

# Psychological interventions for the spectrum of attachment disorders and intrafamilial trauma

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Thomas O'Connor and Charles Zeanah have made an excellent beginning in addressing the current state of affairs with respect to attachment disorders. They describe a paradox in that while we have some knowledge about attachment disorders, their causes, associated conditions and course, 'we have no consensus or protocol for assessing attachment disorder and related behaviors'. Given this reality it is no wonder that many researchers and clinicians have avoided the entire area of study and clinical practice. O'Connor and Zeanah have given us a guide for developing strategies for solving the puzzle and beginning to appropriately address the needs of these children and their families. As a clinician who has worked for years with this population, I welcome the opportunity to offer suggestions for addressing this important topic.

In spite of the difficulties described by O'Connor and Zeanah, I believe that we have no choice but to develop a conceptualization of attachment disorders that is sufficiently defined and congruent with attachment research so as to generate the fundamental clinical research that is required. This would provide a scaffold for research that offers more hope than does our current state of affairs. As the research findings accumulate, the newer framework could be modified as indicated.

The spectrum concept briefly mentioned by O'Connor and Zeanah, in which secure attachments are placed at one end, disordered selective attachments in the middle and disorders of non attachment at the other should be seriously considered. Such a spectrum would both bring the vast body of academic literature regarding attachment more fully into the clinical realm as well as present the clinical entities which require greater research attention in order to be better understood.

Currently attachment disorder is primarily restricted to what Zeanah and colleagues describe as disorders of non attachment (Lieberman & Zeanah, 1995; O'Connor et al., 1999). The spectrum concept thus expands the concept of attachment disorder and hence the range of symptoms that might exist at some point along the spectrum (Greenberg, 1999). It addresses the fact that insecure attachments, and especially disorganized attachment, are seen to be definite risk factors for the development of psychopathology (Cicchetti et al., 1995). Also, features of disorganized attachment, as they become more intense and pervasive, may become symptoms of psychopathology. Examples include aggression, dissociation, and affect and/or behavioral dysregulation (Lyons-Ruth & Jacobvitz, 1999).

The range of symptoms and the factors that need to be considered are expanded even further by the fact that children with possible attachment disorder often have a

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history of having been physically or sexually abused (Allen, 2001; Maughan & Cicchetti, 2002). Questions of trauma and PTSD overlap with questions of attachment disorder, so that clinicians often ask if they are dealing with two disorders or one. Intrafamilial, interpersonal trauma causes greater stress and a greater likelihood of PTSD than does trauma without those two features. Such trauma causes one to be at risk for a variety of symptoms which fall under the concept of Complex PTSD (Courtois, 2001; Gold, 2000). These symptom categories involve poor affect and impulse regulation, alterations in consciousness, damaged self-perception, distorted perception of perpetrator, disrupted interpersonal relations, loss of systems of meaning and somatization. These symptoms are certainly more comprehensive and intense than are those that exist in PTSD alone. There are good reasons to think that the interpersonal nature of the trauma, and especially that the trauma was caused by one's attachment figures, is responsible for the severe extent of the symptoms. To be traumatized by one's attachment figures places one at risk for failing to develop a coherent attachment strategy for turning to his/her parent for safety and to be unable to resolve the trauma.

### PSYCHOLOGICAL INTERVENTIONS

When there is a lack of consensus regarding the definition of attachment disorder as well as the means of assessing it, there most certainly will be considerable difficulty in attempting to provide treatment for this 'undefined' disorder, and extreme difficulty in determining if such treatment for 'attachment disorder' is effective. It might be more accurate to say that research on attachment disorder treatment is now impossible given the current state of affairs

In developing interventions to address attachment disorder one might also consider the 'spectrum of the disorder' concept that was mentioned regarding assessment. Within this concept, the development of a secure attachment would become the first goal at each point on the spectrum. After facilitating the development of a secure, selective, attachment and its associated safety, other interventions could then focus on achieving developmental progress along affective, cognitive, behavioral and social realms. Research that delineates how secure attachments develop within the parent-child relationship can guide efforts to produce and evaluate clinical and parenting interventions that facilitate movement along the most adaptive developmental pathway. Treatment models that are developed would be congruent with attachment theory and research. Once attachment disorder is defined and assessment measures are in place, then research regarding these interventions would be able to proceed.

In looking for treatment strategies that are congruent with how secure attachments are facilitated, it is immediately obvious that the 'holding and coercive therapies' described by O'Connor and Zeanah have no place. Such interventions tend to be based on the premise that the child with attachment disorder needs to be forced to obey the adults in his life. The treatment philosophy is that such obedience 'breaks down' defenses, and leads to dependency on the adult's approval, compliance with the adult's authority, and fear of his/her disapproval. The recommended parental responses which often generate such compliance and fear include isolation, excessive chores, deprivation of privileges, sarcasm, and shaming behaviors that are likely to last until the child complies. Treatment reinforces the parent's strict approach through intense confrontation, with shaming, angry, and/or sarcastic responses until the child

complies, at which point s/he is given comfort and support. Often such confrontations are given in the context of holding the child so that s/he is more vulnerable, dependent, and more likely to comply. If the child does not comply in therapy, s/he is 'fired' from treatment, with the expectation that as a consequence, the parent will then impose the type of responses mentioned above. Clearly such interventions are not based on principles derived from attachment theory and research.

O'Connor and Zeanah rightfully note that clinicians who provide treatment for parents with children who have 'severely disturbed attachment histories ... are among the few who have sought to develop treatments for children and families who are provided few options and little reason for optimism from other clinicians'. It is also important to note that many other clinicians have attempted to provide treatment for these children and families, without the focus on obedience, compliance, and general punitiveness mentioned above. These clinicians, to varying degrees, stress the need for physical proximity in parenting to foster a secure base, help parents to focus on facilitating their child's social and emotional skills through providing mindful opportunities for success, rather than through punishing failures, and provide nurturance and comfort to facilitate affect regulation and the development of positive attributions of parental behaviours.

The following are suggested principles of treatment to address both the risk factors for psychopathology, as well as psychopathology itself, which are secondary to distorted attachments or lack of selective attachments in a child's history, often combined with intrafamilial trauma. Specific interventions may vary depending upon the source of the psychopathology and the nature of the symptoms.

- (1) Efforts to lead children with an attachment disorder into developing secure attachment strategies need to begin with the caregiver and therapist's own attachment strategies. There are reasons to think that the caregiver and therapist's states of mind with respect to attachment need to be autonomous (secure) or, at a minimum, resolved. This is crucial if the adults are to co-regulate the affect and co-construct the meaning associated with the child's behavioural experiences and underlying representations that are associated with unresolved or deficient attachment experiences. Research of Dozier et al. (2001) with foster parents, and Steele et al. (in press) with respect to adoptive parents indicates that the attachment classification of the foster or adoptive parent has a profound impact on the ability of the child to form a secure attachment with his caregiver. Dozier and colleagues also have found that the attachment state of mind of the therapist is important for the success of the interventions with adults (Tyrell et al., 1999). Adults who intend to provide a child with a sense of psychological safety that is sufficient to resolve and integrate experiences associated with trauma and loss, need to have resolved any similar experiences in their own attachment histories in order to remain present for the child affectively and cognitively whenever the memory of those experiences emerge.

When the caregiver demonstrates a resolved state of mind with respect to attachment, there are clear reasons to actively involve her in her child's treatment. The therapist can directly work on facilitating the parent-child relationship, through both modeling and also directly facilitating interactions that are congruent with attachment security. With the presence of such a parent, the child is also more likely to feel safe enough to explore and resolve interpersonal trauma. The parent's comfort and support around this process

will, in turn, facilitate the attachment. Interventions that involve nurturing touch and physical proximity can also be done more safely with the child when the parent is the adult providing them. However, if the parent is not resolved with respect to her own history, then an initial period of separate individual treatment for the parent and the child may be indicated.

- (2) The caregiver and therapist need to assume an active, intersubjective, stance in which their experience of the child's subjective experience is made clear and becomes a bridge to help the child to eventually regulate and construct meaning regarding his inner life. The concept of 'intersubjectivity' which is being developed both by developmental attachment and psychodynamic theorists, will have an important role in efforts to assist children and youth with an attachment disorders.

This stance is modeled on the one demonstrated by a parent for her child, most especially in states of attunement, which is defined by Stern (1985) as the intersubjective sharing of affect. Children who have been traumatized by their parents and most likely have a disordered selective attachment with them, are likely to have a poorly developed ability to access and communicate their inner lives of thought, feeling, wishes and intentions (Maughan & Cicchetti, 2002). When a child is thus disconnected from his inner life, he is at high risk at reacting to situations in rigid, repetitive and fragmented ways without the ability to either recognize the needs of self or integrate them with the demands of the situation. In secure attachment dyads the child is able to access his inner life to a large part initially by the reflected response of his parent to his nonverbal expressive behaviours. As the parent 'sees' her child's inner life, she develops a secondary representation of it, which she communicates back to her child, who only then, becomes able to 'see' it as well (Fonagy et al., 2002). This communication needs to involve both non-verbal and verbal components.

- (3) The caregiver and therapist need to make clear their subjective experience of the child through obvious, and possibly even exaggerated, non-verbal expressions of responsiveness in a manner similar to what is manifested by a parent to an infant or toddler. Nonverbal communication through eye contact, facial expression, voice prosody, movement, gestures, touch, intensity, and timing are emphasized in such communications (Bowlby, 1969). Children with backgrounds of abuse and neglect are at risk to misinterpret facial expressions or be unable to differentiate between them (Pollak et al., 2000). Children who have been abandoned and traumatized often are unwilling to look into a caregiver's eyes due to fear or shame. They do not want to know what the caregiver is thinking and feeling about them. General voice tone or inflections are often misinterpreted and the emotional meaning conveyed in the words is lost. These children are also often not comfortable with touch and thus are deprived of the safety, comfort, and validation that being touched or held can bring.

These same aspects of non-verbal communication are central in the development of a secure attachment. Schore (1994, 2001) summarizes considerable research regarding the importance of facial expressions and reciprocal parent-infant gazing in the development of a secure attachment. Jaffe et al. (2001) demonstrate the centrality of vocal rhythm coordination in attachment formation. Similar conclusions are made regarding the importance of touch (Pelaez-Nogueras et al., 1996) and timing (Trevarthen, 2001) in these

nonverbal interactions. Coordinated gestures (Goldin-Meadow, 2000) and the mother's attuned responses to the infant's affect expressivity (Nicely et al., 2000) are seen as central in early patterns of communication that serve as the foundation for speech. Rough-and-tumble, joyful interactive play is described as being an important experience in the psychobiological development of the infant (Panksepp, 2001). Securely attached infants engage in far more of these varied, nonverbal interactions with their mothers than do anxiously attached infants (Grossmann et al., 1986). While these primary means of nonverbal communication need to be actively incorporated into the treatment of a child with attachment disorder, they must not be forced. If the child is first feeling safe, then it is much more able to respond in a reciprocal manner to the clear affective nonverbal communications of the caregiver and therapist.

- (4) The caregiver and therapist attempt to maintain an interpersonal emotional tone that is consistent with what is shown by parents in secure attachment dyads. These features include acceptance and empathy, curiosity and playfulness, sensitivity, responsiveness, and availability. For these relationship qualities to be effective there must be continuing correspondence and matching between the communication of the child and adult.
- (5) Conflicts and misattunements that occur between parent/therapist and child are directly addressed, with efforts to repair the break in the immediate intersubjective experience. Such breaks are likely to occur due to the shame and fear that is often associated with the exploration with past traumas and current behavioural problems. Children with attachment disorders are likely to experience pervasive shame in response to routine discipline and frustration, just as they are likely to experience intense anxiety and affect dysregulation in situations that might be thought by others to be simply mildly stressful or even novel and interesting. Such pervasive shame often impedes the development of a secure attachment and is an ongoing risk factor preventing the resolution of trauma (Andrews et al., 2000; Feiring et al., 2002; Kessler & Biesschke, 1999; Schore, 1994). Frequently then, in therapy and at home, the child will benefit from empathy, acceptance, curiosity and reassurance over routine conflict, memories, and stress in his life that is experienced by him as being shameful, rejecting, and abusive. The distressing affects of shame and fear need to be co-regulated by the therapist and caregiver before continuing in the interactions.
- (6) Parental interventions that are recommended are congruent with attachment theory. When the child is in distress, manifesting either fear, shame, or anger, he is brought closer to the parent in order to be able to co-regulate his dysregulated affective state. He is not separated from his parent in these situations, unless his parent is dysregulated. Since the child is often directionless and easily becomes dysregulated, his parents provide him with a structured routine, and they reduce his choices when these choices lead to repetitive failure. Essentially, the parents allow the child to rely on their own organized inner states, until he is able to gradually develop a more fully defined and integrated inner state himself. The central stance of the parent is to be able to maintain a vision of the child's inner strength—or at least potential—to resolve trauma and find a more adaptive developmental pathway. If the parent loses this vision, the child will never discover it within himself. The parent's own attachment histories along with parenting strategies that are based on

recognizing attachment behaviour cues and facilitating related emotional and social skills are central to various attachment focused intervention programs (Marvin et al., 2002; Siegel & Hartzell, 2003; Developmental Research Lab, 2001; University of Delaware Psychology Department, 2001).

- (7) Cognitive-behavioral strategies that are effective in the treatment of children with both externalizing and internalizing problems are employed by both therapist and parent. The use of these strategies follows, and does not precede, the intersubjective states of attunement, interpersonal motivation, and meaning-making, which are crucial for facilitating the secure base necessary to utilize these strategies.

The above mentioned principles are a working model of a treatment and parenting approach that incorporates important findings from attachment theory and research. A similar model is presented by Siegel (2001). They are seen as being very applicable for children with problems that are seen to fall within the attachment-based spectrum of risk factors or disorders. They are based on both providing safety as well as intersubjective states needed to resolve shame and trauma and to facilitate the development of adaptive developmental pathways.

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