

Attachment problems as a spectrum disorder: Implications for diagnosis and treatment

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The target article on attachment disorders by O'Connor and Zeanah provides the reader with a thought provoking review of the challenges present day researchers and clinicians experience in diagnosing and treating attachment related disturbances in infants and young children.

Briefly, they present the reader with the following take home messages:

- (1) There is sufficient evidence for one or more clinical entities concerning disorders of attachment. However, there is no clear understanding about the boundaries of this condition and its related behaviours.
- (2) The assessment of attachment disorders, using the parameters described in DSM-IV and ICD-10, has some construct validity. However, there is considerable doubt about the actual set of defining behaviours, including the requirement that a putative cause of the disorder must be present.
- (3) There are various possible ways to assess behaviours denoting a disordered attachment (e.g., observations, interview or questionnaires). However, we know little about the convergence of information from these alternative assessment methods. This compromises progress in the assessment and treatment of this disorder.
- (4) There is no known effective treatment for children with attachment disorders.

The questions posed to us commentators by the authors reflect specific aspects of these messages and I shall try to discuss some of them in order of their presentation, based on my understanding of the literature and my clinical experiences.

WHAT ARE THE CORE SYMPTOMS OR FEATURES OF ATTACHMENT DISORDERS?

One major difficulty in the attachment literature is the fact that the initial description of attachment patterns came primarily from developmental psychologists who had little direct knowledge of psychopathology, especially in children, and its possible relationship to attachment. Their primary interest, therefore, was in describing an important developmental principle that seemed to be valid for all human beings, but not a clinical condition that required validated core symptoms. Even Bowlby, in an

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interview with Jeremy Holmes, stated that he had often been inept as a therapist and was more interested in providing clinicians with 'the appropriate theory' (p. 32) to do their work (Holmes, 1993). Not surprisingly, there has been a relative dearth of discussion and scientific inquiry into the obvious clinical reality that attachment categories and attachment disorders, like most other behavioural manifestations, reflect a spectrum phenomenon where any demarcation between 'normal' and 'disordered' attachments is potentially arbitrary. A good example of the potential problems associated with categorical thinking in attachment behaviour is the observation that in a study of 17 small premature identical infant twins pairs only 10 pairs shared the same major attachment category, although five of the others were classified to be in adjacent attachment categories, such as A2 and B1 and may have been as closely associated with each other as twin pairs coded as B2 and B4 (Goldberg et al., 1986).

In general, core symptoms for any behaviour disorder will likely be most frequently present when describing the more severe cases of the disorder. Attachment disorders are no exception here. Specifically, there is good agreement in the literature on the presence of some specific behaviours in children which denote serious aberrations in regular attachment patterns and are also described as disorders of non-attachment (Rutter et al., 2001; Zeanah et al., 2000). These behaviours seem to reflect a disinterest or inability of these children to seek out and value individuals who could – and may be willing – to function as protective and/or supportive figures in fostering their exploration, play, or other social behaviours. DSM-IV describes two clusters of behaviours; one is characterized by actions indicating a lack of preference for anyone and a blindness toward potential dangers in this world, while the other shows the affected children to be inhibited and/or severely withdrawn and to actively resist intimate contact. On the other hand, the American Academy of Child and Adolescent Psychiatry (2002) in its 'Facts for Families' publication on Reactive Attachment Disorder includes such criteria as 'severe colic and/or feeding difficulties' as well as 'failure to gain weight' and 'preoccupied and/or defiant behaviour' among the six official criteria for this disorder. Brisch (2002) in his book on Treating Attachment Disorders describes among others, an 'Aggressive' and 'Exaggerated' attachment disorder and even includes a form which he calls 'Psychosomatic Symptoms' (pp. 67–70). Such diverse descriptions are confusing to the clinician and must be replaced by a well validated evidence based definition of this important condition.

What the present paper in my opinion does not sufficiently clarify is the relationship between these 'non-attached' children and those Lieberman and Zeanah (1995) describe as suffering from 'disordered attachment'. The latter are seen as having developed a selective, although profoundly disturbed attachment which is demonstrated in three symptom clusters. Two of them (Attachment Disorder with Inhibition and with Self Endangerment) are very similar to those seen in 'non-attached' children, while an additional cluster, called 'Attachment Disorder with Role Reversal' is unique to this group of disturbed children. It appears to me that there may well be a continuity between these two groups of conditions, reflecting an attachment disorder spectrum, but that both are disorders and a more empirical differentiation needs to be developed. One could furthermore imagine that the next category in the spectrum of attachment difficulties would be the disorganized category described by Solomon and George (1999) which in turn will lead into the various types of 'insecure' attachments seen in normal populations. In correlating

the severity of clinical symptoms with their position on this attachment disorder spectrum, one would assume that in disorders symptoms will be present in most situations (i.e., be pervasively present), and be associated with more or less diminished curiosity, exploration, learning and social skills (key cognitive features of a secure attachment) as well as with problematic interpersonal relationships later on in life. One would also assume that the more extreme disorders of non-attachment are less common than conditions characterized by a disordered attachment, and that their treatment might also be different. Some confirmation of this attachment disorder spectrum comes from the clinical work of Brisch (2002). Likewise, Hodges and Tizard (1989) who are often cited as providing the first evidence based long-term reports on attachment disordered children, described interpersonal difficulties, albeit rather mild ones, in their group of previously institutionalized adolescents. In keeping with our hypothesis of a spectrum of attachment problems, the majority of these children did not exhibit the 'non-attached' form of the disorder early on in life and their adolescent behaviour hence cannot be said to clarify the natural history of the non-attached young child as is often assumed in the attachment literature.

As far as the less profoundly attachment disordered children are concerned, problems of definition are quite pronounced. The DSM-IV definition of a reactive attachment disorder includes 'responding to caregivers with a mixture of approach, avoidance, and resistance to comforting', or 'to exhibit frozen watchfulness'. In a recent annotation discussing attachment disorganization and psychopathology, Green and Goldwyn (2002) describe the symptoms of disorganized attachment (i.e., a 'normal' attachment category), among others, as 'contradictory behaviours or affects occurring virtually simultaneously; freezing, stilling, apparent dissociation' (p. 836). The terms used by these investigators are rather similar to those describing a reactive attachment disorder in DSM-IV and highlight the problematic boundaries between a disorder and a 'normal variation' of behaviour.

Another issue, which has not been sufficiently discussed in the literature, is how we can best understand the interplay between the putative cause of the disorder (protracted abuse and neglect) and the clinically observed resilience seen in many children following such difficult experiences. A study by Smyke et al. (2002) pointed out that most of the less damaged children in her sample from a present day Romanian 'standard' (i.e., poorly staffed) institution had been 'favourites' of a caretaker in the orphanage. This would indicate that there is indeed at least some relationship between the level of caregiving and later signs of attachment disorder. However, we have no follow-up data on such samples at the moment and know little about possible temperamental or personality variables which may be helpful in protecting the attachment system in children exposed to severely pathogenic care.

This brings me to another shortcoming of the presently available research in this area. Studies of children with attachment disorder have almost exclusively dealt with institutionalized children. While such groups provide the obvious advantage of good sample sizes of children with similar experiences, clinicians normally deal with individual children whose past experiences differ. Their questions, therefore, often relate to the relationship between the reported trauma and the severity of the observed attachment difficulties. This seems relevant enough considering that attachment and its disorders are said to be caused by environmental events

(O'Connor and Croft, 2001). It is here that clinicians may expect attachment problems as a mediating variable for oppositional or other externalizing symptoms when in reality they are simply a co-morbid symptom of a neglectful upbringing (Rutter et al., 2001). I have also seen children within the same family where the younger child displayed symptoms of inhibition and the older one showed an indiscriminate attachment disorder, suggesting that at least some children may present with a developmental trajectory which moves from inhibition to disinhibition. We do not even know whether the relationship between the length of pathogenic care and the later incidence of an attachment disorder as observed by the English and Romanian Adoptees study team would also hold for children who have undergone similar problematic care outside an institution.

Finally, there is the DSM-IV requirement that all children with an attachment disorder need to have experienced persistent disregard of basic emotional needs for comfort, stimulation and affection by a caretaker. I would challenge this requirement to be mandatory. In my personal clinical experience with some 150 biologically and cognitively fragile small premature infants I have observed at least three children who had bewildered yet 'good enough' parents but nevertheless showed the signs of 'disordered attachment', i.e., they displayed significant and pervasive role reversal and/or excessive clinging at age 4. While the overall percentage of these disorders was low, these children had not experienced a persistent disregard of their emotional needs, although they all exhibited significant biological vulnerabilities. Similar observations have been made by Rutter (1997).

In summary, there is good evidence for valid core symptoms denoting a 'severe' or non-attachment disorder. However, there is also evidence for a group of less severely disordered children who may show a spectrum of abnormal behaviours and who in turn link with children who are classified as Disorganized. The second group show some preference for an attachment figure but this attachment is characterized by severe and pervasive conflict, qualifying for the term 'disorder'. Some of the associated feelings of anger or fear may also be related to biological vulnerabilities rather than pathogenic care as defined in DSM-IV.

HOW CAN ATTACHMENT DISORDERS BE ASSESSED TO PROVIDE WELL DEFINED CRITERIA

O'Connor and Zeanah give an excellent description of the important issues related to the symptoms we need to assess for the diagnosis of non-attached children. They agree that DSM-IV and ICD-10 criteria provide a reasonable starting point for defining behaviours or symptoms but question the adequacy of the descriptive terms for the disinhibited and inhibited forms of attachment disorder. It is correct that the 'friendliness' of a disinhibited child feels 'false' or 'dishonest'. This may be clarified by adding the adjective 'apparent' to the term in the requirements for the diagnosis. It may also be helpful to require that the necessary behaviours not be situation specific but be observed 'in two or more settings', just as is demanded of ADHD in the DSM-IV classification. It might also be useful to add some developmental qualifiers. Thus, readily sitting on a stranger's lap at 15 months may be the equivalent of going off with a stranger at 36 months, while sitting on laps of strangers at 36 months could also suggest additional intellectual difficulties. Cultural variables may also determine the meaningfulness of specific symptoms. For

example, African or Asian children may appear extremely shy and inhibited (Miyake & Yamazaki, 1995, Rothbaum et al., 2000) but reflect culturally appropriate behaviours (Minde et al., 2003).

WHAT TREATMENTS HOLD PROMISE FOR ATTACHMENT DISORDERS

The authors specify types of interventions that have been successfully tried in parent-child dyads, where parents were seen as lacking sensitivity or appropriate responsiveness to their children. Some of them have been based on psycho-dynamic principles (Lieberman and Zeanah, 1999), while others describe a more educational and cognitive approach (van IJzendoorn et al., 1995).

The limitations of these interventions for truly attachment disordered children, especially at later ages, are evident.

Nevertheless, there exist some limited data which may allow us to extend at least the principles of treatment described by Lieberman and Zeanah (1999) to more compromised children. I am thinking here especially of the work of Freud and Dann (1961) who cared for a good number of children during WWII who had experienced traumatic separations and compromised care. In a dramatic example of disruption of the attachment system and continuing losses, they describe the experiences of six 3-year old concentration camp survivors who had been separated from their parents at age 6 months and passed from hand-to-hand until they were admitted to the Tereszin concentration camp ward for motherless children. There they were looked after by other inmates under appalling conditions. Following their liberation, almost three years later, they again were uprooted three times until they arrived at Bulldogs Bank, a country home in England given to them for just one year. On arrival, they were described as hypersensitive, restless, aggressive toward adults and very difficult to handle. At Bulldogs Bank the children were cared for and prepared for a new life by Ms Dann and her coworkers. Thirty-five years later, in a conversation with me, Ms Dann reported that the three girls of the group were married and allegedly happy and good mothers. Of the boys, one was married and well settled, one never married but works in a steady job and one is allegedly 'very unreliable' (Minde et al., 1982). This is obviously a very good outcome and, while anecdotal, suggests that at least in some cases, sensitive and informed parenting for one year is able to allow seriously compromised children to follow a seemingly normal developmental trajectory into adulthood. One important clinical suggestion Freud and Dann make about such children is that they should not be 'forced to be close to adults' but given ample time to learn about closeness and be accepted even if they do need more distance from others. This apparent need for distance is seen in many attachment disordered children and, when not tolerated by subsequent caretakers, can contribute to the breakdown of fostering and adoptive arrangements. It is of interest that similar statements have been made by educators such as Makarenko, a Russian teacher who rehabilitated hundreds of homeless and abandoned youths who were roving through post-revolutionary Russia in the 1920s. By providing them with concrete care and allowing them to discuss their feelings while learning to live with each other in a rural setting, he describes how he could gradually teach these children aged 10 to 16 to respect others as well as themselves and relate to each other in a more caring fashion (Makarenko, 1955). Another example may be the SOS Children's Villages which exist

in more than 50 countries and provide long-term family care to thousands of abandoned and otherwise traumatized children. Although there have been no scientific studies of the outcome of these children, my personal contacts with three villages in sub-saharan Africa have been very encouraging.

What this suggests is that an attachment disorder could be analyzed at different levels. (1) On the attachment level, it refers to activation of attachment behaviour without termination because of the unavailability of an appropriate caretaker. (2) At the level of the child's social cognitions or belief system such an unavailability also violates expectations about the social world and affects the respective internal representations. (3) Subsequent caretakers or other adults will also have expectations and interpretations that will be modified by their knowledge and personal understanding of the trauma of the child. (4) Ecological factors, related to environmental variables outside of the attachment relationship, will also be affected. This can lead to better relationships with substitutes such as peers (as seems to have happened in the children described by Freud and Dann) or to more difficulties with subsequent caretakers.

If we accept the above concept, treatment should consist of modifying as many of these four levels as possible for the best possible outcome. In practice, this would suggest that we initially work on the ecological factors, i.e., assure the child a best possible day-to-day life. This will naturally include work with the child's present caretakers to support their efforts for care and realistic expectations. In addition, such children may be exposed to a cognitively tailored treatment approach where they initially learn the day-to-day behaviours that make life with them a more positive experience for others. This may mean concentrating on managing frustration, on building social skills, understanding natural consequences etc. Once such positive social cognitions are developed, one may gradually also affect the attachment level, i.e., help the child see that living with and caring about others is also more satisfying – although this last goal may not be totally achievable for children who have shown a complete absence of attachment in earlier years. Recent papers by Minde (1999) discussing work with unattached chronically ill children, and Zeanah et al. (2001), describing an individualized treatment programme for severely neglected children, provide examples of a similar approach.

There is one additional form of treatment, called 'holding therapy', which is discussed at some length by O'Connor and Zeanah in their paper, and found to be controversial as it may potentially be experienced by the child as a retraumatization. There has also been no evidence to date of its effectiveness. Nevertheless, in a published report from the 8th Annual ATTACH Conference in Omaha, Nebraska, Dr. B van der Kolk (2002), a neurobiologist who has written widely about the neurobiology of PTSD, speaks about the treatment of attachment or other traumatic disorders from the point of view of the brain and its functions. He claims attachment disorders lead to hyperarousal of the stress response systems and loss of semantic memory (ways of functional and adaptive behaviour learned from parents and other adults), explaining some of the observed therapeutic challenges. He then suggests that attachment and holding therapy may work because it focuses on helping the child to find a different outcome for the trauma. Moreover, to resolve these traumatic memories requires them to be re-experienced in the presence of high arousal, since this is how they were first experienced. Therefore, avoidance of talking about the problematic emotions, as is done by most conventional therapists, will be seen by the child as proof that emotions are dangerous, and will perpetuate the trauma. Hence, holding is not retraumatizing

because its focus is on resolving the trauma. To me, the notion of 'having to shake up the limbic system' in order to get it to change representations looks rather concrete. It is also not clear that a lack of attachment is primarily a post-traumatic condition since neglect may not be transmitted in a violent fashion.

In summary, I see an urgent need to work on further differentiating the phenomenology, epidemiology and etiology of a range of clinically observed attachment difficulties. This will assist in developing more goal specific treatment options and help families and clinicians in assuring a more meaningful life for these unfortunate children.

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