

# Current perspectives on attachment disorders: Rejoinder and synthesis

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## DIFFERENTIAL DIAGNOSIS AND DISCRIMINANT VALIDITY

Several commentators (e.g., Byrne, Green, Minde, van Ijzendoorn and Bakersman-Kranenberg) noted the conceptual and practical difficulties in differentiating behaviours associated with Reactive Attachment Disorder from (a) other forms of very insecure behaviour, such as Disorganized attachment, and (b) a variety of clinical phenomena, particularly problems in social and attachment relationships and difficulty in talking and thinking about these relationships (i.e., problems in 'mentalizing').

With respect to the former, several commentators endorsed the potential conceptual advantages of placing attachment disorder and attachment disorganization on the same spectrum. An advantage of this approach would be to more explicitly link attachment disorders with attachment research on individual differences in normal and high-risk samples. However, although it may be helpful to construct such a spectrum for heuristic purposes, this does not mean that there is a single continuum of disturbance ranging from Secure on one end to a diagnosis of Attachment Disorder on the opposite end. There are two reasons for rejecting, or at least being suspicious about, this particular continuum notion (as distinct from the somewhat looser concept of a spectrum). The first is that we simply do not have the necessary information on how Attachment Disorders connect with individual differences in attachment quality – and indeed if a direct connection can be made. More specifically, several features of the diagnostic formulation of Attachment Disorder are incompatible with the research and theoretical tradition developed by Bowlby, Ainsworth, and others. These incompatibilities need to be resolved, if possible.

A second reason for being wary of a *continuum* is the impression from clinical and research experience that children with an attachment disorder (e.g., defined according to DSM-IV criteria) are, at least in some respects, *qualitatively* different from those classified as having a Secure or Insecure (even Disorganized) attachment. Most critically, the central concern here is whether or not a selective or discriminating attachment relationship exists between the child and his/her caregiver. This has been posed as a distinction between disorders of attachment vs. disorders of non-attachment (Lieberman & Zeanah, 1995). On the other hand, it would be incorrect to say that this supposed qualitative distinction is evident in all cases. This is the point made by many contributors. Indeed, a real dilemma arises because children with a Disorganized attachment may show similar behavioural features to children with

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Reactive Attachment Disorder (RAD), inhibited type. Furthermore, children may show instances of Disorganized/Controlling behaviour concurrently with symptoms of RAD. There are then other subtypes of severe secure base distortions (Lieberman & Zeanah, 1995) that are accounted for neither in diagnostic manuals or attachment coding manuals, but are recognized by clinicians working in this area (e.g., such as Minde). Classifications of attachment derived from the Strange Situation represent an altogether different frame of reference than the nosologies of attachment disorders, and the relationship between these two frames remains unclear. This is a major challenge if the wealth of developmental research on attachment is going to make more substantial contributions to our understanding of disturbances of attachment in the clinical arena.

At this point, perhaps the safest conclusion to make is that future clinical research would benefit from bringing together the theories, methods, and samples that have so far differentiated research and clinical interventions on attachment in the developmental and social care literatures. What conceptual and practical similarities and incompatibilities there will be, and what to do about them, remains to be seen.

Several commentators also note a second difficulty in differentiating attachment disorder symptoms from other forms of disturbance, most especially broad disturbances in social relations and social cognition (Byrne, Green). The difficulty is not with what we could now consider 'classic' attachment disorder behaviour, for example, inappropriate social approach and proximity/contact-seeking toward unfamiliar adults. Instead, the problem found in clinic experience (and detailed more below) is that many children with a history of very poor early care exhibit an array of not well specified problems in social relationships, and these relationship difficulties may have detectable deficits in how children talk and think about their important relationships (e.g., problems in mentalizing). To date, these related problems are not easily placed within an alternative diagnostic framework (although similarities with PDD have been suggested, at least at the more extreme end of social relationship disturbance, e.g., Green).

A somewhat related issue is that children with attachment disorder adopted from the social care or institutional setting show other kinds of problems that do carry diagnostic labels, notably attention deficit or conduct disturbance. However, even in these cases, the suspicion is that where these more traditional behavioural problems are evident, they appear different from what is found in ordinary clinic practice (e.g., Byrne). Insofar as these co-occurring problems do not match what is usually found in clinic practice, it may not be adequate for treatment purposes to consider co-occurring problems as requiring conventional approaches (e.g., parent training for conduct problems, medication for attention deficit). It may be that certain problems play a particular psychologically important role in the manifestation of attachment disorder behaviour and so should be treated within the context of treating attachment disorder.

Thus, there remains some debate about what the core vs. associated features of attachment disorder are. These commentaries, and our target article, raise the possibility that the definition of attachment disorder might be expanded to include problems in social relationships with peers and social cognitive problems indexed by a difficulty in understanding the thoughts and feelings of self and other. Such an expansion may be especially valuable in older children, but may also apply to younger primary school-age children as well. This expansion should be viewed as highly speculative at this point, and there are pros and cons of that approach, and so it needs to be considered after data are collected. What is certain at this point is that the

current diagnostic focus on behaviour in preschool-age children is inadequate: attachment disorder is likely found in older children and the current diagnostic guidelines are unlikely to be useful for older children.

### CLINIC ASSESSMENTS VS. ACADEMIC RESEARCH

A theme emerging in several responses (e.g., Byrne, Green, Howe, Minde) is that behaviours resembling attachment disorder are probably more common in ordinary clinic samples than we appreciate, and that there is probably a high rate of mis- or under-reporting of these behaviours. What is needed to resolve this issue is hardly controversial: clear and effective guidelines for clinical assessment. Some progress toward that aim is evident (American Academy of Child and Adolescent Psychiatry, 2003), but more research is needed, and there is also a need for the wide assortment of clinical observations to be collated in some systematic form. Thus, we still are some way short of knowing how best to assess attachment disorders, particularly in older children.

In fact, a major problem now is that although DSM-IV and ICD-10 conceptualizations of attachment disorders in early childhood are reasonably clear, what happens in middle childhood and beyond is not. The application of criteria for inhibited RAD beyond the first several years of life is unhelpful. Although some children may continue to exhibit disinhibited behaviour, the question remains whether this adequately describes attachment disordered behaviour in older children (Boris). Minnis and Keck note the overlap in older children of putative attachment disorders with conduct disorders and psychopathy. How to classify children who are callous, superficially connected to others, emotionally aloof, and interpersonally provocative remains a significant challenge.

Along similar lines, as Howe states, if the concept of attachment disorder is to be useful, it will need to be accessible to a wide range of mental health and social service professionals. Additionally, the concept and clinical description should extend well beyond the restrictive boundaries of 'classic' disinhibited attachment disorder behaviour found in ex-institutionalized children. This is no doubt a point of general agreement. It is easy to see how the concept of attachment disorder has been so closely associated with institutional samples. After all, much of the well-known history of attachment disorder and empirical findings is attributable to studies of ex-institutionalized children or children still in institutions. Nonetheless, as we note in our target article and as many contributors note, the kinds of disturbances associated with attachment disorder are found in children other than those adopted from institutional settings. In fact, the social care context has consistently documented the attachment problems found in children placed in childhood, especially following neglect/abuse in the biological home. The difficulty in bringing together the information available from the more well-known studies of ex-institutional children with the wealth of experience of social workers and care workers is now lessening, although admittedly slowly.

### ATTACHMENT-BASED TREATMENTS

As expected, there remains considerable interest in extending attachment research-based treatment models to children with attachment disorders. Importantly, a

common theme among those who adopted this view (Dozier, Lieberman, Marvin & Whelan, Hughes) is that there need to be modifications in how existing approaches are applied. The reason is that, as noted by several commentators (Dozier, Lieberman, Marvin & Whelan, Hughes) and as we suggested in the target article, 'ordinary' sensitive and secure types of parenting may not be sufficient to treat a child with attachment disorder. What may be needed is specialty training to help parents override the normal, expectable reaction to aversive child behaviour that does not have the same meaning as the same behaviour in non-deprived children. There is a general consensus that that is needed, and at least anecdotal evidence that it is helpful (if only to help the parent to grasp some order in the child's behaviour). In addition, as Nilsen notes, this message in its general form has filtered down to many agencies working with parents and has been incorporated into existing programmes that prospective adoptive/foster parents receive (although the adequacy and accuracy of this information remains a matter for debate).

Despite the interest in extending attachment research-based treatment approaches to children with attachment disorders, we still lack a set of testable hypotheses concerning the process by which new selective/discriminating attachment relationships form past infancy. That is, what are the mechanisms of therapeutic change? Commentators that addressed attachment research-based therapies seem to hold to the notion of internal working models, and there are good reasons for taking that hypothesis forward. However, according to this model, there is difficulty in explaining treatment failures (i.e., why some children may be genuinely impervious to treatment). What does the theory of working models predict about why treatment of this kind would fail?

#### ALTERNATIVE AND COMPLEMENTARY THERAPIES

Little support for the use of holding therapies was evident in the commentaries. Resistance to the more coercive holding therapies was strong (e.g., Dozier, Minnis & Keck). Clearly, these approaches have no role in the treatment of children and cannot be justified on any basis. All but one response (i.e., Minnis & Keck) also ruled out holding of any kind as having a role in the treatment process. So, for example, Hughes, who has considerable experience in this area, views some holding (non-coercive) at some times as potentially useful. On the other hand, in setting out several conditions that might promote effective treatment, none involve physical contact. This suggests that he views holding as neither necessary nor sufficient for treatment of attachment disorders. Others were more forceful in suggesting that holding (of any kind) risks re-traumatizing children and should be avoided completely. Given that this range of views reflects the controversies more widely expressed in this area (but perhaps in a different proportion), it is worth considering in further detail.

Minnis & Keck note that non-coercive, non-involuntary holding does have a role to play in the therapeutic repertoire, noting that attachment therapy is based on the notion that 'children and young people who have not experienced an early intersubjective relationship with a parent or parent-figure *cannot* form successful new relationships until they have this experience', namely physical contact in the form of holding (*italics added*). That is a particularly strong statement. Anecdotal evidence for successful treatment of children who show attachment disorder disturbances who did not get holding therapy (e.g., Lieberman) suggests that this

cannot be so. The question, then, is not whether or not holding is necessary, but rather whether or not it is a viable treatment alternative. This is a more complicated matter, for several reasons. First, as Hughes and others have noted, the mechanisms by which holding is thought to have its impact is questionable, and in some cases contrary to what is known. Second, despite the interest in evaluating holding therapies by those who are advocates of this treatment, there is doubt that research of this kind would be viewed as ethically acceptable, and so unlikely to pass review boards (Dozier). Third, even if systematic research were to be conducted, it is not clear what would be assessed or what would be the litmus test for accepting or rejecting the usefulness of the treatment. These conditions do not auger well for the debate to move on in any meaningful way. Thus, there is a likely risk that the situation will remain the same: advocates will continue the treatment with undocumented support and the practice will be viewed as ineffective or even irresponsible by those working in clinical academic settings.

It is in this context that it is worth noting that several contributors (Boris, Nilsen, Scott) remind us that there are alternative models of treatment that are currently being conducted with high-risk children who are thought to be at risk for attachment disorder – and with success. Importantly, the same sort of impediments to treatment and placement with a new family are noted by clinicians working with these children, regardless of their theoretical predilections, and no one would suppose that this sort of intervention is easy or likely to be met with complete success. Fortunately, cognitive-behavioural treatment models are beginning to be connected with attachment theory and interventions (Bakermans-Kranenburg, van Ijzendoorn & Juffer, 2003). Perhaps the key lesson is to maintain these conceptual and therapeutic links and consider how the approaches developed from attachment and behavioural/cognitive models may be mutually informative.

There is, of course, a good deal of doubt from parents – many with justified experience – that 'traditional' therapeutic approaches *could* be successful. As a result, they turn to less conventional treatments, such as holding therapy. What is uncertain is why this resistance is as strong as it is, especially given that there are (modest) successes using altered versions of more conventional and evidence-based approaches. That may suggest that those working in this area who use conventional/modified attachment and cognitive-behavioural approaches have been less successful at attracting attention from concerned parents. Nevertheless, the impression from many contributors (Dozier, Hughes, Lieberman, Marvin & Whelan, Nilsen, Scott) is that there is a sound basis for pursuing conventional/modified attachment and cognitive-behavioural approaches for children with attachment disorder needs rigorous investigation, and there appears to be both the momentum and motivation to make this happen.

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