Early Attachment Theory: Research and Clinical Applications

3 CE Hours

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Learning objectives

This course is designed to help you:
- Describe the difference between attachment and bonding.
- Explain how working models of attachment influence a child's perceptions and behaviors.
- Assess attachment classification types or styles.
- Identify factors including caregiver behaviors that influence a child's attachment style.
- Discuss symptoms and behaviors associated with reactive attachment disorder.
- Apply assessment and treatment interventions.

Introduction

Fourteen-month-old Gina accompanies her mother, Raquel, and Raquel's friend Maria to a medical check-up. In the waiting room, Gina contentedly plays with some blocks near her mother. Another patient comes into the room and sits next to where Gina is playing. Gina looks at her but does not attempt to interact and inches closer to her mother. Raquel gets up to go to the front desk to answer a question and Gina crawls after her. Raquel picks her up and she smiles. Shortly after this, Raquel is called into the office and briefly leaves the room, leaving Gina in the care of her friend. Gina cries and attempts to crawl after Raquel; Maria is unable to soothe her or engage her in play while her mother is gone. When Raquel returns to the room, Gina immediately reaches out to her. When Raquel picks her up, Gina stops crying.

One of the most important factors in the growth and development of children is the quality of the relationship between the child and parent or primary caregiver. Healthy development depends on the child's capacity to relate to and care for others. Children depend on their primary caregiver to provide the close, supportive relationship necessary for learning and achieving independence, and this relationship can affect the quality of the child's future relationships.

In the preceding example, Gina displays age-appropriate behaviors and appears to be on track developmentally. She currently prefers her mother to strangers and is able to be easily comforted by her. Gina clearly appears to enjoy a close relationship with her mother. "Attachment" is a term most often used to describe this powerful relationship. While "bonding" is often used interchangeably with the term "attachment," the meanings of these two terms differ considerably.

What is bonding?

The term "bonding" relates to the parental tie to the infant during the first hours and days of its life. Historically, bonding has been described in almost mystical terms and is often linked with the notion of maternal or paternal instinct. Berger (1980) demystified the bonding process, proposing instead that it is the parental reaction to four factors that promote bonding attachment:
- Appearance, meaning the child's immature physical characteristics and helplessness.
- Sense of ownership resulting from identification of the infant as the parent's progeny.
- The degree of physical and behavioral similarity with the parent.
- Hormonal influences.

Early studies by Klaus and Kennell (1976) described a process that takes place immediately after birth. It is during this sensitive period, described by others as the "golden hour," that the mother is felt to be "unusually open to taking in her baby and learning more about the talents of her newborn" (Klaus and Kennell, 2001). They concluded that this period of heightened sensitivity in the mother was the ideal time to develop a strong bonding relationship between mother and child. However, the outcomes of their early study have yet to be replicated and do not account for healthy bonds established in adoptive families (Landy, 2009). While this initial "bonding experience" can help parents develop an emotional connection leading to the development of a more permanent bond, children need ongoing sensitive care from the parent to form strong attachments.

What is attachment?

Attachment refers to the relationship developed between an infant and a parent or primary caregiver during the first two to three years of life. Unlike bonding, which predominantly refers to the mother's initial emotional response to the infant, attachment refers to the child's behaviors and feelings in the relationship and occurs later in the infant's development (Berger, 1980). How this relationship forms depends on the degree the caregiver meets the child's needs for care, comfort and security.

Attachment functions to ensure the survival of the child by keeping the child in close proximity to the caregiver, thus improving the child's chances of survival. Both the child and caregiver learn to reference and respond to each other's cues in a reciprocal and bi-directional affectional process. (Landy, 2009). The attachment system also "motivates young children to seek comfort, support, nurturance and protection from a discriminated attachment figure." (Stafford & Zeanah, 2006). Gina, in the example above, demonstrated proximity

maintenance, a basic characteristic of attachment, by staying close to her mother and resisting separation from her.

A central theme of attachment theory lies in the important role the caregiver plays in establishing a sense of security. Dependable caregiving that is readily available and responsive to the child's needs creates a secure base from which children can leave and return to as they gradually explore their environment and learn to survive independently (Ainsworth, 1982; Bowlby, 1988). In effect, the caregiver functions as a safe haven. When the child feels threatened or afraid, he or she can return to the caregiver for comfort and soothing. It is equally important that the caregiver can be trusted to provide this care whenever needed, because "the formation of social bonds, of social and emotional communication, the development of a sense of confidence and trust in others, the perception of the parent as the source of security and protection, and feelings of self-esteem are dependent on such care and its reliability" (Mukaddes, et.al., 2000).

Attachment isn't just an instinctual biological drive for safety and security. The opportunity to psychologically attach to a caregiver is also an essential developmental task that determines both the child's immediate well-being and the course of his or her future growth and development. The type of attachment relationship a child has can actually alter the structures, neurochemicals and connectivity of the infant's brain that affect language, thinking, motor control and emotions. For example, it appears that pathogenic care giving, the absence of caregivers, and the disruption of the early care-giving environment significantly affect the ability of the hypothalamic-pituitary-adrenal (HPA) axis to regulate the body and brain's response to stress (Corbin, 2007).

As research continues, there is also increasing evidence of the relationship between the development of secure attachment and the development of a child's capacity to regulate both arousal and emotion (van der Kolk and Fisler, 1994; Schore, 2001a).

Several factors can affect the quality of a child's attachment. These can include the child's temperament (more active and outgoing, or the opposite, for example), the context of the situation (stranger present, familiar room, and so on) early history (a traumatic experience, for example) and other things. But the way in which a parent responds to and interacts with a young child is the key factor in how an attachment develops.

Development of healthy attachment

Children are not born attached to their caregiver but instead learn through the repeated experience of significant social interaction with whom they prefer (Bowlby, 1982; Ainsworth, 1967; Stafford & Zeanah, 2009). Healthy development relies on the presence of a stable caregiver who can provide appropriate emotional and verbal stimulation. Early studies in attachment focused on children in institutions. Later research on the effects of abuse and neglect revealed that the quality of care played a more important role than the separation alone and that a small group of consistent, reliable, affectionate and attentive caregivers could promote healthy development in children (Smyke, et.al. 2002).

Infant, toddler and caregiver behaviors that promote attachment by either maintaining proximity to the attachment figure or providing the opportunity for meaningful interaction include:
- Smiling.
- Sucking.
- Looking at each other; gazing into each other's eyes.
- Vocalizing to each other.
- Following and locomotion.
- Clinging and grasping.
- Physical touch and hugging.
- Exploring the surroundings.
- Feeding interactions.
- Crying.
- Playing.
- Relaxing and allowing themselves to be comforted.

The development of the attachment relationship is a gradual process involving numerous interactions between the child and primary caregiver over time. In the first few months of life, the infant's response signals (crying, stretching, finger holding) are indiscriminate. For example, they initially cry in response to things; crying is not used to communicate. Concurrently the parent or primary caregiver is recognizing and responding to the child's signals, nurturing him or her and maintaining a protective closeness. Over time, as responses are reinforced, infants learn to communicate through crying that they are hungry, tired or experiencing discomfort. Though infants continue to respond to other people, at about 2-3 months they begin to discriminate between their primary caretaker and others.

During the first six months of life, children respond best to immediate and consistent attention and comfort and cannot be "spoiled" by it.

From 3 to 7 months, the child begins to smile and vocalize, and the caregiver reciprocates with appropriate emotional responses. The child also can be comforted by the caregiver. As the child achieves milestones in physical and motor development, skills such as crawling and walking enable the child to maintain close proximity.

Infants gradually learn to discriminate between people, and by the latter part of their first year have developed the capacity to form preferred attachments. The onset and establishment of focused attachment occurs from 7 to 18 months. At 12-18 months, a child may protest loudly when his or her caregiver leaves. It is also during this time the infant acquires the ability for person permanence, that is, keeping the caregiver in mind even when he or she is not present (Rosenblum, et.al. 2009). At this stage, infants respond more discriminately, with a striking decline in friendliness to others; do not want to go to strangers; and have distinct preferences for the attachment figures in their lives (Stafford & Zeanah, 2006). They experience stranger and separation anxiety, and caregivers will need to respect their baby's fears and need for closeness.

Between 12-14 months, children begin to demonstrate the ability to develop other attachments and a hierarchy of preference. About 13-18 months of age, they start to explore, using parents as a secure base for exploration. Caregivers need to encourage this, welcome the child back and celebrate his or her accomplishments. The child seeks comfort from the caregiver during times of uncertainty and the caregiver will help interpret new or unfamiliar situations. Children need a stimulating environment that encourages exploration – but overstimulation and the inability of the caregiver to act as a buffer from stress can have negative side effects on children.

As children continue to develop as individuals (19-36 months), it is important that caregivers provide opportunities for the child to make choices. Children will begin to balance their wants and needs with their caregiver's desires, and the caregiver will establish appropriate limits. Other critical tasks for caregivers during this period are helping children cope with the range of emotions they experience, and as they expand their social circle, supporting these new friendships and experiences. Children are also very sensitive to tone of voice during this time and want to know their caregivers are interested in them and proud of their accomplishments.

Attachment theory

The first clinical description of behaviors associated with what is now known as attachment disorders was made by Spitz (1945) in his work in hospitals and institutions with foundlings. These children lacked a specific primary caregiver, but despite adequate care, his research indicated significant impairment in motor and behavioral development as compared to the norm.

Later, Bowlby, also influenced by his early work with delinquent children and Harlow's research with rhesus monkeys, was the first to describe mother-infant attachment. His theory, largely intact and supported by research to this day, identified that healthy social and emotional development was dependent on the presence of a strong relationship between the infant and a primary caregiver. He postulated that the mother's face, hair, voice, touch and so on elicited infant behaviors such as grasping, clinging, smiling and babbling, and that over time, this established an attachment bond. (Kagan, 2011). Bowlby described this attachment as "a lasting psychological connectedness between human beings" (Bowlby, 1969, p. 194).

Bowlby also theorized that during the first 9-12 months of their lives, children develop cognitive schema, or internal working models (IWMs) to represent emotions and expectations resulting from interactions with their parents or caregivers. The internal working models are based on the child's perceptions of whether the caregiver was responsive and whether the child is worthy of such a response (Bowlby, 1973). In other words, individuals form relationship expectations about their role (such as loveable versus unlovable) and that of others (such as nurturing versus cold) based on early experiences with their attachment figure. The consolidation of these internal working models forms the child's conceptual representation of self, others and the world and assists the child's goal-directed behavior, emotional regulation and ability to assess the safety of relationships (Allen, 2011). For example, internal working models help them to "predict and interpret others' behaviors and to plan their own response" (Riggs, 2000).

In the 1970s, psychologist Mary Ainsworth, a student of John Bowlby, expanded upon Bowlby's work. After conducting numerous hours of observation of children and their parents in homes, she developed an observational procedure that could be conducted under a more controlled setting, the strange situation procedure (SSP). This consisted of observation of the child during periods of high and low stress to evaluate the balance between the child's motivation to explore the environment and his or her motivation to seek comfort from a discriminated attachment figure. (Stafford & Zeanah, 2006). Ainsworth's research focused on 23 children between the ages of 12 and 18 months and how they responded when briefly left alone and then reunited with their mothers (Ainsworth, et.al., 1978). Since then, it has become one of the most widely used standardized techniques to assess the quality of attachment between the child and caregiver.

In the strange situation procedure, the mother, child and cohorts are observed through a one-way mirror as they complete various activities and steps. The procedure starts with the mother and child entering a toy-filled room. A few minutes later, a stranger joins them. Then the mother leaves the room and the child is left with the stranger for three minutes. The mother returns, the stranger leaves and then a few minutes later the mother leaves then returns.

During the procedure, observers are focused on the child's behavior, specifically how the child responds 1) to a stranger; 2) when the caregiver leaves the room; and then 3) when the caregiver returns. In a healthy attachment, there is a balance between the child's attachment to the caregiver and a need to explore. But it is how the child responds when reunited with the mother that demonstrates the child's level of attachment security. As it turned out, the length of time the child cried while mother was gone or even whether they cried at all was not what defined their level of security, but rather, the child's behavior when the mother returned. (Stroufe & Siegel, 2011).

Based upon the organization of behaviors displayed by the child during the separations and reunions, Ainsworth and colleagues (1978) identified three major patterns of attachment: secure attachment, ambivalent-insecure attachment, and avoidant-insecure attachment. Later, researchers Main and Solomon (1986) added a fourth attachment style called disorganized-insecure attachment based upon their own research.

Historically, across cultures, maternal attachments are often primary. Consequently, much of the 50-60 years of research has primarily focused on mothers, while fathers have been viewed as secondary caregivers. But this is changing, particularly in Western cultures. Research appears to support that infants become attached to both mothers and fathers, and attachment relationships with either helps establish the regulation of the child's affect and arousal. (Rosenblum, et.al. 2009). Fathers, like mothers, also make significant contributions to the child's development. (Lamb, 1997, 2002). Research does suggest some differences. For example, fathers are more likely to be emotionally supportive and challenging during play, which further supports infant exploration; the emphasis of maternal behaviors is in supporting the infants' ability to seek comfort and other support (Grossman et.al. 2002).

Hazen et.al (2010) conducted a longitudinal study of parental behaviors that demonstrated qualitatively different caregiver roles and patterns of attachment between mothers and fathers; these patterns resulted in different child outcomes. The study focused on sensitive and frightened or frightening caregiver behaviors and the later development of externalized (e.g., attention, regulation) and internalized (e.g., anxiety, depression) problems. Frightening behaviors include physical, facial and verbal threatening behaviors (e.g., sudden invasions of vulnerable areas of the body, baring one's teeth, suddenly roaring); frightened behaviors (e.g., backing away from the infant when infant approaches); dissociative behaviors (e.g., freezing, handling baby like an inanimate object); and role-reversed behaviors (e.g., deferential or sexualized behaviors).

Results indicated that children whose fathers were both insensitive and frightening showed higher levels of emotional under-regulation and attention problems, but that sensitive caregiving by fathers mitigated the negative impact of frightening behaviors for fathers – but, curiously not for mothers. This led researchers to hypothesize that "fathers who stay sensitive while keeping babies highly stimulated, on the fence between fear and fun, may actually be scaffolding their children's later development of the ability to regulate intense emotions, cope with overstimulation and stay focused" (Hazen, et. al., 2010). Why doesn't this occur with mothers? They suggest that the maternal role as a secure base is incompatible with frightening behavior, and this confusion can lead to later internalized problems.

The effects of trauma on attachment

There are still many people who assume that exposure to trauma at a much younger age has no effect because children are too young to understand or too young to remember. However, trauma affects children at any age and can severely disrupt the attachment process. For example, studies on exposure to community and domestic violence clearly demonstrate that trauma threatens a child's attachment and sense of trust (Osofsky, 2004).

This disruption in the attachment process can also lead to disruption in other critical areas of cognitive, physical and social-emotional development. Imagine the additional burden for children who

experience physical or emotional abuse by their primary caregiver(s). Not only do they suffer the immediate effects of the maltreatment, they also experience the loss of the parent or caregiver as a "secure base" (Ainsworth, 1982; Bowlby, 1988). As a result, the child's internal working models view adults as either harmful or unable to protect them from harm. And without their secure base, they will become less curious and limit their exploration of the environment. The results of these early experiences, however, can be changed through appropriate systematic and therapeutic interventions.

Attachment styles

A child's attachment style generally develops based on the child's perception or understanding of the caregiver's reliability in providing comfort, support and security. The attachment style describes the quality of the relationship a child feels toward an adult caregiver, not the parent or caregiver's feelings about the child.

Scientific research on parent-child relationships suggests that two primary types of attachments form, secure attachments and insecure attachments. Currently there are four main styles of attachment described in the literature (Ainsworth, et.al., 1978, Main & Solomon, 1990):
● Attachment Style A: Insecure-avoidant.
● Attachment Style B: Secure/balanced.
● Attachment Style C: Insecure-ambivalent/resistant (also called anxious/resistant).
● Attachment Style D: Disorganized/disoriented.

Children who are secure in their attachments more freely explore their environment and are able to learn with confidence, tend to be more popular with peers and exhibit more positive social interaction with other kids, tend to be more emotionally stable and able to express and manage their feelings well, and demonstrate greater ability to handle stress and help others handle stress.

Children with insecure attachment are more likely to struggle in being confident and learning about their surroundings, seem more at risk for hostile, antisocial or difficult relationships with other children, are more likely to be emotionally unstable and have difficulty in expressing and managing feelings and are more likely to struggle when stressed, act out in unhealthy ways and be insensitive to others who are stressed. The following characteristics highlight each of the four main attachment types:

Secure/balanced – Style B
Infants with secure attachments to their caregivers have a balanced and organized regulatory strategy. They are able to express their emotions and look to their parents for help in regulating emotional and physical distress. A securely attached child will generally appear happy and content when interacting with a caretaker. When separated from the caretaker, the child may or may not exhibit distress, will seek proximity after separation, and calm down quickly when the caregiver returns. The child will freely explore the environment around him or her and will seek contact with the caregiver when distressed. Once comforted, the child moves on and continues play. Essentially, these children trust their caregivers to provide protection and care and are comfortable seeking them out when they are frightened or hurt. (Ainsworth, et.al., 1978; Rosenblum, et.al., 2009).

Parental behaviors that support this style include sensitivity or the ability to be attuned to the child's needs, flexibility and the ability to respond consistently to the child's signals, particularly when distressed. (NICHD Early Child Care Research Network, 1997). Insecurely attached children tend to have unresponsive, insensitive or controlling caretakers. Landy (2009) identified other critical caregiver behaviors that researchers associate with the development of secure attachment. These include:
● Comforting a child, particularly when it is hurt, upset or frustrated.
● Accepting the child's negative feelings, such as anger, jealousy, sadness and fear.
● Being sensitive and responding to the child's cues.
● Frequently directing actions toward the infant and providing emotional support during activities.
● Being careful not to overwhelm the child by being too intrusive or directive.
● Showing positive feelings toward the child and expressing genuine love and interest.
● Allowing the child to be as separate and autonomous in exploring the environment as possible while keeping him or her safe.
● Behaviors synchronized with interactions that are smooth and reciprocal with the child's.

Insecure-ambivalent/resistant (also known as anxious/ambivalent) – Style C
Children who are preoccupied with their caregiver, yet ambivalent, characterize this pattern. They exhibit extreme distress when a parent or primary caregiver leaves. However, while they will seek them out, they do not appear comforted by their return and may struggle to get away from them. They are reluctant to explore the environment and exhibit frustration with their parents' responses to them. (Ainsworth, et.al., 1978). The caregivers of ambivalently attached children are likely to be very anxious about the child and at times overprotective and interfering (Landy, 2009). Research suggests that ambivalent attachment results from the caregivers' inconsistent pattern of availability. Simply put, children with an ambivalent pattern of attachment have learned that they cannot depend on their caregivers to be there when needed.

Insecure-avoidant/defended – Style A
The insecure avoidant/defended style of attachment is characterized by children who tend to avoid or ignore a parent or caregiver's presence, show little response when the caregiver is close by, display few strong emotional outbursts, and avoid or ignore the caregiver or parent's responses toward them. In fact, these children, when given a choice, will show no preference between their caregiver and a complete stranger. In the strange situation procedure, children will explore the room and toys but with no reference back to the caregiver. They tend to snub or ignore the caregiver at reunion and do not need to be calmed (Ainsworth, et.al., 1978).

A child is likely to develop insecurely avoidant attachment when the caregiver consistently fails to respond or ignores the child's negative emotions. In extreme cases, they may neglect all of the child's emotional needs. These caregivers may actually be very good at teaching tasks and setting limits but may be hostile, ignoring or rejecting. (Landy, 2009). Research suggests that avoidant attachment might also be the result of abusive caregivers who punish children when they reach out to them for help. Outwardly rejecting caregivers who respond to children with hostility and indifference teach those children to deny their own needs. Such children may look independent, but in actuality, they appear independent because they have not learned to depend on others (Lamb 2000; Main 2000).

Insecure attachment – disorganized/disorientated – Style D
Children with this attachment style do not demonstrate clear attachment behavior. Rather, they seem to possess characteristics of both the ambivalent and avoidant style. Characterized by a lack of a coherent attachment strategy for interacting with the parent, children with this style are not predictable in their actions and responses to caregivers. Children with disorganized attachment seem unable to cope easily or be comforted when stressed and are hypersensitive to perceived abuse. During reunion, such children often appear dazed and either confused or fearful or demonstrate freezing in the caregiver's presence. One moment they seem anxious to please, and the next

moment angry or openly rejecting of the parent or caregiver. They may control or comfort the caregiver instead of being comforted. Repetitive, stereotyped gestures and motions are also behaviors exhibited. (Main & Solomon, 1999).

According to Main and Solomon (1986), inconsistent behavior on the part of parents might be a contributing factor in this style of

attachment. At times, the caregiver may seem frightened and unable to manage the child and the situation; at other times, the caregiver is the source of fear, exhibiting hostility and anger. In later research, Main and Hesse (1990) argued that parents who act as figures of both fear and reassurance to a child contribute to a disorganized attachment style. Because the child feels both comforted and frightened by the parent, confusion results.

Prevalence of attachment styles

Researchers working with separate data sets and in different cultures have generally found that most children (about 85 percent) can be classified into one of these three main styles. Of those, in general, approximately 60 percent of children can be categorized as B, securely attached, and approximately 18 to 25 percent can be categorized as A, avoidant. The attachment style categorized as C, ambivalent in their attachment, is considered relatively uncommon, affecting an estimated

7-15 percent of U.S. children (Cassidy and Berlin,1994; Ainsworth et al., 1978). Furthermore, the shape of this distribution is similar across cultures, although specific percentages of A's and C's may vary (van Ijzendoorn and Sagi 1999). In addition, in the United States, approximately 15 percent of children are difficult to classify into one of these three styles and have a "disorganized/disoriented" attachment style (National Center for Education Statistics, 2007).

Patterns of early attachment and development

What benefit is there in understanding and studying attachment styles? They are important because children often show different outcomes in their well-being and development based on attachment style. Lundy (2009) outlined some of the important aspects of a child's growth affected by attachment quality including the following:

- **Secure:**
  - Cooperative with parents.
  - Affectively positive.
  - Socially competent and seeks out friends.
  - Has good self-control.
  - Can problem-solve with confidence.
  - Easily comforted if upset/seeks help if overwhelmed.
  - Manages well away from parents.
- **Insecure/avoidant:**
  - Tends to be non-compliant and to disobey rules.
  - Often very angry and hostile.
  - Isolated from group, does not seek interaction.
  - Can be excessively angry but has control in nonsocial situations.
  - May be quite competent.
  - When in pain or upset, withdraws and does not seek help.

  - Manages well away from parents.
- **Insecure-ambivalent/resistant:**
  - May have behavioral difficulties and fluctuate between being tense and helpless.
  - Tends to be fearful and tense.
  - Has poor social skills, tends to be dependent on others.
  - Impulsive, low frustration tolerance.
  - Lacks confidence and assertiveness with little ability to problem-solve.
  - Needs sensitive care-giving, often difficult to calm down.
  - Often misses parents and seems helpless and tense without them.
- **Disorganized/disoriented:**
  - Usually has behavioral difficulties and is unpredictable.
  - Is often both a bully and a victim.
  - Has poor social skills.
  - Low frustration tolerance and self-control.
  - Very disorganized and disoriented in approach to problems.
  - May miss parents and appear frightened when with them as well as away from them.

Long-term effects of attachment style

Attachment styles displayed in adulthood are not necessarily the same as those seen in infancy, though research suggests that early attachments can have a serious impact on later psychological and social development. While the predictive value of various attachment assessments (e.g., strange situation procedure, Attachment Q-sort) requires further study, there is strong evidence that early attachment disorganization, for example, is a powerful predictor of children's later socio-emotional development and of stress management problems and psychopathology (Smeekens, et.al., 2009).

Much that we do know is the result of research by attachment researcher Alan Sroufe and others with the Institute of Child Development at the University of Minnesota. The Minnesota Longitudinal Study of Parents and Children began in 1975 with 267 low-income, first-time mothers and has focused on social relationships, including how people view them and risk and protective factors. The

main goal of the study is to follow the course of human development and identify those factors contributing to good and poor outcomes. (Sroufe, et. al., 2005 & 2010).

The sample of 180 children in Sroufe's study of infant-child attachment lead relatively unstable lives compared to other studies that tend to focus on middle class children. Considering styles of attachment, the study revealed that if children had a secure mother-infant attachment, they were likely to be self-reliant into adolescence, have a better sense of self-esteem, have lower rates of psychopathology, enjoy successful peer relationships through age 16 and do well in school – especially in math – at all ages. They also found that anxious, poorly attached infants could become more secure if their mothers enter stable love relationships or alleviate their symptoms of depression.

Adult attachments

While the focus of this course is on early attachment, familiarity with adult attachment behaviors can be helpful in recognizing patterns that may support or compromise a parent or caregiver's relationships with others and their ability to effectively nurture and discipline a child.

Think about the last time you said or did something that reminded you of one of your parents or primary caregivers. Simplification? Yes, but this illustrates the impact of early relationships on future functioning. An adult classification of attachment can be assessed using the Adult

Attachment Interview (AAI), developed by Main and Goldwyn (1998). This complex assessment process is extensively used in research and identifies four major classifications of adult attachment with additional subcategories.

The main attachment types are described as:
- The **secure-autonomous/free** classification describes adults who seem to be at peace with their experiences with their parents. They recognize the influence of those early experiences on their personality. They value relationships and seek them out.
- **Insecure-dismissing** people do not value relationships. They dismiss the idea that their early experiences affected them and may either idealize their early caregivers or not have any memory of them.
- **Insecure-preoccupied** people want relationships but see them as unpredictable and strive for greater closeness. They are preoccupied with their past and current relationships with their parents and frequently continue trying to get the kind of consistent nurturing they still crave.
- Adults classified as **unresolved** often exhibit distorted, disorganized thought patterns as well as the emotions of anger and fear. The interview will reveal that they have not resolved the loss of a loved one by death, absence or by the trauma or abuse they experienced growing up.

Problems with attachment

What happens to children who have not formed secure attachments or manifest clinically significant symptoms of insecure attachment? As we have seen, research suggests that failure to form secure attachments early in life can have a negative impact on behavior in later childhood and throughout life. To feel safe and develop trust, infants and young children need a stable, caring environment. Their basic emotional and physical needs must be consistently met. What happens when the caregiver response is pathologically inappropriate or there is no response to the child's signals at all? We know that when a baby cries, his or her need for a meal or a diaper must be met with a shared emotional exchange that may include eye contact, smiling and caressing.

A child whose needs are ignored or met with emotionally or physically abusive responses from caregivers comes to expect rejection or hostility. The child then becomes distrustful and learns to avoid social contact. Emotional interactions between babies and caregivers may affect development in the brain, leading to attachment problems and affecting personality and relationships throughout life.

Problems with attachment occur when children have been unable to consistently connect with a parent or primary caregiver. This can happen for many reasons:
- The caregiver rarely responds to an infant's cries or offers comfort.
- No one looks at, talks to, or smiles at the infant.
- A young child gets attention only by acting out or displaying other extreme behaviors.
- A young child or baby is mistreated or abused.
- Sometimes the child's needs are met and sometimes they aren't. The child never knows what to expect. For example, when an infant is hungry or soiled, he or she may not be attended to for hours or even days.
- The infant or young child is hospitalized or separated from his or her parents.
- An infant or young child is moved from one caregiver to another (can be the result of adoption, foster care or the loss of a parent).
- The parent is emotionally unavailable because of depression, an illness or a substance-abuse problem.
- The infant or child is routinely exposed to community or domestic violence.

It is important to remember, though, that most children are naturally resilient, and even those who've been neglected, lived in orphanages or had multiple caregivers can develop healthy relationships and strong bonds. It's not clear why some babies and children develop problems with attachment and others don't. On the impact on adult relationships, for example, Riggs (2010) says, "Although emotional abuse in childhood can jeopardize the functioning of the attachment system, it does not necessarily condemn someone permanently to unhappy romantic relationships. With appropriate support and intervention, it is possible to overcome this unfortunate historical disadvantage and find happiness and contentment with a loving partner" (37).

Early signs and symptoms of disrupted attachment in babies (Mayo Clinic, 2011) may include:
- Withdrawn, sad and listless appearance.
- Doesn't make sounds, like cooing.
- Fails to smile.
- Avoids eye contact.
- Does not follow others in the room with his or her eyes.
- Fails to reach out when picked up.
- Has no interest in playing peek-a-boo or other interactive games.
- Has no interest in playing with toys.
- Engages in self-soothing behavior, such as rocking or self-stroking.
- Cries inconsolably.
- Is calm when left alone; doesn't seem to notice or care when left alone.
- Rejects caregiver's efforts to calm, soothe and connect.

Signs and symptoms in toddlers, older children and adolescents (Mayo Clinic, 2011) may include:
- Withdraws from others.
- Avoids or dismisses comforting comments or gestures.
- Acts aggressively toward peers.
- Watches others closely but does not engage in social interaction.
- Fails to ask for support or assistance.
- Exhibits obvious and consistent awkwardness or discomfort.
- Masks feelings of anger or distress.

Reactive attachment disorder

Nathan was referred to the clinic by his pediatrician after his adoptive mother expressed concerns that he might have a developmental disability. She reported that 4-year-old Nathan usually played alone and in fact appeared to prefer it. He squirmed when she or her husband attempted to hug him. And recently, after tumbling off the swing set, he did not cry or seek her out for comfort despite a nasty brush burn. After an extensive assessment process, Nathan was diagnosed with a disorder of attachment, reactive attachment disorder of early childhood.

Reactive attachment disorder, or RAD, is believed to be an extremely rare but serious condition resulting from the inability of infants and young children to develop healthy bonds with at least one primary caregiver. Because the child's basic needs for comfort, affection and nurturing aren't consistently met, his or her ability to establish loving and caring attachments with others is compromised. This may permanently alter the child's growing brain and hinder social-emotional and physical development.

Reactive attachment disorder typically begins before age 5, usually starting in infancy, and affects both boys and girls. Standardized

criteria for this disorder was first described in version three of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1980), with the diagnostic criteria undergoing further refinement in subsequent editions.

The DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-5, these subtypes are defined as distinct disorders: reactive attachment disorder (RAD) and disinhibited social engagement disorder (DSED). Both of these disorders are the result of social neglect or other situations that limit a young child's opportunity to form selective attachments. Although sharing this etiological pathway, the two disorders differ in important ways. Because of dampened positive affect, reactive attachment disorder more closely resembles internalizing disorders; it is essentially equivalent to a lack of or incompletely formed preferred attachments to caregiving adults. In contrast, disinhibited social engagement disorder more closely resembles ADHD; it may occur in children who do not necessarily lack attachments and may have established or even secure attachments. The two disorders differ in other important ways, including correlates, course, and response to intervention, and for these reasons are considered separate disorders. (APA, 2013)

The DSM-5 provides the following criteria for Reactive Attachment Disorder:
A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
   ○ The child rarely or minimally seeks comfort when distressed.
   ○ The child rarely or minimally responds to comfort when distressed.

B. A persistent social or emotional disturbance characterized by at least two of the following:
   ○ Minimal social and emotional responsiveness to others
   ○ Limited positive affect
   ○ Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.
C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
   ○ Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caring adults
   ○ Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care)
   ○ Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios)
D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
E. The criteria are not met for autism spectrum disorder.
F. The disturbance is evident before age 5 years.
G. The child has a developmental age of at least nine months.

Specify if Persistent: The disorder has been present for more than 12 months.

Specify current severity: Reactive Attachment Disorder is specified as severe when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Disinhibited social engagement disorder (DSED)

A new diagnosis within the DSM-5, the primary defining feature of Disinhibited Social Engagement Disorder is a person's pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers. This behavior violates the ordinary social customs and boundaries of the culture (APA, 2013). Criteria within the DSM-5 are:
A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least 2 of the following:
   ○ Reduced or absent reticence in approaching and interacting with unfamiliar adults.
   ○ Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries). Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
   ○ Willingness to go off with an unfamiliar adult with minimal or no hesitation.
B. The above behaviors are not limited to impulsivity (as in attention deficit hyperactivity disorder) but include socially disinhibited behavior.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
   ○ Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
   ○ Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
   ○ Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
D. The care in the above behaviors (section C) is presumed to be responsible for the disturbed behavior in A — e.g., the behaviors in A began after the care in C.
E. The child has a developmental age of at least 9 months old.

Specify if:
Persistent: The disorder has been present for more than 12 months.

Risk factors

There are no accurate statistics on how many infants and children have the condition, but studies have found RAD to be more common in maltreated children, young children coming into foster care and children living in orphanages and institutions (cited in Zeanah and Smyke, 2009). Other factors that may increase the chance of developing reactive attachment disorder include:
● Frequent changes in foster care or caregivers.
● Inexperienced parents.
● Prolonged hospitalization.
● Extreme poverty.
● Forced removal from a neglectful or abusive home.

● Significant family trauma, such as death or divorce.
● Postpartum depression in the baby's mother.
● Parents who have a mental illness, anger management problems or drug or alcohol abuse.

DSED is considered a result of inconsistent or absent connection to a primary caregiver in the first years of life. Children who are institutionalized may receive inconsistent care, isolation during hospitalization, and parental problems such as mental health problems which interfere with attachment such as depression or a personality disorder, absence, poverty, teen parenting, or substance abuse.

Course

Many problems in later childhood and adulthood, such as delayed learning, poor self-esteem, anger problems, depression, delinquency and poor romantic and peer relationships have been attributed to complications of reactive attachment disorder. Some advocates of controversial therapies for RAD even cite historical figures, such as Adolf Hitler, Saddam Hussein and Edgar Allen Poe as examples of individuals with RAD or DSED who did not get help in time (despite the obvious barriers to assessment and diagnosis) (Thomas, n.d.). Consequently, there is much fear and hype around the diagnosis.

However, the long-term consequences of aberrant attachment patterns on social-emotional functioning are unclear. Although the behaviors have long been recognized in severely neglected, maltreated or institutionalized children, the disorder has only been researched well

in the last decade, and there has been little research on the signs and symptoms of reactive attachment disorder beyond early childhood. Even long-term longitudinal studies, and these are uncommon, do not support a strong predictive value from measurements obtained with the highly regarded strange situation procedure (Rutter, M., Kreppner, J, and Sonuga-Barke, E., 2009).

The course of reactive attachment disorder varies according to the individual factors of the parents and child (such as, their resilience) and the severity and duration of psychosocial deprivation. But with appropriate treatment and appropriately supportive environment, children can develop more stable and healthy relationships with caregivers and others. (APA, 2000).

Differential diagnosis

Symptoms of insecure attachment are similar to the early symptoms of other issues and may or not mean that someone actually has a clinical disorder. Things become more complicated when assessment indicates the possibility of an issue requiring clinical diagnosis and treatment. Reactive attachment disorder, one of the most misunderstood and poorly researched disorders, can be difficult to diagnose without a full history or when other conditions co-occur.

Currently, there is not a valid standardized assessment tool for the diagnosis of reactive attachment disorder, although many symptom checklists – which have not been validated and include behaviors inconsistent with any accepted classification system – can be found on the Internet. RAD is often confused with other neuropsychiatric and behavioral disorders that share symptoms or are co-morbid with RAD, leading to over- and under-diagnosis. These include:
- Autism spectrum disorders.
- Pervasive developmental disorders.
- Childhood schizophrenia.
- Attention deficit/hyperactivity disorder (ADHD).

- Post-traumatic stress disorder (PTSD).
- Oppositional defiant disorder.
- Conduct disorder.
- Social phobia.
- Genetic syndromes.

Delays in language development and stereotypical behaviors, often found with RAD, also resemble pervasive developmental disorder. One of the most significant differences is that in contrast to the other disorders, children with reactive attachment disorder can achieve significant improvement when placed with stable, nurturing caregivers. (Mukaddes, et.al. 2000). Also according to the ICD-10, children with RAD have normal social capacity, despite inadequate language development, if symptoms of autism are not present; there are no severe cognitive deficits present that are resistant to changes in the environment (like autism); and there are no restricted areas of interest or resistant, persistent or repetitive stereotypical behavioral patterns. (World Health Organization, 1992).

Other diagnostic classifications

One of the problems with the RAD diagnosis is that it doesn't adequately align with the primary feature of attachment behavior, a child's act of seeking proximity to a caregiver during distress. (Allen, 2011). That is not to say that all variances in attachment behavior are pathological. Some researchers have proposed alternative diagnostic criteria for a broader range of attachment disturbances, including disorders of nonattachment, secure base distortions and disorders of disrupted attachment. (Zeanah & Boris, 2000; Boris, et.al., 1998; Zeanah, et.al, 1993). Until this is resolved and there are acceptable alternatives, practicing clinicians may diagnose children with RAD who do not fully meet diagnostic criteria for the disorder (Chaffin, et.al, 2006).

Recognizing the need for a systematic, developmentally based approach to developmental and mental health difficulties in children under 4 years old, Zero To Three, the National Center for Infants, Toddlers, and Families, established a diagnostic classification task force in 1987. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3).(Zero To Three, 2005) was designed to complement, not replace existing diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-III-R, 1987) and the International Classification of Diseases of the World Health Organization (ICD 9). The goal was to fill gaps in current systems and to advance professional communication and clinical research into adaptive and maladaptive behaviors of infancy and early childhood.

Deprivation Maltreatment Disorder

Deprivation Maltreatment Disorder is a formal mental health diagnosis given to an infant or toddler by a licensed mental health professional using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R).

According to the DC: 0-3R Revised Edition (2005), deprivation maltreatment disorder occurs in the context of deprivation or maltreatment including persistent or severe parental neglect or documented physical or psychological abuse. This does not imply that all children who are neglected or abused will exhibit this disorder. It may occur:

- If the child has limited opportunity to form selective attachments because of frequent changes in primary caregiver(s) or marked unavailability of an attachment figure.
- When child is seriously neglected (such as with parents who are severely depressed or substance abusers).
- Deprivation maltreatment disorder is characterized by markedly disturbed, developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection or nurturance.

There are three patterns:
1. **Emotionally withdrawn or inhibited** – Child rarely or minimally seeks comfort in distress; responds minimally to comfort; has limited positive affect and excessive levels or irritability, sadness or fear; reduced or absent social and emotional reciprocity (e.g., reduced affect sharing, social referencing, turn-taking and eye contact).
2. **Indiscriminate or disinhibited** – Child is overly familiar around unfamiliar adults; fails, even in unfamiliar settings, to check back with adult caregivers after venturing away; and exhibits a willingness to go off with an unfamiliar adult with minimal or no hesitation.
3. **Mixed pattern** – Requires evidence of two or more behaviors from the first two pattern types. This type persists and is much harder to treat.

The DC: 0-3 is a multi-axial system of five axes. Clinicians diagnosing children with deprivation maltreatment disorder should also list current caregiving relationships on Axis II and psychosocial and environmental stressors under axis IV. Two tools that can be used to evaluate

relationships on Axis II are: The Parent-Infant Relationship Global Assessment Scale (PIR-GAS) and the Relationship Problems Checklist.

The Parent-Infant Relationship Global Assessment Scale (PIR-GAS) is used to assess and describe the quality of caregiving-child relationships on Axis II and offers a wide range of scores that are categorized as either adapted (81-100), features of a disordered relationship (41-80) or disordered relationship (0-40). These include:
- 91-100 Well adapted.
- 81-90 Adapted.
- 71-80 Perturbed.
- 61-70 Significantly perturbed.
- 51-60 Distressed.
- 41-50 Disturbed.
- 31-40 Disorder.
- 21-30 Severely disordered.
- 11-20 Grossly impaired.
- 0-10 Documented maltreatment.

Implications for practice: assessment

Despite years of clinical scientific study, there is still much that we need to learn about attachment and its implications for clinical practice. There is a dearth of misinformation about attachment and problems attributed to disrupted or unhealthy attachment in early childhood. What we do know for sure is that all children do not develop the same or have the same outcomes, even though their early experiences may

be similar. For example, exposure to life events considered risk factors does not mean that the child who experiences these events is destined to develop clinically significant problems. Likewise, there are degrees of insecure attachment most of which doesn't lead to social emotional or developmental problems warranting treatment.

APSAC recommendations: assessment and diagnosis

Despite widespread misinformation and insufficient scientific research concerning the benefits and risks of interventions, attachment therapies have became increasing popular, particularly with maltreated children in foster care and adoptive homes. Concerned about potentially harmful techniques used by certain therapists, the Professional Society on the Abuse of Children (APSAC) convened the Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems (Chaffin, et.al, 2006). The task force report established APSAC's position, including practice recommendations, and was endorsed by the American Psychological Association (2006). Recommendations specific to the diagnosis and assessment of attachment problems include:
- Assessment should include information about patterns of behavior over time, and assessors should be cognizant that current behaviors may simply reflect adjustment to new or stressful circumstances.
- Cultural issues should always be considered when assessing the adjustment of any child, especially in cross-cultural or international placements or adoptions. Behavior appearing deviant in one cultural setting may be normative for children from different cultural settings, and children placed cross-culturally may experience unique adaptive challenges.
- Assessment should include samples of behavior across situations and context. It should not be limited to problems in relationships with parents or primary caretakers and instead should include information regarding the child's interactions with multiple caregivers, such as teachers and day care providers, and peers. Diagnosis of RAD or other attachment problems should not be made solely based on a power struggle between the parent and child.

- Assessment of attachment problems should not rely on overly broad, non-specific or unproven checklists. Screening checklists are valuable only if they have acceptable measurement properties when applied to the target populations where they will be used.
- Assessment of attachment problems requires considerable diagnostic knowledge and skill to accurately recognize attachment problems and to rule out competing diagnoses. Consequently, attachment problems should be diagnosed only by a trained, licensed mental health professional with considerable expertise in child development and differential diagnosis.
- Assessment should first consider more common disorders, conditions and explanations for behavior before considering rarer ones. Assessors and caseworkers should be vigilant about the allure of rare disorders in the child maltreatment field and should be alert to the possibility of misdiagnosis.
- Assessment should include family and caregiver factors and should not focus solely on the child.
- Care should be taken to rule out conditions such as autism spectrum disorders, pervasive developmental disorder, childhood schizophrenia, genetic syndromes or other conditions before making a diagnosis of attachment disorder.
- Diagnosis of attachment disorder should never be made simply based on a child's status as maltreated, as having experienced trauma, as growing up in an institution, as being a foster or adoptive child, or simply because the child experienced pathogenic care. Assessment should respect the fact that resiliency is common, even in the face of great adversity.

Intervention and treatment

Interventions to address attachment problems, including reactive attachment disorder, fall into two categories: attachment research-based interventions and attachment therapies. Several therapeutic ingredients seem to be important in the treatment of RAD and DSED. When caregivers provide these ingredients, the child may experience healthy dependency, come to rely on someone, and begin trust a

new person. In other words, the child may become attached. These therapeutic ingredients include the following:
- Security.
- Stability.
- Sensitivity.

Attachment research-based interventions use recognized, standardized and validated diagnostic criteria to guide diagnosis. However, actions that are considered attachment therapies often describe behaviors characteristic of other disorders or in some cases not a part of any recognized diagnostic system. For example, one attachment disorder symptoms checklist includes behaviors that are either not characteristic of RAD or are more descriptive of the caregiver's behavior instead of the child's. Items on this list include "not affectionate on parent's terms (not cuddly)"; "cruelty to animals"; "parents appear hostile and angry"; and "persistent nonsense questions and chatter" (Thomas, n.d.).

Attachment therapies conceptualize a child's behavior in terms of the child's internal pathology and past caregivers instead of the current environment and relationships. These controversial attachment therapies emphasize the child's resistance to attachment and the need to work through the deeply rooted rage that resulted from adverse experiences (maltreatment, loss, adoptions, changes in child care and so on) in early childhood (Chaffin, et.al., 2006).

In contrast, evidenced-based interventions are designed to affect the child's attachment pattern by focusing on caregiver patterns of behavior and thinking. This is in line with the research by Ainsworth and others because it indicates it is the quality of caregiver sensitivity that most influences attachment security. In a review by Bakermans-Kranenburg et.al, (2003) of more than 70 studies, interventions designed to increase parental sensitivity were the most effective. These

interventions focused on the parent-child relationship and teaching positive parenting skills. Other characteristics resulting in outcomes that are more successful were those interventions that were shorter term, more focused and goal-directed. Based on research to date, Zeanah and Smyke (2009) identify the following practice implications:

- The first priority of treatment is to establish a safe and stable caregiving environment with a warm and consistent caregiver.
- Carefully assess the relationship between the primary caregiver and child. Does the child have an attachment relationship?
- If not, treatment begins by helping the child establish one with a caregiver who can be emotionally available, sensitive and responsive; values the child as a unique individual; and can place the needs of the child above his or her own.
- If the child has an established attachment relationship, what is the quality of that connection? The goal in this case is to enhance and reduce maladaptive qualities in the relationship.
- Treatment can be conducted with the caregiver or with the caregiver and child, but it is essential that the relationship between them is the focus.
- The chief goal of treatment is helping the child learn, through repeated interactions with the adult caregiver, that the caregiver can be relied upon to provide comfort, support, nurturance and protection.
- Additional problems such as cognitive and language delays, post-traumatic symptoms or aggression should be addressed with other appropriate interventions.

Child-parent psychotherapy (CPP)

Child-parent dyadic psychotherapy was developed by Alice Lieberman and associates from "infant-child psychotherapy," a psychoanalytic approach to treating disturbed infant-parent relationships. Both approaches identify the "patient" as the child-parent relationship. Child-parent psychotherapy integrates insight-oriented psychotherapy, psychodynamic, developmental, trauma, social learning and cognitive behavioral theories into its attachment-focused approach. In addition to the focus on the parents' early relationships, the intervention also addresses current life stresses and cultural values.

Child-parent dyadic psychotherapy focuses on safety, affect regulation, improving the child-caregiver relationship, normalization of trauma related response, and joint construction of a trauma narrative. The goal of child-parent psychotherapy is twofold: 1) improve the parent-child relationship, and 2) return the child to the appropriate level of social-emotional functioning and developmental course. Child-parent psychotherapy incorporates a variety of treatment modalities, including assistance with problems of daily living and modeling appropriate

protective behavior; interpretation and unstructured developmental guidance; and play as a core modality. (Lieberman & Van Horn, 2004). Because the focus is to help parents interpret the child's responses to them from a developmental perspective, a thorough understanding of child development is essential to this approach.

Child-parent psychotherapy is one of the few empirically validated interventions for traumatized children under age 6. According to the National Child Traumatic Stress Network (n.d.), there have been three randomized control trials of child-parent psychotherapy with trauma-exposed children. In addition, four published studies provide support for the efficacy of relationship-based models with at-risk samples, including anxiously attached dyads and children of depressed mothers, with improvement in attachment security, maternal empathy and goal-corrected partnerships. NCTSN also reports that the treatment is flexible and allows for the incorporation of a discussion of cultural values and culture-related experiences. And it appears to be well accepted by clinicians.

Interaction guidance

Interaction guidance (McDonough, 2004) is also another dyadic therapy designed for families overburdened by barriers and problems – such as poverty, lack of education, large family size, substance abuse, inadequate housing and lack of social support – and who have not been successfully engaged in treatment previously. Interaction guidance therapy helps families enjoy and understand their child's

behavior through interactive play. Parents view their videotaped play interactions, reflect and discuss what is observed. The parent's interactive strengths are emphasized and praised. Discussion about interaction challenges may also become a focus of treatment. (Stafford & Zeanah, 2006).

Circle of Security

The Circle of Security project is an educational and group parent psychotherapy protocol developed by Glen Cooper, Kent Hoffman and Bert Powell (2002), designed to shift problematic or at-risk patterns of attachment-care-giving interactions to a more appropriate developmental pathway. A major goal of the Circle of Security project is to develop a theory- and evidence-based intervention protocol that can be used in a partnership between professionals trained in scientifically based attachment procedures and appropriately trained community-based practitioners.

The Circle of Security (COS) protocol is based on contemporary attachment and developmental theories and affective neuroscience. Interventions, according to Cooper, et.al, (2000) are based on the following core constructs:

- Learning (including therapeutic change) occurs from within a secure base relationship.
- The quality of the parent-child attachment, which is amenable to change, plays a significant role in the life trajectory of the child.

- Interventions need to be based on a differential diagnosis that is informed by research-based theory.
- Lasting change comes from parents developing specific relationship capacities instead of learning techniques to manage behaviors.

The capacities needed for a secure relationship include:
- Observational skills informed by a coherent model of children's developmental needs.
- Reflective functioning and the ability to enter into reflective dialogue.
- The ability to engage with children in the regulation of their emotions.
- Empathy.

Before treatment, there is an initial assessment using the strange situation procedure, (Ainsworth, et.al., 1978), observations, a videotaped interview using two validated assessment tools and caregiver questionnaires about the child. The child's attachment pattern is classified as well as the caregiver's attachment strategy (secure/secure, dismissing/avoidant, preoccupied/ambivalent and unresolved/disorganized).

COS is a collaborative, visually based approach (with extensive use of both graphics and edited videotapes of their interactions with their children) to helping parents better understand, both cognitively and emotionally, the needs of their children. The group circle serves as a graphic representation of the child's needs and attachment system, with the caregiver serving as the safe haven. In a common-sense fashion, it can be used in a variety of settings, including group, family

therapy or home visitation. The group protocol involves a 20-week parent education and psychotherapy intervention. All learning centers on the following themes:
- Teaching the basics of attachment theory via the Circle of Security.™
- Increasing parent skills in observing parent-child interactions.
- Increasing capacity of the caregiver to recognize and sensitively respond to children's need to move away to explore and to move back for comfort and security.
- Supporting a process of reflective dialogue between clinician and parent to explore both strengths and areas of parent difficulties (i.e., being "bigger, stronger, wiser and kind"; supporting exploration; and supporting attachment).
- Introducing parent to a user-friendly way to explore the caregiver's miscued defensive strategies.

Therapy is individualized based on each dyad's attachment-caregiver pattern. Common misattunements are explored, and alternative strategies provided. For example, a caregiver with an insecure/dismissing adult attachment pattern whose child has an avoidant pattern will often "overfocus" on the child's exploration to avoid activation of the child's attachment behavior (such as distress about an impending separation or at the time of reunion). For a preoccupied parent with a resistant/ambivalent child, the moment to focus on might be just the opposite, (that is, a moment on the videotape when the child engages in competent, independent exploration when not distressed.).

About attachment therapy

"Attachment therapy" is a term informally used to describe treatment for reactive attachment disorder. Attachment therapy practitioners and advocates frequently report that it is more effective than traditional therapies despite the lack of a coherent rationale and any meaningful empirical evidence. (Stafford & Zeanah, 2009). Because there is no officially recognized and quantified entity called "attachment therapy," definitions differ based on the practitioner or group doing the defining.

The Association for Treatment and Training in the Attachment of Children (ATTACh) is an international coalition of practitioners and families hoping to raise public awareness about the role of attachment in humans and the benefits of attachment therapies. ATTACh believes that addressing the internal beliefs that drive these behaviors is the proper stance for attachment-focused treatment, contrary to research findings supporting a focus on the relationship between child and caregiver.

In recent years, this group has sought to clearly redefine "attachment therapy" and defend it from charges that it is harmful to children after the highly publicized death of 10-year-old Candace Newmaker, who was being treated for reactive attachment disorder with a type of holding therapy referred to as "rebirthing." (Crowder & Lowe, 2000; Janofsky, 2001).

While ATTACh continues to strongly support and endorse non-traditional attachment therapy, it has taken steps to distance itself from more coercive forms of treatment, including posting a "White Paper on Coercion in Treatment" on its website (ATTACh Board of Directors, 2007).

Currently, ATTACh promotes a definition of attachment therapy as one that "denotes the focus of the therapeutic process rather than a specific intervention technique" and identifies the goal of attachment therapy as enabling "the person to form secure, reciprocal relationships that the person can heal from the trauma and other psychological disorders such as anxiety and depression caused by, or made worse by, the disruption of early attachment." The focus of attachment therapy is twofold, according to ATTACh:

"The first is to build a secure emotional attachment between the child and caregiver (or in the case of an adult in therapy, building the attachment between the client and the therapist). Once the person is able to make use of a trusting relationship to learn new information and skills, the focus then shifts to healing the psychological, emotional and behavioral issues that develop as a result of the parent-child disruption and/or early trauma." For those issues, ATTACh advocates the use of a variety of treatment interventions including those based on behavioral, cognitive and psychodynamic theory.

Holding therapy

Proponents of this treatment and other controversial therapies believe that most children with RAD usually experience extreme feelings of anger. They also believe that all children with RAD have control issues and trust issues and problems developing a conscience. Parents are encouraged to establish control so they can achieve relief from the anger, manipulations and other disturbing behaviors and thus be able to provide the safe, compassionate care essential to bonding. However, attachment therapy practitioners report that attachment between the child and caregiver versus anger control is the primary goal of therapy. Practitioners also believe that once the child is bonded, other changes in behavior will occur simultaneously (Buenning, n.d.).

Although the term "holding therapy" was used more in the past in reference to specific type of intervention, it is currently recognized by ATTACh and others in the attachment therapy community as "a technique which can be one part of a more comprehensive treatment for attachment issues during which other supportive therapeutic techniques may be utilized. Essential components include eye contact, appropriate touch, empathy and genuine expression of emotion, nurturance, reciprocity, safety and acceptance. While a variety of holding positions can be used, the physical safety of the client is the primary consideration".

Rage-reduction therapy

Like holding therapy, the description for rage reduction therapy has also undergone a public relations face-lift in recent years. Currently the term "rage reduction" refers to a therapeutic goal, not a specific technique. Reducing the client's rage in order to facilitate more adaptive emotional regulation, cognitive processing and relational capacity may be a goal of attachment therapy. In the early years of attachment work, the phrase referred to a confrontational and physically intrusive technique developed by Robert Zaslow used to elicit rage in order to reduce resistance and thereby facilitate the healing of the child (ATTACh, 2007; Zaslow, 1975).

Rebirthing

Rebirthing is the name of an intervention that is often associated with holding therapies (and one that many in the attachment therapy community now are hoping to distance and distinguish their therapies from). It is based on the theory that one of the major issues children need to resolve is trauma from around the time of birth. The state of Colorado made this procedure illegal after the death of several children, most notably 10-year-old adopted girl Candace Newmaker, who suffocated after she was wrapped in a flannel sheet for more than an hour to simulate birth – or ''rebirthing''.

The law was enacted midway through the trial of two therapists who treated Candace and were charged with child abuse resulting in death. The unlicensed therapist and practice owner, whom the therapists assisted, was also charged with unlicensed practice of psychotherapy, criminal impersonation and falsifying documents in addition to child abuse resulting in death. The adopted mother was also charged in the death of her daughter. (Lash, 2001; Crowder & Lowe, 2000).

Candace, the adopted daughter of Jeane Newmaker, was being treated for reactive attachment disorder and the inability to form a loving bond with her adoptive mother. Her biological mother lost custody of her to North Carolina state officials over issues of neglect. The expectation of the two therapists was that by pushing against Candace with sofa pillows from the outside to simulate contractions, she would fight her way out of the sheet, as if emerging from a womb, and form a close attachment with Ms. Newmaker. (Crowder & Lowe, 2000).

APSAC recommendations: intervention and treatment

The Professional Society on the Abuse of Children's (APSAC) Task Force on Attachment Therapy, Reactive Attachment Disorder and Attachment Problems (2006) recommends the following on treatment and interventions:

- Treatment techniques or attachment parenting techniques involving physical coercion, psychologically or physically enforced holding, physical restraint, physical domination, provoked catharsis, ventilation of rage, age regression, humiliation, withholding or forcing food or water intake, prolonged social isolation, or assuming exaggerated levels of control and domination over a child are contraindicated because of risk of harm and absence of proven benefit and should not be used. *(This recommendation should not be interpreted as pertaining to common and widely accepted behavior management approaches used within reason, such as time-out, reward and punishment contingencies, occasional seclusion or physical restraint as necessary for physical safety, restriction of privileges, "grounding," offering physical comfort to a child and so on).*
- Prognostications that certain children are destined to become psychopaths or predators should never be made based on early childhood behavior. These beliefs create an atmosphere conducive to overcorrection and harsh or abusive treatment. Professionals should speak out against these and similar unfounded conceptualizations of children who are maltreated.
- Intervention models that portray young children in negative ways, including describing certain groups of young children as pervasively manipulative, cunning or deceitful, are not conducive to good treatment and may promote abusive practices. In general, child maltreatment professionals should be skeptical of treatments that describe children in pejorative terms or that advocate aggressive techniques for breaking down children's defenses.
- Children's expressions of distress during therapy should always be taken seriously. Some valid psychological treatments may involve transitory and controlled emotional distress. However, deliberately seeking to provoke intense emotional distress or dismissing children's protests of distress is contraindicated and should not be done.
- State-of-the-art, goal-directed, evidenced-based approaches that fit the main presenting problem should be considered when selecting a first-line treatment. Where no evidence-based option exists or where evidence-based treatment options have been exhausted, alternative treatments with sound theory foundations and broad clinical acceptance are appropriate. Before attempting novel or highly conventional treatments with untested benefits, the potential for psychological or physical harm should be carefully weighed.
- First-line services for children described as having attachment problems should be founded on the core principles suggested by attachment theory, including caregiver and environmental stability, child safety, patience, sensitivity, consistency and nurturance. Shorter term, goal-directed, focused, behavioral interventions targeted at increasing parent sensitivity should be considered as a first-line treatment.
- Treatment should involve parents and caregivers, including biological parents if reunification is an option. Fathers and mothers should both be included if possible. Parents of children described as having attachment problems may benefit from ongoing support and education. Parents should not be instructed to engage in psychologically or physically coercive techniques for therapeutic purposes, including those associated with any known child deaths.

Additional ethical considerations: advertisement of treatment services

Clinicians in private practice and practice groups educate the public about their services and the issues affecting their clients through a variety of methods: public seminars, written and Internet advertising, blogs, and more. Most are also guided by their profession's ethical code of conduct for competent practice and truthful representation of credentials and services. For example, the National Association of Social Workers Code of Ethics (2008) requires that social workers:

- Base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.
- Should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation and supervision) to ensure the competence of their work and to protect clients from harm when generally recognized standards do not exist in an emerging area of practice.
- Ensure that their representations to clients, agencies and the public about professional qualifications, credentials, education, competence, affiliations, services provided or results to be achieved are accurate.

- Give thorough, accurate information about the service so clients may weigh the benefits and risks of treatment.
- Protect research participants from unwarranted physical or mental distress, harm, danger or deprivation.
- Do not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

Several concerns expressed about practitioners who use and promote controversial attachment therapies (or other flavors of the month) is that these therapies have been developed outside of the scientific community, and literature promoting the efficacy of these therapies hasn't undergone independent peer review. The information is widely distributed to parent groups, the public and other clinicians as self-published website material. Because of ethical concerns about how some of these services are advertised, the ASPAC Task Force on

Attachment Therapy, Reactive Attachment Disorder and Attachment Problems (2006) included the following recommendations in its report:
- Claims of exclusive benefit (i.e., that no other treatments will work) should never be made. Claims of relative benefits (e.g., that one treatment works better than others) should only be made if there is adequate controlled trial scientific research to support the claim.
- Use of patient testimonials in marketing treatment services constitutes a dual relationship. Because of the potential for exploitation, the task force believes that patient testimonials should not be used to market treatment services.
- Unproven checklists or screening tools should not be posted on websites or disseminated to lay audiences. Screening checklists known to have adequate measurement properties and presented with qualifications may be appropriate.
- Information disseminated to the lay public should be carefully qualified. Advertising should not make claims of likely benefits that cannot be supported by scientific evidence and should fully disclose all known or reasonably foreseeable risks.

Attachment theory and social services practice

In addition to clinical interventions, attachment theory has also influenced other aspects of social services, medicine and law. For example, the assessment of attachment is increasingly a crucial component in termination of parental rights (TPR) cases. The purpose of "bonding evaluations" is to assess the nature and degree of attachment between a child and his or her birth parents and foster parents (or other caregivers): (Barone, et.al. 2005).

Additional ways attachment theory has changed how social service practitioners and programs work include (Landy, 2009):
- Using family-friendly practices during and immediately after childbirth, such as providing birthing centers, allowing fathers to be with their partners throughout labor and delivery, and having newborn infants room-in with their mothers.
- Providing extended visiting hours for parents visiting children in the hospital.

- Preferring the use of foster families instead of institutions for children who are without parents or in protective care.
- Making efforts to keep children with natural parents or extended family whenever possible, and if not, trying to ensure continuity of care and to avoid repeated moves and foster care placements for the child.
- Promoting increased understanding of the effects of loss and the stages of grieving in young children.
- Considering the contribution of parent-child interactions and relationships in the etiology of emotional, social or behavioral problems in infants, children and adolescents.
- Paying attention to interpersonal issues rather than only internal conflicts of children and adults in therapy.

APSAC recommendations: child welfare

Recognizing the particular vulnerability of children in the child welfare system to misinformation about attachment issues and questionable interventions and practices, The Professional Society on the Abuse of Children's (APSAC) Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems (2006) recommends the following:
- Treatment provided to children in the child welfare and foster care systems should be based on a careful assessment conducted by a qualified mental health professional with expertise in differential diagnosis and child development. Child welfare systems should

guard against accepting treatment prescriptions based on word-of-mouth recruitment among foster caregivers or other lay individuals.
- Child welfare systems should not tolerate any parenting behaviors that normally would be considered emotionally abusive, physically abusive or neglectful simply because they are alleged to be part of attachment treatment. For example, withholding food, water or toilet access as punishment; exerting exaggerated levels of control over a child; restraining children as a treatment; or intentionally provoking out-of-control emotional distress should be evaluated as suspected abuse and handled accordingly.

Summary

Attachment is a developmental achievement that lays the foundation for future social-emotional development. From research, we know that young children normally form strong attachments with one or two primary caregivers and that the ability of the caregiver to consistently provide sensitive and responsive care determines the quality of attachment. Internal working models represent emotions and expectations resulting from a child's interactions with his or her

parent or caregiver and determine whether the child develops secure or insecure and organized or disorganized attachments. However, the quality of attachment can vary over time depending on circumstances, and there are researched and evidence-based interventions and programs to help children form strong, secure attachments if this has been lacking in their early development.

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1. Research on the effects of _____ revealed that the quality of care played a more important role than the separation alone and that a small group of consistent, reliable, affectionate and attentive caregivers could promote healthy development in children.
   a. Parenting styles.
   b. Abuse and neglect.
   c. Learning techniques.
   d. Culture.

2. Children who are preoccupied with their caregiver, yet ambivalent, characterize this pattern:
   a. Attachment style A: Insecure-avoidant.
   b. Attachment style B: Secure/balanced.
   c. Attachment style C: Insecure-ambivalent/resistant (also called anxious/resistant).
   d. Attachment style D: Disorganized/disoriented.

3. _____ typically begins before age 5, usually starting in infancy, and affects both boys and girls.
   a. Oppositional defiant disorder.
   b. Reactive attachment disorder.
   c. Attention deficit disorder.
   d. Obsessive-compulsive disorder.

4. The primary defining feature of _____ is a person's pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers.
   a. Reactive attachment disorder.
   b. Attention deficit disorder.
   c. Disinhibited social engagement disorder.
   d. Oppositional social disorder.

5. RAD is often confused with other _____ disorders that share symptoms or are co-morbid with RAD, leading to over- and under-diagnosis.
   a. Neuropsychiatric and behavioral.
   b. Medical.
   c. Personality.
   d. Anxiety.

6. _____ is a formal mental health diagnosis given to an infant or toddler by a licensed mental health professional using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R).
   a. Developmental Mental Disorder.
   b. Deprivation Maltreatment Disorder.
   c. Attachment Bonding Disorder.
   d. Attachment Maltreatment Disorder.

7. Attachment therapies conceptualize a child's _____ in terms of the child's internal pathology and past caregivers instead of the current environment and relationships.
   a. Thoughts.
   b. Behavior.
   c. Perception.
   d. Verbalization.

8. Child-parent dyadic psychotherapy focuses on safety, affect regulation, improving the child-caregiver relationship, _____ of trauma related response, and joint construction of a trauma narrative.
   a. Reduction.
   b. Elimination.
   c. Avoidance.
   d. Normalization.

9. The Circle of Security project is an educational and group parent psychotherapy protocol designed to shift problematic or at-risk patterns of attachment-care-giving interactions to a more appropriate _____pathway.
   a. Developmental.
   b. Cultural.
   c. Educational.
   d. Alternative.

10. _____ is the name of an intervention that is often associated with holding therapies.
    a. Rage relief.
    b. Rebirthing.
    c. Anger avoidance.
    d. Behavior analysis.

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