Why Caregivers Turn to 'Attachment Therapy' and What We Can Do That Is Better

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It is time that child abuse professionals formally raise concerns about the "attachment therapy" programs that have proliferated across the country. As was noted in the Summer 2002 *APSAC Advisor*, little scientific support exists for the diagnosis of reactive attachment disorder (RAD, as currently conceptualized in the DSM IV-TR), and there is much reason to be concerned about the frequency with which it is applied to maltreated children, especially those in long-term foster care. Further, some therapeutic regimens of this type appear to be based on dubious or outright erroneous interpretations of established psychological principles and carry significant risks for children. The risks are not only the use of coercive techniques that are likely to exacerbate behavior problems rather than ameliorate them, but also the fact that, in at least a handful of cases, therapists or parents have misapplied them and caused the death of children.

At the same time, it is important to examine why attachment therapy has become the treatment of choice with some foster and adoptive parents. One reason why caretakers seek out unconventional or fringe therapies is that conventional approaches have been ineffective in addressing the problems of bringing up these foster and adopted children. Therefore, if we are to successfully discourage participation in risky therapies, acceptable and effective alternatives must be made available.

Behavior Problems of Foster and Adopted Children

Children in long-term foster care and children who are adopted from the child welfare system or other extremely adverse circumstances, such as in the orphanages of some foreign countries, often have significant behavioral problems and impairments in their capacity to form relationships. This is not surprising, considering the factors that must be present for children to be in long-term foster care or to be available for adoption from the child welfare system.

In the first place, these children must have been maltreated in some fashion or have been at high risk for maltreatment to be placed in foster care. It is well established that maltreatment is associated with many emotional and behavioral problems (Horowitz,Widom, McLaughlin, & White, 2001). In addition, when children remain in foster care or become available for adoption, it is because their parents do not agree that they have maltreated their children, are unable or unwilling to correct the conditions that led to placement, or both. Children can readily interpret this parental failure as rejection or abandonment. For example, substance abuse is a common problem in families in which children are not reunified (Dore, Doris, & Wright, 1995). Despite the fact that effective treatments exist for such disorders, many parents do not follow through or they relapse. Children may view this failure as the parent choosing drugs over them. It is also possible, if not likely, that these parents were not responsive to the children as infants, which can lead to children's insecure attachment styles.

The end result is that most of these children will present significant difficulties for foster or adoptive parents. Many are depressed or anxious, but of greater relevance is the presence of externalizing behavior problems in a large percentage of them. They can be defiant, disobedient, aggressive, or delinquent, and they may lie, cheat, and steal. These children often have trouble getting along at school, with peers, or in the community. In addition, some children will suffer from enuresis or encopresis. All of these behaviors are extremely taxing to deal with on an everyday basis. They interfere with family life, require high levels of supervision and parental involvement, and can evoke negative emotional reactions in caretakers (Zeanah, 2000).

The attachment-related behaviors that characterize these children's presentation will further exacerbate the family situation. Instead of being grateful and responsive to caretakers who are providing a potentially loving and safe home, children can be aloof, rejecting, demanding, hostile, angry, manipulative, superficial, or sneaky. Quite understandably, caretakers can feel frustrated, inadequate, or unappreciated. In some cases, they may begin to see the children as intentionally resisting their well-intentioned efforts. It is hard enough to deal with children's serious behavior problems, but the difficulty is dramatically magnified when such behavior co-occurs with a child's impaired capacity to relate to caregivers.

Exacerbating Circumstances

A further complication is that in foster or kinship care situations, the caregiving relationship is explicitly intended to be temporary. Foster parents are cautioned against becoming emotionally invested in long-term relationships with the foster children, because the goal is to return them to their families. It is not considered desirable for children to become too attached to foster parents either, because it might exacerbate ambivalence toward their own parents or produce yet another experience of loss if the placement is not permanent. Even though some children will live with these alternative caregivers for years, foster parents have no legal standing, and their interests in a relationship with the child are essentially irrelevant to case planning. Although the policy interest in reunification is legitimate, it has relational consequences for both children and foster parents. In effect, a situation is created in which there are disincentives and even specific deterrents to establishing close emotional connections. It should not be surprising that this context is not ideal for repairing insecure attachment styles.

Thus, foster parents are often faced with a toxic combination of circumstances. The children have serious behavior problems and disrupted capacities to relate to others. Yet, neither children nor caregivers can approach their relationships as secure or permanent, despite the fact that secure and permanent relationships would be most corrective for the children.

Adoptive parents do not have to remain emotionally distanced from their adopted children, even though they each bring a different set of expectations and hopes in such relationships. However, such parents are not always prepared or able to tolerate the fact that many of these children are older and will continue to feel some loyalty to even the most abusive and rejecting of parents. Adoption may legally make the child their own, but it cannot erase the past or eliminate yearnings that may stand in the way of full commitment to the new parental relationship.

Nevertheless, it is important to remember that not all foster or adoptive situations involve such compromised circumstances. In most cases, foster or kinship care is a temporary situation, just as

intended. The majority of children who are placed out of the home are reunified within a relatively short period. Although most children have some emotional and behavioral problems, these are not always severe. Even so, the majority of maltreated children do have insecure attachment styles (Cicchetti & Toth, 1995). Our concern here is with a subset of situations that is especially trying, one in which parents become desperate for help.

Ineffective Treatment for Troubled Children

Ideally, help is supposed to be available. For example, all foster children are eligible for Medicaid mental health services under Title 19. This means that they can be served at community mental health centers, at community agencies, or by community providers who accept Medicaid. In some states, if the children have been crime victims, counseling may be reimbursed through Crime Victims Compensation programs. In addition, state child welfare departments often provide home-based or family preservation services to help maintain placements, and federal and state laws provide for adoption support. The question then is why these services are not perceived as sufficiently helpful by the caregivers. Why do they instead seek help from attachment therapy programs?

One reason is that traditional child psychotherapy is typically the only resource available. Traditional child psychotherapy might be described as an eclectic mix of supportive, psychoeducational, expressive, and interpretive approaches that are delivered individually. Although these elements have utility, especially in engaging children and in ameliorating internalizing problems such as depression, anxiety, and posttraumatic stress, they are insufficient even for these problems when the conditions are severe. Moreover, traditional approaches do not work for externalizing behavior problems (Kazdin, 2002). It is clear that changes in children's environments and behavioral contingencies are necessary to bring about change in behavior problems.

A second reason why caregivers do not perceive current services as sufficiently helpful is that effective treatments for externalizing behavior problems have been developed and tested in research settings but are not widely used in the real world. These proven treatments are based on behavioral or cognitive behavioral principles and require the participation of caretakers. A central element in assisting parents is to help them understand that negative behaviors persist because they are reinforced in some fashion and that positive behaviors will not ensue unless they also are consistently reinforced. Parents are taught specific skills that include praising positive behavior, ignoring inappropriate behavior, giving effective instructions, and carrying out consequences, such as time out or loss of privileges. They learn the importance of consistency and persistence as necessary ingredients for achieving results. Interventions with children are also skill-based. Children are taught self-control procedures, problem solving, and how to interact appropriately with others to meet needs. These interventions ordinarily involve practice, feedback, and homework as the mechanisms by which the new behaviors are acquired and transferred from the clinic into everyday life.

Barriers to Effective Treatments

Why don't mainstream mental health services deliver these treatments? In part, the explanation rests with the fact that most mental health treatment is delivered by professionals or paraprofessionals who have not received training and who are not supervised in providing these particular interventions. The proven treatments are usually manualized and intended to be applied in a atic way. This kind of approach is not only unfamiliar to many field practitioners but it also runs contrary to beliefs about the flexible and creative application of interventions. Also, practitioners perceive that proven interventions often ignore the complex circumstances of many children and families as well as the frequent crises they experience.

Another complication is the prerequisite that caretakers participate in treatment and be prepared to change the way they respond to the children. It is not hard to see why this becomes an obstacle. Foster and adoptive parents who are willing to take on these very difficult children are doing a great service to the child welfare system. They often get paid a pittance and must accommodate to extraordinarily difficult situations: children who are unrewarding and a burden, the marginalized role of the foster parent in permanency decision making, and the uncertainty of outcome. To expect them, in addition, to attend counseling sessions and to alter their usual parenting practices is a huge demand.

A third reason caregivers may resort to the use of attachment therapy is the absence of a proven treatment for insecure attachment. Many therapists have only a passing familiarity with formal attachment theory. They appreciate the basic concept that attachment theory relates to the capacity to form and maintain secure relationships, but they often reduce this to being "attached" or not. Attachment theory, on the other hand, suggests a universal biological imperative that begins with seeking proximity to a caregiver for survival purposes and that evolves into an adaptive response, resulting from safety and comfort-giving caregiver responses (Bowlby, 1982). For example, when parents are inconsistent, unresponsive, or the source of harm, children adopt relationship strategies that work in these situations. The theory contends that early experiences produce "working models" that are applied to new caregivers. There is evidence that children do transfer their attachment styles to foster parents.

This means that children may enter foster or adoptive families with working models and relationship strategies that were adaptive in their biological families, but are maladaptive or counter productive in new family environments. It seems likely that if professionals are unable to explain why children behave in relationships the way that they do or if those who are most knowledgeable cannot offer ways to change the outcome of such interactions, then alternative caregivers would naturally be confused, hurt, or frustrated.

It is this confluence of circumstances that creates the conditions under which the attachment therapy programs appear to be a godsend to foster and adoptive parents. They offer treatment that is guaranteed to work, is relatively brief, and locates the problems as residing in the children. As with most coercive interventions, including physical punishment, there is often an immediate response by children. When children are afraid, they may comply in the moment, but the real shortcomings of such approaches are eventually revealed in children's resentment and hostility and the impermanence of the therapeutic impact.

Solutions

In order to address this situation, there must be a resolution among the mismatch of several factors: the needs of the children, what is acceptable or perceived as reasonable to foster or adoptive parents, and the services that are typically available. The question then becomes "What changes might be helpful?"

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First, caseworkers must play a key role. For the most part, they know that simply giving children a safe environment in which they are loved will not be sufficient in many cases. These professionals are in a position to educate potential foster and adoptive parents about the problems children may have. If caseworkers increase their understanding of how children develop externalizing behavior problems and insecure attachment styles, they can explain to foster and adoptive parents the children's behaviors and reactions and what may be required for change. As a result, caretakers will need to realize that they may need to participate in therapy, change their parenting approach, and adjust to children's attachment styles if the placement is to be successful.

Second, making more services available and acceptable to caregivers would be helpful. Therapists need to learn and apply the components of effective treatments for externalizing behavior problems. The proven approaches require environmental changes and involve caretakers as change agents (Barkley, 1997). Therefore, it is essential not only to be familiar with the specific strategies that work, but also to know how to engage caretakers in carrying out interventions. For example, motivational interviewing is a strategy that may be productive in bringing caregivers to acknowledge their participation as essential (Miller & Rollnick, 1991). In addition, these treatments usually work best when there is homework, practice and feedback, and consistent application of principles in day-to-day situations. Therapists must be prepared to offer support and reinforcement to caregivers because, without their participation, intervention with children alone is unlikely to make a difference.

In the absence of proven interventions for insecure attachment styles, both caseworkers and therapists can help foster and adoptive parents to appreciate how children's responses to alternative caregivers have an adaptive origin and are not necessarily evidence of pathology. Children whose parents have been inconsistent or unresponsive or a source of pain and hurt will have learned ways of interacting that may be inappropriate with caring parent figures. It will take a long time before these children learn news ways of responding. Alternative caregivers need help in being patient with or even accommodating to these adaptations over the long term.

Attachment-Style Specific Interventions

In addition, caregivers might benefit from learning strategies for how to respond to different types of insecure attachment styles. For example, children whose parents were inconsistently responsive may show insecurity through whiny, clingy, demanding behavior and angry outbursts. These children may best respond to frequent comforting and enthusiastic praise, delivered whenever they are behaving appropriately. Explicit and consistent ignoring of the obnoxious behavior will eventually lead to its extinction. However, it may take many months for results.

In other cases, children have learned not to expect parental responsiveness and have become aloof or indiscriminately responsive to noncaretakers. For these children, it may make more sense for caretakers to be careful not to pressure them for emotional intimacy. It may be more helpful to take a very gradual approach to showing affection and have few expectations for reciprocity. Over time, many children will become more responsive, but in some cases, the caregiver may need to adjust to the child's style.

The attachment style most likely to be discomfiting to caregivers is that of children who have adapted to abusive parents by being sneaky and manipulative, who show little remorse or empathy, or who are superficially emotional. These children are generally seeking to control their environment and avoid punitive reactions. It may be helpful for caretakers to see why this behavior has a survival function and is not necessarily evidence of an emerging psychopathic personality. In such cases, a caregiver strategy of being firm and consistent, but avoiding angry responses, may be most useful. The children may respond best to an environment in which they are given more control and choices within a framework of clear expectations and consequences. Caregivers will often need a great deal of support in handling their own reactions when children appear to be driven primarily by meeting their own needs even at the expense of others.

Enhancing Caregiver and Professional Relationships

Finally, an especially gratifying characteristic of attachment therapy is that caregivers feel very validated and supported by the programs. This is in contrast to the experience that many caregivers have with busy caseworkers and mainstream therapists, who too often do not take the time to regularly check in, offer support, and express appreciation to foster or adoptive parents. The caregivers may feel taken for granted or able to get the help they need only when there is a placement crisis.

Both caseworkers and therapists need to be in regular communication with foster and adoptive parents. In addition to engaging caregivers in the therapeutic process with the children, these professionals should make a point of acknowledging the contribution that alternative caregivers are making. They can also be offered support services, respite care, and consultation in managing ongoing problems.

Summary

In sum, attachment therapy programs have flourished because they fill a need. Caseworkers and therapists serving foster and adoptive children can do better in responding to the burden of caring for these children. Solutions include educating caregivers about the nature of the children's problems, helping them understand what is required for change, and providing effective treatment. Most important, perhaps we will reduce their susceptibility to risky therapies when they experience us as supportive, available resources working collaboratively with them in a very difficult endeavor.

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