Attachment Theory and 'Attachment Therapy'

L. Alan Sroufe, PhD &
Martha F. Erickson, PhD
University of Minnesota
with William N. Friedrich, PhD, ABPP

Eminent attachment theory researchers Sroufe and Erickson have answered some critical questions (developed by colleagues) to help advance caregiver and therapeutic interventions with and treatment of children in cases involving maltreatment, unresolved trauma, attachment disorders, and the like.

1. Foster Cline, a principal figure in "attachment therapy," has created his own criteria for attachment disorders. Do attachment disorders exist?*

(L.A.S.) I think there are children whose attachment capacities are so compromised that the term attachment disorder applies. The most appropriate criteria are the ones elaborated by Charles Zeanah and his colleagues (Zeanah & Boris, 2000). However, I have a number of problems with the concept, separate from the absence of any independent reports that substantiate its reliability and validity. Many children who have attachment problems do not qualify for attachment disorder. However, they receive this diagnosis because of underlying attachment problems. What I dislike most about Cline's work is that I firmly believe that the majority of the children he calls "unattached" are attached. Bowlby wrote that attachment is an instinctual process (Bowlby, 1982). It is going to happen, although the form it takes may not be optimal to the child.

(M.F.E.) Children may be misjudged as "unattached" because they protect themselves from further rejection by acting as if they don't care. For example, during separations from their attachment figure (as in the Ainsworth Strange Situation procedure), their heart may beat faster, indicating emotional distress, but behaviorally they do not exhibit signs of upset. And when their caregiver returns after the separation, these children, rather than looking relieved or happy, may turn away or crawl away. It is almost as if they're rejecting the caregiver before this individual has a chance to reject them again. They have adapted to the caregiver's emotional unresponsiveness in a way that makes sense, but ultimately it becomes difficult for these children to engage positively with others as they get older and move into the larger social world.

2. Is there a distinction between attachment disorders and the effects of maltreatment?

(L.A.S.) Although it is true that the majority of maltreated infants and toddlers are insecurely attached (Cicchetti & Toth, 1995) and that a significant number of maltreated children have disorganized attachment, the majority of maltreated children do not qualify for an attachment disorder diagnosis, whatever the criteria.

(M.F.E.) If a child meets diagnostic criteria for attachment disorder, it's fair to say that the child has experienced maltreatment of one form or another. However, as Alan says, many maltreated children do not meet criteria for attachment disorder. The consequences of maltreatment can take many forms.

3. Is there a causal relationship between maltreatment, attachment insecurity, and sociopathy?

(L.A.S.) There is a rather sizable link between maltreatment and disorganized attachment. There is also a link between avoidant attachment and disorganized attachment, on the one hand, and later conduct problems as well as a lack of empathy, on the other (Troy & Sroufe, 1987). Because of these connections, I would say there is a developmental relationship. However, it is now widely understood that singular, linear causes will rarely be obtained. Individual risk factors are seldom that powerful, and when they are, typically they are surrogates for multiple influences (Cicchetti & Sroufe, 2000).

(M.F.E.). I agree with Alan's comments.

4. Is there a method to assess attachment quality that can be used in the typical clinical setting (separate from the Adult Attachment Interview and the Strange Situation)?

(L.A.S.) No valid method is available at this time.

(M.F.E.) I would say, however, that clinicians who are well educated in attachment theory and research—and who understand how to watch the "dance" that goes on between a parent and a baby—often can tell a lot about the quality of attachment through observation. Things to watch for are a parent's sensitivity to infant cues, how the child seeks and accepts comfort from the parent at times of distress, and how the child uses the parent as a secure base. I would be extremely cautious about drawing categorical conclusions based on these observations, especially for purposes of making major decisions, such as custody or placement. But, from an interventionist perspective, these observations can be very helpful in knowing how to work with the parent and child to move toward better competence and well-being.

5. Are there some specific treatments or interventions that can positively affect the quality of attachment? If not, what are the elements of an intervention that attachment theory would suggest?

(L.A.S.) There is a developing literature on this topic. For example, Patricia Sable (1995) has written an article on the use of pets and facilitating the attachment process at various stages of the life cycle. She also has a recent book (2001) that integrates attachment theory and psychotherapy with adults.

In his book, *The Making and Breaking of Affectional Bonds*, Bowlby (1979) reformulated the psychoanalytic principles of therapy into four attachment theory-related suggestions of his own. The following principles primarily apply to therapy with adolescents and adults:

1) Take the reported experience of the person seriously. For example, trust the patient that the problems they report to you arise from actual experience and are not the function of fantasy;
2) Treat human expressions of need and worry, which can arise over interruptions or separations in the therapy process, as normal and not as indicative of weakness. Rather, they provide

patients an opportunity to examine and then correct their subsequent relationships;

3) Provide a secure base within which the person can freely explore needs and feelings and reach his or her own conclusions; and

4) Focus the therapy on the details of how their parents behaved towards them, not only when younger but also presently.

All of this takes time. There are no quick fixes to deep attachment problems. In fact, in his book, *A Secure Base*, Bowlby wrote that treating such deeply distrustful people is comparable to trying to make friends with a shy or frightened pony; both situations require prolonged, quiet, and friendly patience (Bowlby, 1988).

(M.F.E.) To elaborate, I think there are promising strategies for working with the parent-child relationship to enhance parental sensitivity, which over time can enable the child to develop greater security. For example, in our own preventive intervention work (e.g., the STEEP™ program, i.e., "Steps Toward Effective, Enjoyable Parenting"), we videotape parent-infant interaction and then watch the tape with the parent, using questions to help the parent recognize his or her own strengths and understand the meaning of the baby's behavior and cues. (We call this the Seeing Is Believing™ approach and have trained professionals in the United States and abroad how to incorporate this strategy into their work with families having a variety of risk factors or identified problems.) Then, through both home visits and groups, we work with the parents to identify and address the factors that support or hinder them in responding sensitively to their baby day after day.

I think this kind of approach could be very helpful to adoptive parents whose child has difficulty forming an attachment because of trauma prior to adoption. It can be terribly frustrating for adoptive parents to give so much and get so little in return. But, with supportive intervention at the very beginning, perhaps they can understand and overcome the difficult behaviors their child presents. There is a need for careful, long-term study of such interventions that are grounded in attachment theory and research, especially with special populations, such as families who have adopted older infants from abroad.

For older children, I think the treatment challenge is to help them develop new models of self and other. This involves therapy with someone who can be a "secure base," to use attachment terminology, but it is also a vigorous effort to support parents, extended family, teachers, and recreation workers, who must hang in there with a child even when the child's behavior makes a person want to run the other way. This intention is easy to say and hard to do!

6. Is there a role for arousal and physical contact in therapy with disturbed children? More specifically, if the contact were not coercive, as it is in traditional holding therapy, then might these ingredients be desirable?

(M.F.E.) I'm very cautious about saying anything that would encourage such approaches with these vulnerable children. Everything I've learned about attachment indicates that sensitivity is the pathway to a secure attachment, so I'm uneasy about approaches that are intrusive. I am especially concerned about doing anything with these children that replicates a cycle of violence and control, poking and provoking until the child submits. If some professionals are convinced that arousal approaches are the way to reach these children, then I think those professionals should go out of their way to subject these strategies to rigorous research. And, above all, they should remember, "First, do no harm."

7. There is a debate about the continuity of attachment status over the period of childhood. Does attachment theory account for changes based on environmental and life circumstances?

(L.A.S.) This question always amazes me, because the answer is so clear to developmental researchers. People always think there are only two possible answers: 1) The person carries nothing forward, and all continuity is in the environment, or (2) What happens in infancy permanently scars the person.

Neither of these is a developmental position. No developmentalist believes that the attachment to mother in infancy ineluctably leads to adult personality. We do think it has a special status because it is the first primary attachment. The nature of development is that what is there before is both formative and transformed by later experience. Continuity is complex, because development is not like adding lego pieces. Yes, there should be continuity from infancy, and connections will be specifiable to some degree. Still, the problem is difficult because outcomes are complex products of infancy, toddlerhood, preschool, middle childhood, and adolescence. The experiences of infancy have different meaning depending on what happens later. But what happens later has different meanings, depending on earlier experience.

The idea that continuity is simply dependent on living in a stable environment is too simple. First of all, later environment is in part determined by earlier experience. For example, when children with avoidant histories isolate themselves from others at preschool, they are guaranteed to have a different experience than is had by others even in the same setting. In addition, the differential treatment of children by teachers is predictable from the children's histories.

Second, even similar experiences are interpreted differently (and therefore have different consequences) by different children. Some children will feel rejected when someone does not want to play, and others in the same circumstance do not. This is predictable from history, as are interpretations of hostile intent when none is present. Even the lack of continuity is typically lawful and understood (Weinfeld, Sroufe, & Egeland, 2000).

Third, developmentalists all think children have multiple models. Bowlby (1988) wrote that the child had to develop two principal types of models. One model is that of himself as a child in interaction with each parent. Another model is that of each parent in interaction with himself. How these become integrated is one of the leading developmental questions.

(M.F.E.) Another way of saying this is that infants develop certain behaviors as a natural adaptation to the way they are treated, and those behaviors in turn serve to draw to the child more of the same. This works well for the securely attached child and poorly for the insecurely attached child. Let's say, though, that a wise, sensitive adult comes into the life of the insecure child and repeatedly "contradicts the child's expectations" (i.e., treats him warmly and sensitively despite his off-putting behavior). Or, perhaps the parent becomes much more available and sensitive to the child, through

cont'd on page 6

treatment or a major life change of some sort. It will take awhile for the child's behavior to catch up to this new reality. But, given enough time and persistence, the child most likely will begin to adapt. The earlier this happens in the life of the child, the more quickly and completely the new adaptation is likely to occur. We really don't know the answer to the question "When is it too late?"

8. Some of the children who are referred for "holding therapy" are viewed as budding "psychopaths." Is psychopathy a matter of insecure attachment or is there something missing from the start?

(L.A.S.) Like many developmental questions, this one is not yet fully answered, but I think antisocial personality ultimately will be shown to have roots in early attachment experiences (as well as in later experiences) (Aguilar, Sroufe, Egeland, & Carlson, 2000). We will have adult data on this in two more years.

9. Is there a developmental window after which attachment security is not possible? For example, what is the range of outcomes for a child adopted at the age of 4 or 5 after a life of abuse and neglect while living in an institution? Are there children for whom no intervention can be helpful?

(L.A.S.) This is another question for which there is yet no answer. What Bowlby's theory says is that the longer a pathway is followed, the more difficult it will be to change. A British study of 165 children who were adopted from Romania found that the duration of deprivation was linearly related to the number of signs of attachment disorder. For example, the cluster of children who were still exhibiting indiscriminate sociability at 6 years of age had been deprived twice as long as the cluster of children who exhibited no signs of attachment disorder (O'Connor, Rutter, et al., 2000). It was completely predictable that there would be great difficulty with the Eastern European orphans who were adopted as children. There is likely something vital about having emotional connections in the first years.

(M.F.E.) Please refer to my comments to Question 5.

10. What should be the treatment target with children who evidence disorganized attachment? Should it be 1) the associated maternal history of unresolved trauma; 2) the child's behavior and manageability; or 3) skills to help the parent be more consistent and caring?

(L.A.S.) Absolutely all of the above interventions are needed.

(M.F.E.) I agree wholeheartedly. We need to do everything in our power to address all the factors that support or hinder a parent from providing sensitive care. (And, a parent's state of mind about his or her own attachment history is a big one!) Also, depending on the age of the child, we need to engage others (therapists, teachers, grandparents) in teaching and reinforcing positive behaviors that will, in turn, help the child do his or her part to build and maintain connections with others.

I would add that one does not necessarily do this intervention work once and call it a done deal. As children grow older and develop the capacity to make new meaning of their experience, they may need a"booster shot" to help them along the way. For example, a child who gets on a more positive developmental track at age 3 or 5 or 7 nonetheless may need to reconsider his or her early experience in the teen years, when questions of identity begin to emerge. Typical questions older children may have are "What kind of person must I be if my own parents couldn't even love me?" and "If I'm the biological product of a couple of losers, I must be a loser, too."

Footnote

* The attachment disorders described by Elizabeth Randolph, a frequent trainer in "holding therapy," have five criteria (Randolph, 2001). The first is that the child fails to exhibit five or more normal attachment behaviors, e.g., making long-lasting and intense eye contact, gently touching, hugging, or playing with the primary caregiver. A second criterion reflects a history of disrupted caregiving, e.g., living in an orphanage; and the third criterion is that the child exhibits neurological immaturity, e.g., mid-brain immaturity. (In actuality, the neurological symptoms are measurable only indirectly and via the presence of disturbed behaviors, e.g., if you are hyperactive you must have brain dysfunction.) The fourth criterion includes a potpourri of symptoms, e.g., food hoarding, pathological lying, and inability to keep friends. The final criterion accounts for the overlap between RAD and either 1) conduct disorder or oppositional defiant disorder, or 2) whether the child still qualifies for the attachment disorder diagnosis, as long as there is not mental retardation or a pervasive developmental disorder.

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