
Attachment Disorders, their Assessment and Intervention/Treatment

BAAF Position Statement 4

1 Introduction

1.1 It is widely accepted that some children and young people in adoptive or foster families find the closeness of relationships with parents/carers very difficult indeed. The mutual intimacy of loving family relationships seems to be resisted and/or rejected and this can show itself through behaviour and emotions that are very hard to live with for all concerned. Attachment theory has been used to explain some of the underlying developmental issues in an insightful and positive way. However, a number of interventions have developed to address these issues which claim to be based on attachment theory but where the theoretical links and evidence base cannot be substantiated. Indeed, they are the very opposite of what attachment theory would suggest is helpful to children. One of these interventions is “holding therapy”, an intervention which was developed in the United States but may also be found in the UK. Holding therapy is a risk to children’s physical and emotional welfare and has been banned in a number of American states. After lengthy exploration of the basis and use of holding therapy, BAAF is issuing this Position Statement to clarify for carers, parents, practitioners and commissioners of services an evidence-based position in relation to this form of intervention.

Its use has also been advocated to parents as a part of a general approach to parenting (Welch, 1988), whether problems are ‘major or minor, or seemingly nonexistent’. It has gone on to be more specifically advocated for children with attachment disorders (Cline, 1992) and children placed for adoption (Keck and Kupecky, 1995).

2.2 The identified problems which are the target and which underpin the rationale for the use of holding therapy are usually:

- ‘Developmental problems...caused by a break or disturbance in the mother–child attachment or bonding process, where systematic and protracted holding might, in fact, repair the relationship’ (Welch, 1988).
- The existence of untapped rage in the child where the ‘ego’s system of defences’ need to be ‘broken through’ to ‘reduce the child’s rage’ and enable reciprocal and loving relationships. This includes the necessity of the child feeling ‘helpless and hopeless’ and ‘destabilising their maladaptive defences’ – before the child is in a position to begin to attach to their parents (Cline, 1992).
- The ‘freezing’ of the child’s development as a result of abuse and neglect. Intervention aims to induce regression to earlier (infantile) stages of development.

2.3 The techniques advocated in ‘therapeutic holding’ are described by Welch (1988):

The child is held in a position that allows the parent to make direct eye contact while controlling the child’s attempts to protest, to struggle, and to escape. The technique anticipates and indeed facilitates confrontation so that problems can be

2 The evolution of holding therapy

2.1 The development of holding therapy as a therapeutic intervention with children can be identified from the 1950s for children with autistic disorders (Zaslow and Menta, 1975).

resolved...As the child's emotions are aroused, the child struggles to turn away. The mother expresses verbally her feelings – concerns, frustrations, hope, anger as well as affection and love – to the child. She uses her strength and tenacity to intensify contact and prevent withdrawal. The struggle becomes desperate for both, and then, if the mother perseveres throughout the child's rejection, it dissolves into tender intimacy with intense eye contact, exploratory touching usually of the mother's face, and gentle conversation highly gratifying to both mother and child.

2.4 The technique has been explicitly recommended to adopters and foster carers by Archer (2000).

2.5 It has also been developed for use by therapists such as Hughes (1997):

The standard therapeutic position is for the child to be lying across my lap with his head and sometimes his legs supported by pillows. One of his arms is behind my back: I hold his free hand. In this position, it is considerably easier to maintain good eye contact with him while exploring difficult themes. He is much more attentive when my face is directly above his as I speak with emotion. He is inclined to feel more ready to address a trauma when I stroke his hair, pat his shoulder, squeeze his hand, or give him a quick hug. When I lead the conversation with an emotion similar to what he might have felt in the past, he is likely to have the same feeling state again. Thus I might yell, 'You must have been really mad when he pulled your hair and threw you down'.

2.6 The intensity of the physical and emotional confrontation with the child where resistance is overcome by the greater physical or emotional force of the parent/therapist is argued to be essential because of:

- The failure of any other approach to make a sufficient impact or connection with the child to

stimulate the growth of "healthier attachments".

- The immediate risk of placements disrupting because of the challenging behaviour of the child.
- The long-term risk to the child in terms of mental health problems, social exclusion and isolation and those associated with being returned to public care.

3 Reactive Attachment Disorder

3.1 Although its roots are in the treatment of autism, holding therapy has become closely associated with the treatment of attachment disorders and particularly Reactive Attachment Disorder (RAD). RAD is a formal psychiatric diagnosis defined in *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) and is one of two types – *emotionally withdrawn and inhibited* or *indiscriminate and uninhibited*.

3.2 There are a number of identifiable features to each type. However, both centre on the observed absence of the primary developmental expectation in the child that, at times of separation, distress or anxiety, they can turn to an identified, consistent adult with whom they have developed a close relationship, with the expectation that they will be sufficiently comforted and reassured to reduce their distress or anxiety. Any pervasive and consistent failure in this primary developmental goal so seriously distorts the child's behavioural and emotional expectations and responses in relationships as to put them at risk.

- In the inhibited type of RAD, the child's need for comfort from others and the associated emotional and behavioural cues they might evidence for this are so seriously curtailed that comfort and security in relationships becomes a largely unobtainable goal.
- In the disinhibited type of RAD, the child makes their need for comfort and reassurance known but it is not selective – it may be randomly focused on strangers.

3.3 In both forms of RAD, the child's behaviour and emotions create patterns of social relating that are disturbing to observe and extremely challenging to be a part of. This includes lack of responsiveness in relationships, excessive inhibition/over-familiarity, hyper-vigilance, and role reversal with carers.

3.4 When discussing RAD, it is critical that the distinction is made between:

- The four patterns of attachment which focus on the dimensions of security/insecurity in a relationship when the child identifies adults who they relate to as a preferred and selective attachment figure. *Where there are difficulties, these must be identified as difficulties in attachment relationships.*
- Reactive attachment disorders which are *disorders that arise from non-attachment.*

3.5 Reactive attachment disorders depend on the presence of a number of features:

- The absence in the child's experience/expectation of a preferred attachment figure despite one being available.
- The early experience of extreme neglect or maltreatment. In some cases this may have resulted from institutional care in the first few months and years of life.
- Clear evidence that the disorder was evident before age 5.
- Clear evidence that the disorder is not exclusively explained by identifiable features of developmental delay.

4 Links with other disorders

4.1 In the course of assessing/diagnosing reactive attachment disorders, a child may present behaviours and emotional states which indicate other forms of disorder, particularly post-traumatic stress and anxiety disorders. In older children, there may also be clusters of behaviour which strongly suggest other difficulties, such as conduct disorders, oppositional defiant disorders and attention deficit disorders. Accurately and

meaningfully identifying the specific nature of the child's disorder, the circumstances and context in which it developed, the impact the disorder has on the child, the child's family and others who come into contact with the child takes considerable experience and expertise.

5 Conclusion

5.1 While there has been considerable development in explaining and understanding RAD, the picture is far from complete. As a result there must be considerable caution in diagnosing the disorder and prescribing interventions. However, what is clear is that there is nothing in the evidence that would support the arguments to support the developmental explanations used to justify any coercive therapies including holding therapy. The complexity of defining and tracking the development of RAD and the difficulty in identifying the longer term consequences must result in caution by professionals and carers.

6 BAAF's position

6.1 Concepts and framework

- Attachment theory provides a powerful conceptual and evidence base for explaining and exploring the development of a child's capacity to establish meaningful, satisfying and satisfactory relationships with parents/carers and other people as well as their own coherent and positive sense of a personal and social self.
- The existing classification of attachment patterns¹ is rigorous and evidence-based. The systems and the tools that support them are principally research tools and require considerable training and expert interpretation. Even when used by those trained to do so, attachment classifications cannot be equated with a clinical diagnosis of disorder. While the insecure patterns may indicate a risk factor in a child's development, they do not by themselves identify disorders (Howe, 2005).

¹ Secure, Avoidant, Ambivalent, Disorganised.

- Attachment disorders are described in one of two classification systems² for psychiatric disturbance. The link between the psychiatric classification system and the child development, research-based system is loose.
- The lack of clarity about the use of attachment concepts in describing children's relationship difficulties can create confusion for practitioners, parents/carers and commissioners of services. It warrants caution when trying to use terms around which there is some uncertainty. As a result, when discussing children who may be thought to have an attachment disorder, practitioners must carefully describe and evidence the child's difficulties and their context and not rely solely on generic descriptions such as "attachment difficulty or disorder".

6.2 Assessment

- A diagnosis of an attachment disorder can only be undertaken by a psychiatrist. Particular care should be exercised about the classification of attachment disorders,³ their reported symptoms and/or behaviour and what may be the cause of them.
- Any assessment or diagnosis of a child's difficulties or distress must recognise the possibility that the same presentation may be accounted for by a number of causative factors. This may also include other forms of difficulty such as emotional, conduct, hyperactivity disorders and post-traumatic stress.
- Any assessment or diagnosis of a childhood emotional or behavioural disorder must take account of the history, context and circumstances of that child's life, including the people that care for the child, their social circumstances and their access to opportunities and resources.
- Assessments must be comprehensive and include other needs such as physical health and education as well as opportunities for individual and social development.
- The needs of carers should also be assessed, including their knowledge and skills to effectively care for a child whose experience and expectations of adult carers may have been formed in the context of maltreatment.

- Assessments must take into account both the current situation in which the child is living as well as previous experiences with carers, especially where these included maltreatment.
- Assessments must include appropriate consultation with children and young people themselves, their carers and others who know them well. Any assessment must include a comprehensive evaluation of the child's individual and family history.

6.3 Intervention/treatment

- The most effective intervention for attachment disorders is prevention. Services must be available that enable and support all parents to develop sensitive, attuned, reliable ongoing relationships with their children from birth. Some parent/s will require intensive support to enable them to do this. When this is not possible, alternative arrangements must be made to ensure that children have at least one reliable and sensitive long-term relationship with an adult that will last as long as they need it.
- Attachment theory has not developed a widely applicable, evidence-based set of interventions based on current diagnostic categories. However, there are a number of important developments in attachment-based interventions which are being evaluated.
- There are no shortcuts to relationship building when children have been neglected or abused. The processes that enable the development of a loving and secure home with carers that the child grows to know and trust and where the child feels that they belong is still the best intervention for most children. However, it may in itself not be enough to reverse the earlier damage for some children, and they and their carers may require specialist help.
- Where children have not had relationship experiences in which they feel secure or where it was dangerous to seek contact with their carers, it may take considerable time to enable them to feel secure enough with new carers. In some

² DSM-IV and ICD-10.

³ Inhibited and Disinhibited.

instances, it may take intervention/treatment from professionals for both the child and the family to develop skills, understanding and resilience for a sense of belonging and security to develop.

- Each child will need an individual care/treatment plan that identifies the nature of the difficulties and possible ways of alleviating the distress for the child and the carers and other family members. This may involve a single form of therapy or a number of approaches.
- Helpful approaches may include individual therapy for the child, support, training or therapy for the parents/carers, or work with the whole family.
- Given the serious long-term impact of relationship difficulties on all concerned and the lack of clarity about assessment/diagnosis/treatment, a multi-professional approach and perspective is important.
- Family and home-based interventions may not be enough to address the needs of some children and short-break care or other forms of “out of home” care may be necessary.
- All children need to learn the importance of limits and boundaries in behaviour, emotion and routines. Carers need to find and be supported to find effective ways of setting limits and boundaries with children that can be communicated with authority and clarity.

6.4 Holding therapy

- There is nothing in attachment theory to suggest that holding therapy is either justifiable or effective for the treatment of attachment disorders. While most children benefit from age-appropriate touching, cuddling, physical play, eye contact and general intimacy as a part of family life, this must not be forced on the child or the child be coerced into such activity as a therapeutic intervention (O’Conner and Zeanah, 2003).
- Agencies or adoptive parents should not use or commission interventions generally termed holding therapy.

6.5 Consent to treatment

- The giving of consent to any form of treatment requires that the person whose consent is sought understands the reasons for the proposed treatment, what it involves, the desired outcome and the likelihood of this being achieved. The more invasive the proposed treatment, the greater the onus on the therapist to provide a detailed explanation of what is involved, including any undesired or unpleasant outcomes or side-effects. Where treatment is experimental, the person involved is entitled to be told what evidence, if any, exists to support or contradict its use and, in general, medical ethics do not permit unproven treatment to be provided to children.
- The methods advocated for holding therapy may make it effectively impossible to withdraw consent (even if this could have been validly given in the first place) since they involve compulsion on the part of the therapist.

6.6 Restraint

- Where children put themselves or others in danger and need to be restrained, this should only be carried out in a safe way. Safely restraining a child should not be confused with therapy. Where residential or foster carers are involved in providing physical restraint, they will be subject to regulation, policy and guidance. Where adoptive parents need to restrain children to keep them safe, they should seek assistance and advice from their adoption agency or other regulated provision on safe ways of doing this (Morgan, 2004).

6.7 The dangers of institutional abuse of children

- A number of public inquiries (Butler-Sloss, 1988; Kennedy, 2001; Levy and Kahan, 1991; Kirkwood, 1993) have established that children and their carers are in some circumstances particularly vulnerable to institutional abuse which masquerades under the banner of “concern” or

“help”. This has been notable in health and social services. The lessons from these inquiries must be built into any developments aimed at helping this particularly vulnerable group of children and their carers.

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Bibliography

Ainsworth MDS, Blehar MC, Waters E and Wall S (1978) *Patterns of Attachment: A psychological study of the strange situation*, Hillsdale, NJ: Erlbaum

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders* (4th edition), Washington DC: American Psychiatric Association

Archer C (2000) 'Making holding time', in Adoption UK *Making Sense of Attachment in Adoption and Foster families*, London: Adoption UK

Berlin L, Ziv Y, Amaya-Jackson L, Greenberg M (2005) *Enhancing Early Attachment: Theory, research, intervention and policy*, New York, NY: Guilford Press

Butler-Sloss E (1988) *Report of the Inquiry into Child Abuse in Cleveland*, London: HMSO

Cline, FW (1992) *Hope for High Risk and Rage Filled Children*, Evergreen, CO: EC Publications

Howe D (2005) *Child Abuse and Neglect*, Basingstoke: Palgrave Macmillan

Hughes DA (1997) *Facilitating Developmental Attachment: The road to emotional recovery and behavioural change in foster and adopted children*, Oxford: Jason Aaronson

Keck GC and Kupecky RM (1995) *Adopting the Hurt Child: Hope for families with special needs kids*, Colorado Springs, Co: Piñon Press

Kennedy I (2001) *The Inquiry into the Management of Care of Children Receiving Complex Heart Surgery at the Bristol Royal Infirmary*, Bristol: Bristol Royal Infirmary Inquiry

Kirkwood A (1993) *The Leicestershire Inquiry 1992*, Leicester: Leicestershire County Council

Levy A and Kahan B (1991) *The Pindown Experience and the Protection of Children: The Report of the Staffordshire Child Care Inquiry 1990*, Stafford: Staffordshire County Council

Morgan R (2004) *Children's Views on Restraint: The views of children and young people in residential homes and residential special schools*, London: Commission for Social Care Inspection

O'Conner T and Zeanah C (2003) 'Attachment disorders: assessment strategies and treatment approaches', *Attachment & Human Development*, 5:3, pp223-244

Welch MG (1988) *Holding Time*, New York, NY: Simon & Schuster

Zaslow R and Menta M (1975) *The Psychology of the Z-Process: Attachment and activity*, San Jose, Calif: San Jose State University Press