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Attachment disorders

Several effective interventions for disturbed attachment relationships rely on a developmental rather than psychiatric classification approach.

ABSTRACT: Attachment disorders are serious disorders that have potentially deleterious effects on a developing child. Identification of attachment disorders is best done by direct observation of the child in the context of the child's relationship with the primary caregivers by trained early childhood clinicians. Diagnosis involves complex issues. The point of entry for interventions can be the infant, the mother or other caregiver, dyadic interactions, triadic interactions, or group work. Physicians can also help their patients by utilizing a variety of clinical resources.

Attachment behaviors embody what an infant does to promote proximity to a caregiver and ensure safety, security, and survival. Warm, sensitive, and responsive parenting generally contributes to secure attachment. In order for an infant to be attached, an attachment figure or object must, of course, be available. The attachment figure needs to have an ongoing emotional investment in the child.[1,2] In some situations caregivers other than parental figures, often out of necessity, act as temporary attachment figures; not all of these will become attachment objects. Certain situations may preclude the development of relational stability and secure attachment. Children placed in emergency foster homes, children placed in orphanages with multiple caregivers, and children displaced by environmental and other disasters are at risk. When attachment falls outside of a normative range and into extremes, mental health clinicians commonly use the term "attachment disorder." Unfortunately, this term is sometimes used in an imprecise manner to refer to general relationship disturbances in early infancy. Empirical data through longitudinal and cross-sectional studies is emerging but is fraught with methodological constraints. Here we will address the current clinical understanding of what an attachment disorder represents and what to do when you encounter a clearly disturbed attachment relationship.

What is not an attachment disorder?

In identifying attachment disorders we look at what is happening to individual partners *and* what is happening within their relationship. An attachment disorder is not defined solely in terms of an infant's behavioral disturbances. Day-to-day parenting errors are commonplace and do not contribute to an attachment or relationship disorder. A typical parent-infant relationship is not always optimal; repairing mismatches or interactive errors is an essential part of the ongoing negotiation within the dyad.[3]

Secure attachment facilitates infant mental health and can mitigate the effects of other social-emotional risk factors, thus operating as a protective factor. However, not all atypical attachment patterns (insecure, disorganized) described previously in this theme issue (*BC Med J* 2007; 49[3]:117) give rise to an attachment disorder or future psychopathology.

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Nor do social deprivations necessarily give rise directly to an attachment disorder. However, research findings indicate that those in the social high-risk sample who also have insecure attachment often develop psychopathology when followed to adolescence.[4] Even disorganized attachment is best viewed as a vulnerability factor for adverse social and emotional outcomes.[5]

Parents who plan to adopt may approach physicians with questions regarding attachment disorders. They should be told that attachment security has been related to the timing of the placement and adoptive caregiving quality. Research suggests that infants adopted early in the first year of life are just as likely as non-adopted infants to develop healthy attachment relationships[6] and are not always destined to experience disordered attachment.

Attachment cannot be quantified and every dyad has unique qualities. Measurement of attachment security is complex and includes variables that are sometimes difficult to decipher on clinical observation alone.[7,8] Traditionally, clinicians have depended upon observable attachment behaviors in relation to a particular attachment figure, the caregiver's accessibility and responsiveness to the child, and the constancy of this relationship over time, especially in situations where the infant is distressed.

Diagnostic classification

For the formal diagnosis of an attachment disorder (reactive attachment disorder) in 1980, earlier versions of the *International Statistical Classification of Diseases*[9] and the *Diagnostic and Statistical Manual of Mental Disorders*[10] (*ICD-9* and *DSM-III*) required an age of onset before 8 months, failure to thrive, and a pervasive lack of social responsivity. Despite revisions, newer versions of both manuals continue to be less than adequate in that they do not describe the full range of observed difficulties. Also, children with attachment difficulties may not show problems across all relationships. A child may experience an attachment difficulty with the primary caregiver but not with other adults or peers.[11] Finally, attachment

Cases of attachment disorder seen at the Infant Psychiatry Clinic at BC Children's Hospital

Referral criteria

Patients who are accepted to the Infant Psychiatry Clinic range in age from birth to 5 years.

Patients are assessed for a the full range of concerns, including (but not limited to) attention deficit hyperactivity disorder (ADHD), anxiety disorders, attachment disturbances, autism, behavior problems, developmental delays, mood disturbances, and regulatory difficulties.

After patients are assessed, families that require long-term intervention are directed to resources in the community.

Case 1

"Mary," a 16-month-old girl, was brought to the clinic by her stepmother and natural father. This child was previously caught in a bitter custody battle and was removed from her biological mother because of extreme neglect. She was subsequently placed with her father.

The stepmother did not have children of her own and had no previous parenting experience. She became very alarmed by Mary's demands on male and female strangers. Mary would follow any stranger with a smile, and participate in interactive games. This was in contrast to Mary's previous behavior, while in her mother's care, when she seemed withdrawn and uninterested in adults. The stepmother took Mary's behavior as a rebellion against her new parental figures and sought psychiatric advice regarding what she should do.

During assessment Mary's indiscriminate social behavior continued with the examiners, with the resident trainees, and the patients waiting in the reception area.

The important parts of therapy recommended for Mary included:

- Working with the stepmother regarding her feelings of guilt and her concern about not being a good parent.
- Framing the child's behavior as adaptive to the previously experienced neglectful environment.
- Empowering the stepmother and father to act as secure bases and provide a safe haven.

The empowerment of the parents was the most important strategy. This was achieved through parent-infant psychotherapy.

Case 2

"Roger," a 2$^1/_2$-year-old boy, was referred to the ADHD clinic. He was considered a hyperactive, aggressive child, and was seen as destructive and aggressive during play.

His impulsive behaviors included leaving home in the middle of night and darting into heavy traffic. He had been lost in the local supermarket on

disorders are *relational* disorders and do not conform to nosological systems that characterize the disorder as residing in the individual. The *DSM-IV-TR* describes reactive attachment disorder that can manifest as either inhibited or disinhibited behavior.

The *DC: 0-3R*[12] is somewhat more useful when classifying attachment disorders but also limited. The advantage of this system over that of the *DSM-IV-TR* is the introduction of a relationship measure on axis 2, with no relationship disorder at one end and an abusive relationship disorder at the other end. In between these two poles, we find over-involved, under-involved, anxious, angry/hostile, and mixed relationship disorders. There are prob-

Table 1. Types of attachment disorders.[16]

Disorder of nonattachment	• Infant has no preferred attachment figure • Can be associated with the infant's emotional withdrawal or indiscriminate sociability and extend to all social interactions • Behaviors highly suggestive of emotional withdrawal: comfort seeking and displays of affection are remarkably restricted; emotional blunting is observed • Behaviors highly suggestive of indiscriminate sociability: seek proximity or comfort from strangers, with an absence of usual social reticence with unfamiliar adults
Secure base distortion	• There is a discriminated attachment figure, but the infant does not have secure base, which is created when the caregiver allows infant to explore the world while being available to the infant if he or she feels insecure • Behaviors highly suggestive of secure base distortion: self-endangerment, clinging, inhibition, vigilance, hypercompliance, role reversal
Disrupted attachment	• Involves a response to abrupt separation from significant caregiver or sudden loss • Phases of behavior highly suggestive of disrupted attachment: protest (intense reaction, searching for caregiver), despair (sadness or withdrawal), detachment (suppression of attachment behaviors with renewed interest in activities and social relationships)

two occasions. Because his mother had been diagnosed with ADHD in her school days, this diagnosis seemed plausible. However, examination on three different occasions in three different situations found Roger to be a cooperative, intelligent child with good play skills. The history confirmed that his unruliness came out prominently with his mother but not with other caregivers.

A diagnosis of attachment disorder was made, much to the chagrin of Roger's mother. The important aspects of therapy were to support the mother in understanding and accepting this diagnosis and to help her become a powerful regulator of Roger's impulses.

Case 3

"Mia," a 3-year-old girl, was referred through her day care for persistent and excessive separation anxiety. No matter what the day-care staff tried, they were not successful in soothing Mia after her mother was forced to leave. After 2 months at the day care, staff found that Mia was at her worst during the first hour after her mother left and when her mother came to pick her up. It was as if Mia acted as a younger child as soon as her mother arrived and lost her skills.

In the clinic office interview, a similar situation prevailed. Mia was clingy with her mother, did not say one word, and showed total lack of interest in toys. Throughout the interview, Mia sat on her mother's lap making face-to-face contact and staring, not shifting from that position even when she seemed calmer.

At the clinic's request, a community health nurse made a home visit. The nurse reported that Mia seemed happy and chatty at home, and was an unusually witty child. However, the nurse also thought that the mother was smothering Mia by giving her so much attention. Apart from parenting, the mother seemed to have given up other responsibilities at home. She had stopped working and asked her husband to cook the meals and do the shopping because Mia was so demanding. The most important clue was that the mother would not let Mia get out of her hearing.

Each of these three cases depicts an attachment disturbance.

Mary shows indiscriminate social behavior and no particular preference for an attachment figure.

Roger shows secure base distortion. He exhibits impulsive risk-taking behavior in response to a caregiver who is not able to provide emotional care *and* to set limits and become a container for the child's anxiety and disorganization.

Mia shows classic secure base distortion in response to her mother's overprotective and anxious stance, which has not provided Mia with opportunities to explore and learn problem solving in an unfamiliar setting.

lems, however, in that parental behaviors are emphasized to the exclusion of the child's attachment behaviors.[13]

Clinical presentations that can resemble attachment distrubances include an infant's withdrawal due to depression or autism. Although the significant social impairments associated with autism may resemble an attachment disorder, autistic children are capable of forming attachment relationships with their caregivers.[14]

Zeanah and Boris[15] suggest revised criteria for attachment disorders. According to their classification system (Table 1), there are three main types of disorders: disorder of nonattachment, secure base distortion, and disrupted attachment.[16]

Assessment

In spite of having an improved understanding of attachment disorders, we still have difficulties with classification and validation of attachment disorder, and assessment can be challenging. In reality, it is often difficult to sort out whether early attachment disturbances constitute a risk for disorder, or are in themselves a clinical problem requiring treatment.

Assessment for an attachment disorder is best done by a clinician trained in mental health problems in early childhood. An assessment in the clinical setting includes the following:

- Focusing on the child's relationship with attachment figures, especially the caregiver's ability to provide a secure base and a safe haven for the infant.
- Directly observing relevant infant behaviors through structured observational paradigms that capture attachment to a caregiver, especially reunion experiences and various attachment-seeking behaviors, including controlling behaviors.
- Taking the infant's developmental level into consideration—for instance, the later development of attachment relationships in a child with Down syndrome (between 12 and 24 months).[14]

Examples of cases where these principles have been followed and children have been diagnosed with an attachment disorder can be found in the box on page 188, "Cases of attachment disorder seen at the Infant Psychiatry Clinic at BC Children's Hospital."

Preventive intervention

Family physicians and pediatricians are well positioned to begin the process of alleviating the suffering arising from relational disturbance. Some interventions do not need a child therapist or a child psychiatrist. Watchful monitoring of the parent-child relationship can be very useful and can help prevent relational disturbance in some cases.

One effective form of preventive intervention involves home visiting by a professional (e.g., community health nurse) or paraprofessional. Home visiting prevents abusive parenting in vulnerable families by providing a therapeutic holding environment.[17] The physician may also need to advocate regarding psychosocial issues, such as financial assistance and housing. In general, policies that promote economic security, enhance the parent-child relationship (e.g., through maternity and paternity leave), strengthen parenting skills, and reduce the isolation of the nuclear family can indirectly and positively affect the parent-child relationship.[18]

Another preventive strategy involves using psychoeducational models to encourage parents to respond promptly to their child's distress. Several well-known approaches are available. For example, the Keys to Caregiving program[19] provides educational material (videotapes, pamphlets) for parents to learn how to read infants' cues appropriately. The materials can be used on their own or with the support of a professional.

Where a mother presents with signs of depression, timely referral to an appropriate community resource is important. Maternal depression and anxiety are known risk factors for the offspring's development,[14] particularly in the social and emotional domains. Physicians are encouraged to pay attention to the dyadic relationship in this situation and refer the dyad, and not only the mother, when necessary. In the Lower Mainland, physicians can refer patients to the Infant Psychiatry Clinic at BC Children's Hospital (604 875-2719) and the Alan Cashmore Centre (604 454-1676). Outside the Lower Mainland, community health nurses and local child and youth mental health centres are a good source of information about community resources.

Specific interventions

Interventions that rely on a developmental rather than psychiatric classification approach have proven useful. In this approach, disturbed attachment relationships are seen as initiating processes that compromise development, whereas secure attachment increases resistance to stress and promotes resilience.[15]

In attachment disorders the patient is neither the parent nor the infant alone, but both together. Stern describes several "ports of entry" where intervention may occur.[20] These may be through the infant[21] or mother.[22,23] Intervention models may be based on dyadic interactions,[24-27] triadic interactions,[28] or group work.

More detailed information about different intervention models is provided in Table 2.

Child maltreatment and neglect

In situations involving child endan-

Table 2. Interventions for attachment disorders.

Infant-specific	One approach that makes use of the infant's behavior was developed by Brazelton.[21] Otherwise, few therapies use infants as a sole focus. • Example of strategy: Clinician simply calls baby's name and then asks parent to do the same (a baby knows a parent's voice better than that of a clinician, confirming unique place for parents in relation to their infant).
Mother-specific	Maternal representations of her own experiences of being parented are of interest to infant psychiatrists. Interventions that focus on the mother's emotional and physical health have been described in the literature.[22] • Example of strategy: Having a mother narrate her own experiences (coherence and consistency) to predict how she will fare with her baby.[23]
Dyadic models	This approach identifies a new "patient" population, namely the relationship between caregiver and infant. Several validated approaches are used: *Interaction Guidance*[24] • Most commonly used mode of dyadic intervention. • Developed specifically to meet the needs of infants and their families strained by poverty, poor education, family mental illness, substance abuse, inadequate housing, and other psychosocial stressors. • Aims at promoting and nurturing the caregiving relationship. • Focuses on observable interactions between the baby and the caregiver to gain understanding of caregiver and baby's representational world. • May use videotape to allow for immediate feedback to the parent(s) or family regarding their own behavior and its effect on the infant's behavior. *Modified Interaction Guidance*[25] • Aims at decreasing caregiving behaviors associated with disorganized attachment. *Watch, Wait and Wonder*[26] • Relies on a child-led interaction followed by discussion between therapist and parent reflecting on the infant/child's inner world of feelings, thoughts, and desires. • Relatively brief treatment consisting of 12 to 14 sessions over 5 months. *Infant-parent psychotherapy, San Francisco model*[27] • Initially served a population composed of poor, ill-educated, homeless, sometimes mentally ill parents. • Explores links between parent's early childhood experiences and their current practices and emotional dialogue with their babies. • Uses a combination of insight-oriented psychotherapy, unstructured developmental guidance, emotional support, and concrete assistance as well as crisis intervention as required. • Focuses on therapeutic relationship as an important component of change.
Triadic model	Based on research of the Lausanne University Centre for Family Studies on the development of three-person relationships between new parents and their first child.[28] • Example of strategy: "Trialogue play" is used to enable three-person families to share moments of pleasure and experience intersubjectivity (intentions, feelings, and meanings shared between family members).
Group-based approach	"Bonding" groups at BC Children's Hospital are a prototype of this approach. • Usually follows a psychoeducational approach in empowering parents. • Groups conducted with a specific goal of helping attachment bonding processes between insightful but demoralized mothers and their newborns. • Aims to create a warm, welcoming environment where each participating parent is taught bonding exercises using several modalities, including infant massage, to connect with a child. • Each parent is given a co-therapist to work with who helps as a co-parent would, thus providing a secure base for practising parenting skills. • Includes booster sessions and home visitation as part of ongoing monitoring designed to maintain success obtained during groups. This monitoring can be particularly important in cases of postpartum depression, where relapses are common and preventable.

germent, attachment therapy takes a different form. Physicians are mandated to report their concerns to the appropriate authorities, even though they may sometimes feel that they cannot continue to be helpful to the child and family if an adversarial relationship ensues. These situations usually occur within multiproblem families and need multimodal interventions. A collaborative approach involving legal and social welfare systems is necessary. The intervention approaches often include a combination of dyadic therapies such as therapeutic visitation, interaction guidance, modified interaction guidance, and parent-infant psychotherapy.[29] Taking steps to stop therapist burnout in these challenging cases is crucial.

Day-to-day parenting errors are commonplace and do not contribute to an attachment or relationship disorder.

Effectiveness of therapeutic modalities

More unconventional attachment interventions (e.g., "holding therapy"), have not been shown to be effective.[6] Evidence suggests that programs that directly address the desired behavioral changes (e.g., improving maternal sensitivity and infant security) tend to be more effective than those that address more general issues.[30] The external component, that is, interactions that can be observed, appears to be a necessary component of effective intervention.

When Bakermans-Kranenburg and colleagues completed a metaanalysis of 70 studies of sensitivity and attachment interventions in early childhood in families with and without multiple problems, they found that the most effective interventions used a moderate number of sessions and a clear-cut behavioral focus. Increased parental sensitivity was associated with increased attachment security, supporting the causal role of sensitivity in the development of attachment.[31]

Conclusions

Attachment difficulties hamper the developmental course of young children and are stressful for caregivers. In order to help troubled families, clinicians need to understand that they have an important role to play. Nearly all infant and dyadic interventions emphasize the therapeutic alliance with the parent and indirectly with the infant. Interventions do not have to be lengthy but they do have to be timely. Moreover, a combination of therapies is recommended with multiproblem families, provided team building occurs so that multiple therapies are synchronized. Currently, there is a major thrust to evaluate all the modalities and we hope to gain insight soon into what works best for whom.

The psychoanalyst Michael Balint referred to the doctor herself or himself as a powerful "medication."[32] The power of relationships is undeniable, and makes the patient-doctor relationship an important ingredient in promoting healthy parent-child interaction.

Competing interests

None declared.

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