Attachment & Human Development
Vol 5 No 3 (September 2003) 297–301

Taylor&Francis healthsciences

A clinical/research dialogue on Reactive Attachment Disorder

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Since 'modern' descriptions of Reactive Attachment Disorder (RAD) in the early 1990s, developments in clinical practice have largely been ignored by researchers and there has been little dialogue. We welcome O'Connor and Zeanah's paper as a stimulus to get the 'two camps' talking.

Helen Minnis is an academic child and adolescent psychiatrist with a longstanding research and clinical interest in RAD. Gregory Keck is a clinical psychologist with 14 years of clinical experience with RAD. He runs the ABC (Attachment and Bonding Centre) in Ohio, USA, which uses Attachment Therapy to treat, mainly, adopted children with RAD and their families. In 2000, Greg invited Helen to spend 2 weeks observing practice at ABC and this spawned an ongoing dialogue between us. Because we believe dialogue between researchers and clinicians will drive the field forward, we have included excerpts of our discussions.

We agreed on much of the target paper – with each other and with O'Connor and Zeanah. We share the frustration that there has been little research on the Inhibited form of RAD. Clinically, both forms are seen as equally important and many clinicians do not distinguish, in practice, between the two forms (Howe & Fearnley, 1999). The majority of children attending ABC are late-placed in-country adoptees who would be expected, aetiologically, to fall into the Inhibited category. Apart from the work of Quinton, Rushton, Dance, & Mayes (1998), follow-up studies of adoptees placed after infancy from a background of abuse and/or neglect are rare. More such studies are ongoing and, if measures of RAD are included, may begin to answer some important questions about the Inhibited form. Research suggests that there is some validity in both Disinhibited and Inhibited subtypes, but that they may not be symptomatically distinct (Minnis, Rabe-Hesketh, & Wolkind, 2002).

The symptom checklist used at ABC, in common with various instruments used by clinicians, does include symptoms which go beyond those described in DSM-IV and ICD-10. Our discussion regarding this went as follows:

Greg Our check list is only a small part of our assessment, but most of the children we see have behaviours that fall within the symptoms on the list.

Helen One of the criticisms made of symptom checklists used by various clinics is that they are over-inclusive and that they actually describe general psychopathology, for example, conduct disorder.

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Attachment & Human Development ISSN 1461-6734 print/1469-2988 online © 2003 Taylor & Francis Ltd
http://www.tandf.co.uk/journals
DOI: 10.1080/14616730310001593929

Greg I think that is probably accurate. I think conduct disorder is probably an extension of the attachment difficulties ...

Of course, this raises more questions – to what extent are conduct disorder symptoms core, or associated, features of RAD? Do conduct disorder symptoms develop, in later childhood, from RAD symptoms? For researchers, it is essential to develop assessment tools which can distinguish RAD and conduct disorder symptoms in order to answer these questions, but this may not be as high a priority for clinicians. We welcome O'Connor and Zeanah's comments on assessment and hope that, in due course, assessment research will guide clinical practice.

Assessment at ABC includes asking parents to produce written biographies of the child and of themselves (which allows therapists to get an impression of both the content and the form of the parents' responses which can give useful clinical insights into likely parental attachment styles), and a clinical assessment of the family and of the child individually, during which time it is possible to observe the child's interactions with parents and with strangers. In addition, school reports are requested.

Issues to do with intervention were more contentious and we need to address some inaccuracies. O'Connor and Zeanah suggest that there have been six reported deaths somehow connected to Attachment Therapy (AT), but in fact only one of these deaths took place in a 'therapy' situation. That was a result of unlicensed therapists doing something referred to as 're-birthing' therapy. Re-birthing is not practised by reputable attachment therapists, and its practice would not be within the Professional Standards of Practice promulgated by the Association for Treatment and Training in the Attachment of Children (ATTACh). ATTACh has attempted to regulate and define the practice of AT via registration and requiring members to practice within the standards developed by the organization. The other deaths were of children murdered by their parents who then claimed they were either doing something therapeutic or were in AT. Even if children were in therapy, it is hard to see claims by families who beat their child to death with a wooden spoon that they were doing what a professional told them to do as anything other than desperate attempts to mitigate legal liabilities.

Another apparent misunderstanding regards the 2-week intensive treatment programme. No one doing this kind of intensive treatment, to our knowledge, presumes to complete treatment in 2 weeks. Therapists at ABC say over and over again to families, 'an intensive is a quick beginning and NOT a quick fix.' After the intensive period, families attending ABC are offered appointments every 2 weeks, reducing if possible to monthly follow-up over approximately 1 year.

The issue of indiscriminate affection towards strangers, and the management of this in AT, is an important one. In AT, it is not the goal of the therapist to develop a therapeutic relationship with the child, but with the family unit as a whole. With younger children, parents hold the child exclusively. With adolescents, therapists usually begin due to the extreme antagonism commonly found between the adolescent and parents. This tends to reduce the young person's aversion to close physical- and eye-contact with the parents and models these interactions for the family. Whether or not the therapist holds the child, the parents hold him/her in every session. A central aim of treatment is to improve the relationship between parents and child, so every opportunity to facilitate parent–child interaction is taken.

At ABC, no adolescent is forced to participate and therapy will not proceed if the adolescent does not wish to enter into therapy – regardless of the wishes of parents or the courts. For younger children, the parents take more control of the child's participation – as they would for immunizations, haircuts, going to school etc. We have had numerous discussions about this crucial issue over the years and here is an excerpt from a recent one:

Greg I'd just like to clarify some of the treatment issues – the thing about boundary violation and uninvited contact with strangers. Its just not coercive – I don't think its any more coercive than when families bring a child against their will to sit and talk to a therapist.

Helen Having observed what you do at a time when I had no prior knowledge of Attachment Therapy, I think that is one of the biggest misconceptions people have. I certainly had the misconception that you would be pinning children down.

Greg Right. Well there certainly were people who did that when it first began and what one or two individuals did was horrible.

Helen What intrigues me is how some 'therapists' could be so coercive and yet you manage to be the opposite.

Greg Well, they would get very forceful about it. They really believed that that is what it takes.

Helen And was that supposed to be to do with rage reduction?

Greg I think it was the belief that the child needs to finally surrender physically.

Helen And are there other attachment therapists who still go along with that idea?

Greg No, I don't think so, very few. I mean therapists with those views are not active in ATTACH and clearly what they do is outside the standards of professional practice.

We are both of the view that good intervention research is much needed, but we have had great difficulty in beginning to gather this evidence base. Our attempts to find funding for a randomized controlled trial of the kind of AT practised at ABC have so far fallen on stony ground due to ethical committees balking at supporting a study which includes physical contact with children in one of its treatment arms. This is despite the existence of clear stopping rules and the backing of experts in medical law. Concern about physical contact with children, and perhaps the perception that it must be coercive or likely to be experienced as sexual, appear to be major stumbling blocks.

The idea of physical contact, especially with a therapist, does not easily fit into an attachment theory framework. For example secure base behaviour, in which an infant

engages in exploratory play and intermittently checks back with the parent, does not require touch. We agree with O'Connor and Zeanah that RAD 'may index a broader disturbance in social relationships' and suspect that there may be a problem of semantics here. 'Attachment' as described by attachment therapists (Keck & Kupecki, 1998) encompasses a wider domain of behaviour than 'attachment' as described by developmental psychologists (Goldberg, 2000). The description used by attachment therapists is more akin to what developmental psychologists have described as 'intersubjectivity' whereby the adult has a crucial input in stimulating brain development using verbal and non-verbal communication, including eye-contact and touch (Schore, 1997; Trevarthen & Aitken, 2001). Animal research suggests that physical contact between infant and parent is necessary for the normal development of the hypothalamic-pituitary-adrenal axis (Kraemer, 1997; Liu, Diorio, & et al., 1997) and that infants who have not experienced this have unpredictable stress responses (Kraemer, 1997). Attachment therapy is based on the theoretical model 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 (Howe & Fearnley, 1999; Keck & Kupecki, 1998). When seen in the framework of intersubjectivity, physical contact would be a logical component of a therapeutic intervention which also involved eye-contact and verbal interaction between parents and children. There is, as yet, no empirical evidence that AT does have positive effects on intersubjectivity between parent and child, and hence on the child's stress responses, but this may prove at least as fruitful an area of research as searching for effects on the attachment system.

O'Connor and Zeanah clearly had great difficulty accepting the possibility of developmental 'unfreezing'. This term was used, by Greg, in a book aimed at adoptive parents and was a metaphor to describe the stimulation of developmental catch-up (Croft, O'Connor, Keaveney, Groothues, & Rutter, 2001). Children with Post Traumatic Stress Disorder may show regression and a loss of previously acquired developmental skills (Scheeringa, Zeanah, Drell, & Larrieu, 1996; Yule, 2002) and massive emotional trauma in adults can result in changes in brain function, e.g. abnormalities of the hippocampus, which appear to be persistent (Ornitz & Pynoos, 1989). The hippocampus, however, has the capacity for significant neuronal regeneration (Bremner & Vermetten, 2001) and these findings provide a logical theoretical framework within which the effects of Attachment Therapy could be explained and which remains to be tested empirically. Critics of this model have questioned whether such physiological change could take place after infancy because of an assumption that there is a critical period in early life within which such changes can occur (Mercer, 2001). While there is some evidence for the existence of such a critical period in rodents (Francis & Meaney, 1999), this is as yet unproven in humans (Cicchetti & Walker, 2001).

Attachment therapy has changed and developed over the years in response to clinical experience rather than to empirical research. Some of the early excesses and the dangerous practices of individuals on the fringes of the field have raised barriers which have prevented serious intervention research. There is clearly now a will among researchers to understand RAD and to examine what attachment therapists may have to offer.

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