should be targeted. This may hold not only for studies based on SLT concepts, but also studies using alternative models, including attachment (Bakermans-Kranenburg et al., 2003; Sutton, 2001). The most effective SLT parenting programs address the proximal processes of parenting, rather than more distal risk factors. Thus programmes that include skills rehearsal have larger effect sizes than those that address parental beliefs only, or offer non-directive support (Scott, 2002).

SLT can also provide the basis for effective direct help for children where the parents cannot change. To relate well, children also need their parents to model the clear communication of emotions, and to offer a range of strategies to cope with relationship difficulties. Where the parent has not inculcated these, outside professionals can. Teaching emotional awareness and problem-solving social skills directly to children has been shown to improve child functioning with peers, siblings and other adults, and it also leads to a more harmonious parent-child relationship, as measured by direct observation (Webster-Stratton, & Hammond, 1997). Future studies could investigate whether attachment security is also improved. Equally, attachment theory based parenting interventions may improve treatments of antisocial behaviour – for example most do not directly address helping parents to respond to cues from children.

### Multiple foster care placements

A final example comes from children who have had multiple foster placements. Here attachment patterns can suffer ongoing damage where there has been not only abuse from the original birth parents, but subsequent breakdown of relationships with several sets of foster carers. Assessment typically reveals not only a lack of lasting relationships in which the child could place trust or find succour at times of need, but other difficulties such as learning disabilities, ADHD, anxiety and depression.

Foster carers can be skilled up to use behavioural principles to help the child, who as well as exhibiting psychiatric disorders may be re-enacting highly disturbed attachment patterns with each set of new foster carers. They can be trained to respond more effectively and calmly to challenges, and to use a problem-solving negotiating style with the young person, backed up by a clear system to reward prosocial behaviour. In a recent trial, this was shown to increase foster carer's confidence, reduce child behaviour problems, and reduce the chances of placement breakdown (Pallet, Scott, Blackeby, Yule, & Weissman, 2002). This then, in turn, provides the backdrop for a long stable placement during which more trusting attachment relationships can develop. SLT helps foster carers provide a secure and containing base for the young person.

In conclusion, narrowly defined attachment problems often come with a host of other difficulties that could usefully be addressed using other approaches from developmental psychopathology, and a wide range of clinical problems might be better understood and treated if attachment theory were applied. In future we need better integration at both a research and a clinical level.

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