

# Attachment-based treatment for vulnerable children

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Holding therapy, sometimes known as attachment therapy, has become an extremely popular form of treatment for children thought to have attachment disorder (e.g., Cline, 1992; Keck & Kupecky, 1995; Levy & Orlans, 1998). Indeed, holding therapy is probably better known throughout the foster care and adoption communities than attachment theory itself. Attachment theorists and researchers have for the most part remained fairly silent about holding therapy. This silence may be a function of the zeal of many holding therapy advocates, as well as the reluctance among many academics to make forays into the practice realm. But, for the reasons raised by O'Connor and Zeanah, it is critical that attachment researchers speak up about their objections to holding therapy. I am appreciative that the authors of the target piece have confronted holding therapy, and have reminded us of the importance of doing so. In this commentary, I wish to amplify several points raised by O'Connor and Zeanah, and take issue with another, somewhat tangential, point.

## HOLDING THERAPY IS NOT DERIVED FROM ATTACHMENT THEORY

I agree with O'Connor and Zeanah that holding therapy does not emanate in any logical way from attachment theory or from attachment research. Few if any of the components of holding therapy are consistent with the tenets of attachment theory. Several examples include rage induction, shame induction, and forced holding, techniques that are at odds with an attachment framework. Nonetheless, holding therapy represents all of what many practitioners know about attachment, and is seen by many as an attachment-based treatment. So, how has this misperception developed?

Not surprisingly, those who have worked with children in foster care have often been impressed with the challenges confronting these children as they form attachments with new caregivers. To understand the development of these children, some holding therapists turned to the literature on attachment theory and research. This turning to the research literature is laudable – all too often clinical practice and research remain distinct. The most thoughtful writers from the holding therapy tradition (e.g., Archer, 2003; Hughes, 1998) present attachment theory and research findings in rich and thorough fashion. These writers have clearly thought carefully about how attachment theory can inform the treatment they provide.

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What is jarring, however, is the incorporation of holding therapy as a treatment technique. Whereas some (e.g., Archer, 2003; Hughes, 1998) have taken less extreme positions, Cline (1992) argues that the troubled child needs to be made to feel helpless and powerless for change to occur. Therapy is directed toward this end, with the therapist intentionally behaving in a way so as to lead the child to feel shame and rage. The physical 'holding' component of the therapy takes away from the child the possibility of escape. I agree with O'Connor and Zeanah that these elements are quite inconsistent with an attachment perspective.

The child's experience of powerful shame and rage while being physically restrained may well subject the child to terrifying or traumatic conditions. In that traumatic experiences can have extremely deleterious effects on development across a range of systems (e.g., Perry, Pollard, Blakely, Baker, & Vigilante, 1995), choosing to intentionally expose children to such conditions in the hopes of positive outcomes is very difficult to justify. It will be surprising if there is ever a randomized clinical trial assessing the efficacy of this treatment because no Institutional Review Board will approve of assigning children to such a treatment as part of a research protocol. It is unfortunate that we can 'assign' children to such a treatment when it is not a part of a research protocol.

#### SENSITIVE VERSUS COUNTER-SENSITIVE INTERVENTIONS

O'Connor and Zeanah state, 'from the perspective of the established attachment therapies, the holding approach would be viewed as intrusive and therefore non-sensitive and counter-therapeutic.' Although intrusive interventions are clearly counter-therapeutic, I suggest that if an intervention is 'non-sensitive,' it could nonetheless be therapeutic. Indeed, in order for interventions to be therapeutic, a component of non-complementarity, and hence non-sensitivity, is often necessary.

Consider the following two examples. By three months of age, infants of depressed mothers behave with strangers in 'depressed-like' fashion, and elicit from the strangers less optimal behaviors than elicited by other infants (Field et al., 1988). By 12 months of age, children in foster care behave in avoidant or resistant ways when hurt or frightened (Stovall & Dozier, 2000). Even their otherwise nurturing caregivers (i.e., caregivers with autonomous states of mind) respond to the infants' behavior 'in kind' (Stovall & Dozier, 2000). If adults behave in ways that are complementary, and hence sensitive, to these infants, the infants will experience a non-nurturing world. These infants will be 'leading the dance' (Stern, 1985) of interaction from a very young age in ways that perpetuate their expectations. Sensitive mothering is typically 'enough' for caregivers in intact, well-functioning dyads; however, sensitive responding to infants who have experienced inadequate early care may well be problematic. The role of the effective foster mother may be as a *therapist* rather than as simply sensitive caregiver.

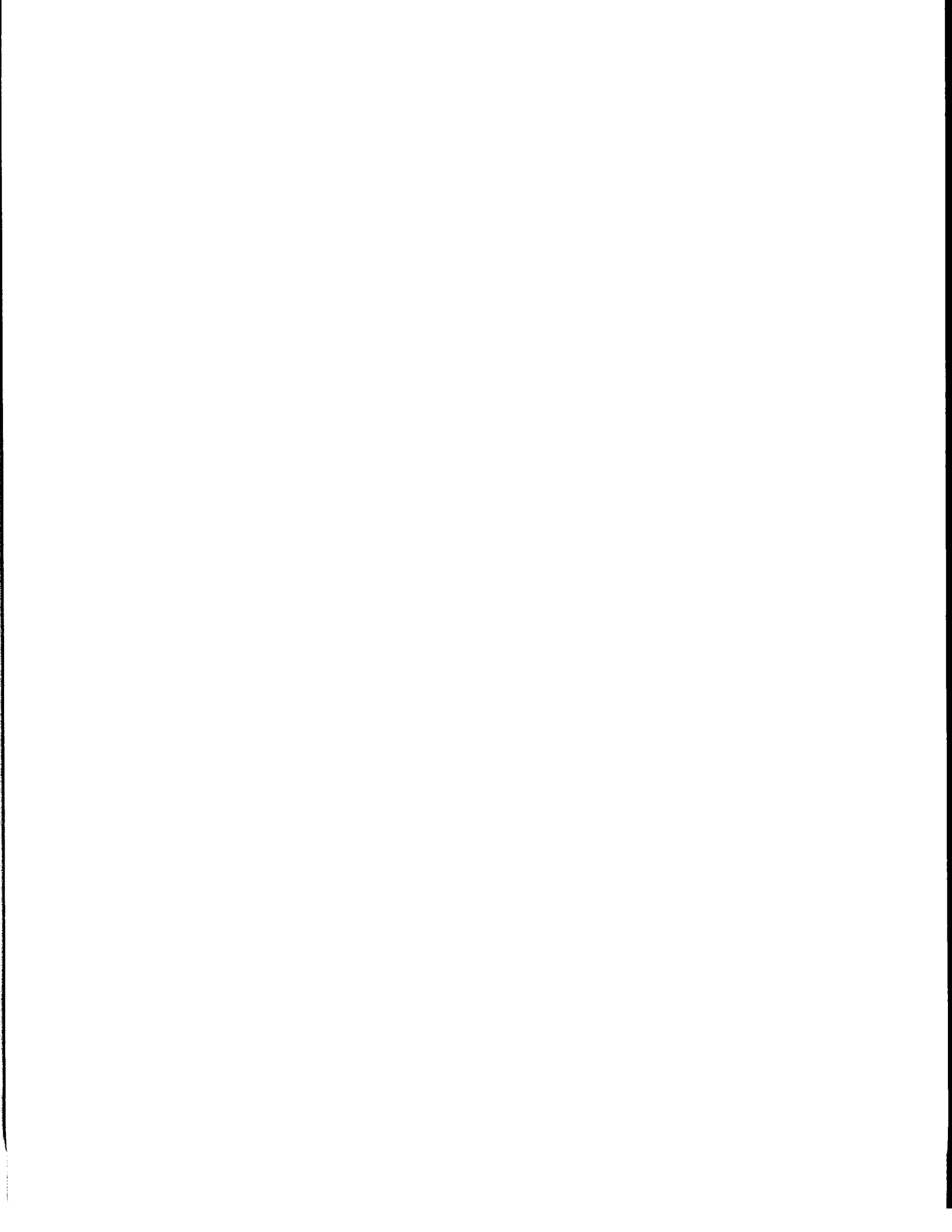
The therapist's providing 'gentle challenge' to the client is central to most therapeutic work (Dozier & Bates, 2003; Dozier & Tyrrell, 1997). The rest of the world provides confirmation of one's world view; it is the therapist who challenges this world view through his or her own interactions with the client, and/or through more directly challenging the client's views of relationships. Our

research with clinicians and their clients with serious psychiatric disorders demonstrates two ways in which therapeutic challenge might work (Dozier, Cue, & Barnett, 1994; Tyrrell, Dozier, Teague, & Fallot, 1999). In a first sample, clinicians who were autonomous provided more challenging (counter-complementary) interactions to clients than did non-autonomous clinicians (Dozier et al., 1994). In particular, in comparison with non-autonomous clinicians, autonomous clinicians provided more psychologically-oriented interventions to clients who were dismissing (those who would not be comfortable with psychological) and more independence-promoting interventions to preoccupied clients (those who would not be comfortable with independence). In a second study (Tyrrell et al., 1999), we found that 'mis-matching' clinicians and clients in terms of attachment state of mind resulted in the best client outcomes. For example, clients who were dismissing showed the best outcomes if they worked with clinicians who were on the more preoccupied end of the continuum. (Although all of the clinicians in this study were actually autonomous, they varied in how dismissing or preoccupied they were.) Clients who were preoccupied showed the best outcomes if they worked with clinicians who were on the more dismissing end of the continuum. In both of these examples, more challenging interventions were considered those which did not provide complementary feedback to clients. In the latter example, we demonstrated that greater challenge was associated with positive change.

#### ATTACHMENT AND BIOBEHAVIORAL CATCH-UP: AN INTERVENTION FOR FOSTER PARENTS

Our intervention with foster parents provides an example of an attachment-based intervention that challenges infants to change their expectations (Dozier, Higley, Albus, & Nutter, 2002; Dozier & Infant Caregiver Lab, 2002). The intervention has three components that derive from our empirical findings. First, as mentioned earlier, we found that foster infants often push new foster parents away, and foster parents often respond in complementary ways to these behaviors, i.e., by being pushed away. Our first intervention component, therefore, helps caregivers to provide nurturance to these children even though the children are behaving in ways that suggest that they do not want or need nurturance. So, rather than responding to children's signals directly, foster parents are urged to see that children need them even though they may not appear to need them. For example, if a child turns away from the caregiver when hurt, the caregiver is encouraged to respond in a nurturing way to the child. For example, at first the foster mother may just pat the child's back gently while the child sits on the floor turned away from her. Over time, the child usually allows the foster mother to come closer, and offer more support and nurturance.

I am reminded of my Golden Retriever, Django, who became quite lethargic and apparently depressed when his canine companion of many years died. We eventually got a new puppy in hopes of raising Django's spirits. The puppy very much wanted a relationship with Django, but Django, acted grumpy and uninterested. The puppy persisted and consistently moved to the closest distance allowed, which became progressively closer and closer to Django. Ignoring Django signals to stay away, the puppy managed to move close enough to prop his head up on Django's hip within a



week or two. From that point on, this insensitive but therapeutic puppy developed a wonderful relationship with the older dog.

Similarly, the first component of our intervention helps foster parents behave in nurturing ways to their children, even when children send out the message that they do not want their nurturance. This intervention component does not enhance sensitivity; rather, it enhances a caregiver's ability to provide a nurturing relationship by over-riding the natural propensity to respond in a complementary fashion to a child's behavioral signals.

Thus, the first component of our intervention shares two features with holding therapy: the premise that these children need something that they do not want; and the objective that children develop more trusting relationships with caregivers. However, the mechanisms by which that objective is obtained are quite different. Our intervention seeks to create an environment in which children feel nurtured and loved even when that is contrary to their expectations; holding therapy seeks to increase children's sense of shame and worthlessness.

There are two additional components of our intervention, but they are not as central to the points raised in this article. I mention them quickly in the interest of completeness. We have found that children in foster care need caregivers who have autonomous states of mind. Children placed with caregivers with non-autonomous states of mind show very high rates of disorganized attachments (Dozier, Stovall, Albus, & Bates, 2001). In that disorganized attachment is associated with a number of problematic outcomes, it seems critical that foster parents provide nurturing care even if this does not come naturally to them.

In addition, we have found that, even when children develop secure attachments with surrogate caregivers, they are at risk for dysregulation at the biobehavioral level. Whereas most children show a very regular drop in cortisol from the morning to near-zero levels in the evening, many foster children show atypical levels across the day (Dozier, Levine, Gordon, Manni, Gunnar, Fisher, & Stovall-McClough, 2001). For example, many foster children show very low levels of glucocorticoids across the day, with some showing very high levels. Thus, our third intervention component helps foster parents provide a very controllable interpersonal world to children such that children can better develop regulatory capabilities.

Thus, we suggest that challenge is a key component of treatment for individuals whose pathways have deviated from an optimal one. Nonetheless, we stress that challenge be gentle, and in the service of helping a child feel loved and worthwhile, in the short-run as well as the long-run.

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