Clinical Interventions for Children With Attachment Problems

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TOPIC: Applying the current evidence to treating clinical populations with attachment disorders.

PURPOSE: This study aims to review the literature regarding the treatment of childhood attachment disorders, with the goal of guiding clinicians towards evidence-based practice.

SOURCES USED: MEDLINE, CINAHL, PsychBooks, EMBASE and PsychINFO were searched and all articles reporting results of a treatment intervention for attachment disorder were reviewed. Ancestry analysis garnered additional sources.

CONCLUSIONS: There are few studies addressing therapeutic interventions for attachment disorder, but the literature supports benefits to the child–parent attachment relationship in biological families in the application of both psychoeducational and psychotherapeutic treatment modalities. A summary of the important components of applying these techniques in therapy is included. Foster and adoptive families with attachment disorders require different types of intervention than biological families. In particular, foster and adoptive parents need to help repair their child’s negative internal representations by responding appropriately to their child’s cues. Advanced practice psychiatric nurses are well-prepared to provide evidence-based interventions to both biological and foster families with attachment problems. More research is needed to determine the most appropriate treatment interventions for children with attachment disorders.

Search terms: Attachment, intervention, reactive attachment disorder, treatment

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Introduction

The purpose of this paper is to examine treatment interventions for children with attachment disorder for the purpose of guiding clinical practice with this population. Currently many psychiatric nurse practitioners are treating children identified as having “attachment problems.” In addition, the child mental health community has not agreed upon a gold standard for treating this population. For these reasons, it is important that psychiatric nurse practitioners be aware of the current evidence on attachment interventions. This paper will examine treatment interventions for both reactive attachment disorder (RAD) and the nonsecure attachment categories as frequently defined in research, as the literature concludes that children with both these labels are at risk for negative outcomes (Egeland & Farber, 1984; Hall & Geher, 2003). Preventive interventions are not a focus of this paper, but interested readers may see Lieberman and Zeanah (1999) for a review. Attachment theory is used as the theoretical framework to provide an understanding of the importance of early relationships. The major research questions are: Which interventions does the evidence support as best practices for infants and children with existing attachment problems? Does the evidence show that distinct interventions are required for infants and children living with their biological families as opposed to those living with foster or adoptive families?

Methods

Research articles reporting the efficacy of treatment interventions for infants and children with attachment disorder were examined. Databases searched include MEDLINE, CINAHL, PsychBooks, EMBASE and PsychINFO. Ancestry analysis of relevant articles garnered

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additional resources. Articles were excluded if they were non-English language or if the main focus of the paper was not an attachment treatment intervention for infants or children. Many of the articles were excluded because they focused on preventive interventions.

Attachment Theory

Attachment between a child and primary caregiver is a biological function that enhances proximity and helps protect children from predators and other dangers. The caregiver is often the mother, but can be any consistent figure that provides for the needs of the infant. Attachment behavior is observed when an infant uses smiling, crying, and other behavior to engage the caregiver, and when a caregiver reacts to the child’s wants and needs (Bowlby, 1982). While attachment serves a necessary role in the survival of the species, it is also how infants learn to connect and interact with others and allows them to begin to learn social norms. Infants learn through attachment that they are worthy and loveable, and that the world will respond to their needs. An interruption or problem in the development of a secure attachment in infancy does not allow the infant to develop the skills to form a framework for reciprocal relationships with others, potentially leading to failure to thrive and other developmental lags. Problems with attachment early on can continue throughout the life span, and include negative outcomes such as peer relational problems, poor self-esteem, delinquent and aggressive behavior, abusive relationship patterns, and antisocial behavior and other adult psychopathology (Egeland & Farber, 1984; Hall & Geher, 2003; Main & George, 1985; Perry, Pollard, Blakely, Baker, & Vigilante, 1995).

Concepts in Attachment

The problem in children with attachment disorders, and the focus in the majority of attachment interventions, is the relationship between the child and primary caregiver. Following are some important concepts to consider when assessing an attachment relationship or when evaluating possible treatment interventions.

Social cues may include verbalizations, body language, and facial expressions that indicate a child’s level of engagement with or withdrawal from a caregiver. It is important in infancy that a child’s cues are appropriately responded to, so that the infant knows she will be cared for. In later childhood, children need to know how to read and respond to social cues to develop relationships with peers.

Reciprocity is the natural give-and-take interactions of healthy relationships, and is based on accurate cue-reading. High reciprocity indicates parents’ awareness of and response to their children’s needs.

Internal representations begin developing at birth, as an infant conceptualizes how the world works, and continue to be altered by new experiences. For example, a child whose physical needs are met and who is encouraged and praised will likely have an internal representation of self as “good, loveable, successful.” Children also develop internal representations in regard to how they expect others to behave.

Caretaking behavior by the parent is often lacking in relationships with attachment problems. Due to this, an important clue that an attachment problem exists may be failure to thrive or a less dramatic problem in growth and development. Poor caretaking on the part of the parent may be related to the parent’s inability to read the child’s cues or provide reciprocity. It may also be related to the parent’s negative internal representation of self or child, or a problem such as substance abuse or depression.

Children with attachment problems often do not use their caregivers as a secure base.

A parent is a secure base to a child when the child can enjoy a healthy amount of both exploration and
security. For example, an older infant may crawl to another part of the room to explore, but will often look back and crawl back to the caregiver to check in. A secure base indicates that the child trusts the parent to protect him from dangers, and finds comfort in the parent’s presence. Children with attachment problems often do not use their caregivers as a secure base.

**Defining Attachment Disorders**

The *DSM–IV* outlines specific criteria for the diagnosis of RAD, a clinically significant attachment problem that manifests before the age of five. RAD may present as Inhibited type, in which the child fails to initiate and respond appropriately in social situations. This behavior may include, for example, responding to others with hypervigilance or a confusing mix of approaching and avoidance. The other presentation of RAD is Disinhibited type, in which the child attaches non-preferentially to any available caregiver. Children with this subtype often approach and interact with strangers in the same manner they would a caregiver. The diagnosis of RAD also requires pathogenic care, which includes emotional or physical abuse or neglect or multiple changes in caregiver that keep the child from forming a primary attachment relationship (APA, 2000).

Researchers have made progress in describing the behavioral characteristics associated with attachment problems, which include decreased or indiscriminate social responsiveness, destructiveness, lying, stealing, and inappropriate sexual behavior (Hall & Geher, 2003). They have also identified at-risk families and demonstrated preventive interventions, such as in-home programs, to help promote positive attachment in this population (Hall & Geher; Wendland-Carro, Piccicici, & Millar, 1999).

What is less clear in the literature is the relationship between the *DSM–IV* definition of RAD and attachment symptoms as they are commonly described in research. Mary Ainsworth’s Strange Situation Procedure is frequently used in research to identify a child’s attachment category as (a) secure, (b) insecure-avoidant, (c) insecure-ambivalent/resistant, or (d) disorganized (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Solomon, 1990). Researchers do not agree upon a clear understanding of how Ainsworth’s attachment categories relate to the clinical diagnosis of RAD. However, disorganized attachment in particular overlaps with the characteristics of RAD. Disorganized attachment is not necessarily related to abuse, neglect, or absence of a caregiver, but to frightening behavior demonstrated towards the child by the caregiver. Environmental risk factors include parental loss or trauma, maternal mood disorder or substance abuse disorder, poverty, institutional care, maltreatment, or witnessing domestic abuse. Any frightening scenario activates the child’s need for security and comfort; however, in this situation the parent who is supposed to be the child’s source of comfort is also the child’s source of fear (Zeanah, Keyes, & Settles, 2003). In this attachment style children display contradictory behavior, stereotypic movements, frozen watchfulness, and disorientation and apprehension in relation to the parent (Van Ijzendoorn & Bakermans-Kranenburg, 2003).

Compared to the other insecure attachment styles, disorganized attachment in particular can lead to serious psychopathology, including borderline personality disorder (Holmes, 2004). While there are similarities between RAD and disorganized attachment, Boris et al. (2004) differentiated between disorders of non-attachment, such as RAD, and disorganized attachment, in which the child identifies a preferential attachment figure but the relationship is disturbed. The authors also determined that children identified as having disorganized attachment were at higher risk than securely attached children to be diagnosed with RAD, which highlights that attachment categories are related to but not the same as attachment disorders.

**Etiology**

The exact prevalence or incidence of RAD is unknown (Richters & Volkmar, 2002). Zeanah et al. (2004) identified the prevalence among high-risk toddlers in
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foster care as 38–40%. Theories exploring the etiology of attachment problems include maltreatment or the absence of a primary attachment figure, child characteristics such as irritability, and genetic factors (Lakatos et al., 2000; O’Connor, Bredenkamp, Rutter, & The English and Romanian Adoptees Study Team, 1999; van den Boom, 1994).

Measures for Identifying Attachment Disorders

There are several measures used in clinical and research settings to identify children with attachment disorders. Ainsworth’s Strange Situation Procedure is a laboratory-based measure that evaluates an infant’s response to a series of separations from and reunions with the caregiver, as well as to the introduction of a stranger (the clinician or researcher). The child’s response to this stress is coded by an observer, and used to categorize the child into one of the attachment categories discussed above. The Strange Situation does not diagnose RAD, but rather identifies children with insecure attachment styles. This measure is most useful in research situations, as most treatment settings have neither the appropriate laboratory setting nor clinicians trained in administering the procedure. Interrater reliability for the Strange Situation is reported as ranging from .75 to .97 for trained scorers (Ainsworth et al., 1978).

The Randolph Attachment Disorders Questionnaire (RADQ) is a 30-item screening completed by an adult who has lived with the child for at least 3 months. A higher score on the RADQ is associated with more severe symptomatology. Randolph’s definition of attachment disorder differs from the DSM–IV diagnostic criteria, since the RADQ only identifies a child as attachment disordered if they meet both the DSM–IV criteria for RAD plus the criteria for Conduct Disorder or Oppositional Defiant Disorder. In addition, the RADQ claims to differentiate between attachment disorder and disruptive behavior disorders. However, Cappelletty, Brown and Shumate (2005) point out that the RADQ is not specific for RAD when correlated with the Child Behaviors Checklist, and that the measure has not been adequately validated.

The Attachment Q-Sort (AQS) specifically assesses attachment behavior and describes children in terms of constructs such as security, dependency, sociability, and social desirability. An observer sorts piles of cards with child trait and behavioral descriptions in order from most characteristic to least characteristic of the child. The AQS is performed by a parent or an observer spending a few hours with the child. The AQS has excellent construct validity (> .95), and good interrater reliability (.75–.95) (Waters & Deane, 1985).

Nursing Role

Prenatal visits and well-child visits are two common points of contact that nurses can use to identify families at-risk or already struggling with attachment problems.

Prenatal visits and well-child visits are two common points of contact that nurses can use to identify families at-risk or already struggling with attachment problems. In addition, some infants with attachment problems will be brought to medical clinics for non-organic failure to thrive (Tibbits-Leber & Howell, 1985). Many children with attachment difficulty have mothers with a history of psychiatric disturbances (Zeanah et al., 2004), some of whom may be receiving care in outpatient mental health clinics. These families’ contact with either primary care or mental health services give advanced practice nurses and other clinicians opportunities to intervene. Psychiatric nurse practitioners see children with attachment problems in their practices
frequently. In addition, in their assessment of adult clients psychiatric nurse practitioners may identify a problem in the adult’s attachment relationship with his or her child. As skilled diagnosticians and psychoeducators, advanced practice nurses are good candidates for providing interventions for families with attachment problems.

**Treatment Interventions**

There are two common approaches in treating families with attachment problems. The first is psychoeducational treatment focused on increasing parental knowledge of development, child and self-care, and relationship building. The other is psychotherapy with the parent and the child, focusing specifically on the attachment relationship and dysfunctional internal representations.

**Psychoeducational Models**

Psychoeducation in treating children with attachment disorders can involve both the parent and the child or the parent alone. Carmen (1994) recommends that the therapist take on the role of coach to the parent, not modeling but simply teaching practical information then helping the parent implement it. In her in-home intervention with mother–infant/toddler dyads (babies 2 years and younger) with attachment problems, she teaches parents to notice and respond to their child’s social cues, develop reciprocity in the relationship, and either soothe a cranky baby or alert a withdrawn baby. This method teaches basic caregiving skills and orients the parent to appropriate developmental expectations.

Mukaddes, Kaynak, Kinali, Besikci, and Issever (2004) used a similar method in a study comparing the efficacy of 3 months of psychoeducational group treatment for the parents of 11 children (30–70 months old) diagnosed with RAD and 10 children diagnosed with autism. The intervention focused on educating parents about their child’s diagnosis, increasing positive parent–child interactions, and dealing with behavior problems. The authors administered the Ankara Developmental Screening Inventory pre- and postintervention, and reported significant improvement in language-cognitive development, fine and gross motor skills, social interaction, and self-care abilities for both groups of children. However, the children with RAD had significantly more improvement postintervention than the autistic group. Although the study design did not allow for randomization, by comparing the RAD group with a PDD group the authors were able to show that their intervention is particularly efficacious for RAD. It would have been helpful if the researchers had included some measure of attachment status to see if treatment led to improvement in the attachment relationship. However, this study raises an important question in this field of research: Is it necessary to focus on the attachment relationship, or can targeting specific behaviors lead to improved functioning in attachment-disordered children? Long-term follow-up would be required to begin to sort out this question, but most attachment researchers suggest that positive long-term outcomes require addressing the underlying problem with relationships that is diagnostic of this disorder.

Another study by Mukaddes, Bilge, Alyanak, and Kora (2000) also examined the effect of 3 months of parent training on 15 toddlers with RAD, this time measuring indicators more typically associated with the disorder. This study used a semistructured interview and observation of mother–child interaction to assess the family system, psychiatric symptoms of the child, and the attachment relationship. The intervention included strategies for coping with guilt, initiating developmentally appropriate interactions, behavior management, parental self-care, limiting television viewing, and language training. The authors reported significant improvement postintervention on symptoms such as eye contact, interest in others, social imitation, and reciprocity. This population is interesting because the Istanbul participants were mostly upper-middle class, two-parent nuclear families with no history of
abuse. Instead the mothers suffered high rates of depression and indifference, with children in the study watching TV an average of 7.26 hr per day starting at the age of 7 months. Although there are cultural differences that make this population difficult to compare to American populations, these findings certainly challenge our ideas about the typical family at high risk for attachment difficulty.

**Psychotherapeutic Models**

Cicchetti, Toth, and Rogosch (1999) examined the effects of toddler–parent psychotherapy (TPP) on the attachment security of toddlers with depressed mothers. The toddlers with depressed mothers were not evaluated for the presence of RAD, but before intervention this group as a whole had poorer attachment than the toddlers of nondepressed mothers. In this randomized, controlled study, the intervention consisted of providing a “corrective emotional experience” for the mother through her relationship with the therapist. The therapist’s role is to observe the dyad and intervene to improve the mother–child relationship at both the interactional and relational levels. This approach does not include modeling or teaching, but rather links the mother’s previous relationships with her current perceptions of her child. The 27 dyads that received treatment were classified according to attachment style pre- and postintervention by the Attachment Q-Sort and the Attachment Q-Scales. After intervention, the treated group had significantly increased rates of attachment security (74%), reaching similar rates of secure attachment as nondepressed control-group dyads (80%). A group of dyads with depressed mothers who received no treatment actually had an 11% increase in insecure attachment.

The results are noteworthy, but due to the population they may not be generalizable to attachment relationships in which maternal depression is not a major variable. However, in community mental health settings it is not unusual for a mother to be receiving treatment for depression and a child receiving treatment for an attachment disturbance. It could be particularly helpful when these dyads are identified. While the authors give a descriptive account of what should be achieved in TPP, they do not address exactly how to meet those goals. For this reason this intervention may be more appropriately applied by clinicians already experienced in providing psychotherapy.

**Combination Treatment and Comparison Studies**

The benefits of psychoeducation and psychotherapy can be seen in some approaches that combine aspects of both models. In treating nonorganic failure-to-thrive, Fraiberg and Bennett (1978) provided in-home treatment to 11 infants ranging in age from 4 to 30 months old. This intervention is applied after hospitalization, when the child has made adequate weight gains. Mothers were taught basic caregiving skills, such as feeding and when to access medical care for the baby. Each mother was also encouraged to explore her past and how it may affect her current relationship with her infant. Significant outcomes included achieving and maintaining weight goals for the infants in the study. In addition, the authors reported improved parent–child bonding, and that the children showed no evidence of long-term psychopathology in the 4 years they were in treatment. In-home treatment is particularly suitable in situations where parents need guidance in meeting the basic physiological needs of their children.

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**In-home treatment is particularly suitable in situations where parents need guidance in meeting the basic physiological needs of their children.**
Meeting the parent in an environment that is non-threatening may decrease resistance to treatment and build trust in the therapeutic relationship.

Toth, Maughan, Manly, Spagnola, and Cicchetti (2002) in a randomized, controlled study compared the efficacy of preschooler–parent psychotherapy (PPP), psychoeducational home visitation (PHV), and community standard (CS) in changing 87 maltreated 4-year-olds’ negative internal representations. In the PPP intervention, mothers and preschoolers were seen weekly to improve the mother’s negative internal representations that affect her interactions with her child. The improvement in mother’s representations leads to improvement in the attachment relationship, increasing positive representations in the child. In the PHV intervention, the therapist came to the home weekly to assess risk and protective factors, and to educate the parent to child development, parenting strategies, and meeting self-care needs. The children in this group were also enrolled in a full-day preschool. A CS group received varying treatments from the Department of Social Services. At baseline and after 12 months of treatment, children’s internal representations were measured using narrative story-stem completion task. The PPP group had the most change after intervention, with significant decreases in negative maternal and self-representations. The PHV group had significant decreases in negative maternal representations. All groups had a significant increase in maternal-child relationship expectations, but the PPP group evidenced the most change. One perplexing finding is that there were no significant differences in baseline internal representations in maltreated preschoolers versus normal controls. This calls into question whether measuring internal representations provides the most accurate reflection of the difficulties that face maltreated children. In addition, we do not know the attachment status of the children in the study. They were not diagnosed with RAD or any type of insecure attachment. This study shows positive results towards changing negative internal representations, but it is unclear which populations would benefit from this intervention.

Robert-Tissou et al. (1996) compared the efficacy of infant-mother psychotherapy versus interaction guidance for 75 dyads referred to a clinic for “relationship problems.” Infant–mother psychotherapy addresses the mother’s perceptions of the child that affect interactions in the relationship. Interaction guidance uses videotaped play sessions between the mother and child as a tool for coaching the parent through more positive interactions. The children in the study were aged 2 to 30 months, and their presenting symptoms included sleep and feeding problems, tantrums, and aggression. Dyads were randomly assigned to one of the treatment conditions, which were quite brief at an average of six sessions. Outcome measures included the Symptom Check-List, the R-Interview (evaluates maternal internal representations), the KIA/KIDES Profile (measures infant affect), and observed mother–child interactions. The authors report a significant decrease in both treatment groups on symptom severity, in particular with eating and sleep problems. In addition, maternal sensitivity improved significantly and infant affects were more positive. The percentage of “insensitive” mothers decreased from 66% at pretreatment assessment to 38% post-treatment, and continued to improve by dropping to 17% 6 months post-treatment. There were no significant differences between the two types of treatment on outcome measures. This study does not specifically address attachment disorders, but it supports the efficacy of interventions typically used with the attachment-disordered population. In addition, even though the children were not diagnosed with RAD or an insecure attachment, the study population is at high risk of developing attachment problems. These are important findings because they provide evidence that there are several potential methods for improving attachment relationships (Robert-Tissou et al.).

Marvin, Cooper, Hoffman, and Powell (2002) combined psychoeducation and psychotherapy in a 20-week group-based intervention aimed at shifting the attachment styles of 75 parent–child dyads. The children ranged in age from 1 to 4 years old. Parent
and child attachment styles were assessed before and after treatment using Ainsworth’s Strange Situation. Parents were taught the basics of attachment theory, which were used for group analysis of videos of parents in the group interacting with their children. The early attachment pattern of the caregiver was also addressed, and parents were guided in applying this insight into improving their accuracy in reading and sending cues. The authors nicely outlined components of the program, which could easily be manualized for community clinician use. Preliminary results showed a 35% decrease in disordered attachment style post-intervention for children in the study, and a 45% decrease in disordered attachment style for parents in the study. This is quite promising data for a short-term, economical intervention. However, more studies are needed comparing psychoeducational and psychotherapeutic techniques as well as combinations of these models to determine the most effective treatments in improving attachment.

Intervening With Foster or Adoptive Families

Adoption or fostering of a child with attachment disorder can be a therapeutic intervention in itself, but research shows that some of these children still have significant difficulty even when placed with loving families. Even after 2 or more years of placement with adoptive families, approximately 40% of children adopted from extremely neglectful situations showed signs of at least mildly disinhibited attachment (O’Connor et al., 1999). The evidence regarding the effect of the child’s age at adoption on later attachment status is unclear. Children adopted from an institutional setting at greater than 6 months of age are significantly less likely to have a secure attachment with their adoptive parents than those children adopted before 6 months of age. In addition, these institutionalized children are more likely to have an atypical insecure attachment than are noninstitutionalized adopted children (O’Connor et al., 2003). However, children adopted before 6 months of age still exhibit a high percentage of attachment disorder (O’Connor et al., 1999). Juffer, Bakermans-Kranenburg, and Van Ijzendoorn (2005) have shown that an attachment-based intervention with the adoptive mothers of 6-month-old infants can decrease disorganized attachment at 12 months of age. This finding implies that even children adopted at a very young age are at risk for attachment difficulty and should be considered for intervention.

Several treatment interventions target the potential causes of this continued difficulty in foster/adoptive families. While the specific techniques used vary, all the treatment approaches focus on the importance of the parent’s role in the therapy.

Several treatment interventions target the potential causes of this continued difficulty in foster/adoptive families. While the specific techniques used vary, all the treatment approaches focus on the importance of the parent’s role in the therapy. From birth, infants use their relationships with caregivers to develop a worldview that will continue to evolve as they have new experiences. In children with traumatic early relationships, these often dysfunctional internal representations of self and other are carried into the new relationships with adoptive/foster caregivers. This affects not only the way the child interacts with the caregiver, but influences how the caregiver perceives the child
Lieberman reviewed 83 attachment-based psychotherapy treatment cases and noted that adoptive parents are distressed about their relationship with their children, tending to feel guilty and responsible for their children’s continuing attachment problems. Adoptive parents misinterpreted their child’s cues and overlooked their need for nurturance, as well as tending to respond with disciplinary measures when comfort measures would have been more reassuring. Lieberman recommends that more than good intentions are required when parenting an attachment-disordered child; parents should be given specific education regarding how to interpret the child’s signals and how to reassure the child that he is secure.

Similarly, Dozier’s (2003) Attachment and Bio-behavioral Catch-Up (ABC) intervention targets the signals and cues likely to be misinterpreted by both parent and child. She describes a cycle in which infants and toddlers with attachment disorder continue to behave as if they were in a relationship of poor attachment, eliciting a reciprocal response from the parent. Dozier recommends teaching parents to be aware of when their child may be appearing to push them away and suggests the parent respond “insensitively.” She argues that by always responding sensitively, parents confirm their child’s negative expectations that were learned in previous relationships. Only by responding insensitively—that is, by being nurturing to their child even if the child does not appear to want nurturance—can adoptive parents stop enabling harmful patterns learned in earlier relationships.

Hart and Thomas (2000) and Hughes (2003) advocate for even greater involvement of the parent in the child’s psychotherapeutic treatment. Hughes stresses the importance of identifying the parent’s attachment style and doing initial corrective treatment if the parent does not have a secure attachment style. In this model the parent’s and therapist’s abilities to accurately reflect an appropriate response to the child allow the child to regulate his own internal world. This may require exaggerated facial expression, eye contact, and touch on the part of the parent and therapist to build trust and teach the child self-worth. The adults should also keep the child close, limit choices, and provide structure, in essence allowing the child to use the adults’ organizational system to enhance security until the child can become organized. The facilitation of a secure base for the child is a primary goal, after which Hughes recommends CBT strategies for continued treatment. However, Hughes did not specify what type of goals should be set after the initial establishing of trust in the primary relationship.

In Hart and Thomas’ Parent Co-therapy (PCT), the therapist serves an educational and advocacy role to the adoptive parents, who provide the direct therapy to the children. They believe that by limiting the myriad of health professionals to whom many attachment-disordered children are exposed, children and parents can more easily develop a more secure primary relationship. PCT utilizes the relationship between the therapist and the parents to teach parents strategies from different models including multisystemic, behavioral, and psychodynamic therapies. In a case study where PCT was applied to three adopted siblings (6 years, 4 years, and 22 months of age), the authors reported more secure attachments, decreased symptomatology, and increased parental satisfaction with parenting. These changes were not systematically measured, but were noted by parent, teacher, and clinician report. A benefit of PCT is that it recognizes the need for individualized treatment strategies and empowers the family to actively participate in solutions. However, this model requires dedicated, insightful, and highly functioning parents as well as therapists skilled in multiple modalities.

In a single case study with a maltreated child recently moved to a residential center, Ryan (2004) concluded that little benefit was found by using play therapy as the treatment modality. Ryan engaged in play therapy with a maltreated 8-year-old diagnosed with RAD, Disinhibited type. His play included both direct reenactments of traumatic experiences, as well
as symbolic work on the abuse and neglect he had suffered. At the conclusion of treatment, Ryan determined her client was too emotionally unstable to be a good candidate for play therapy, and that the therapy did not seem to address his underlying attachment difficulty. It must be noted that the child did not have a secure primary attachment figure throughout his treatment, which is in itself a contributing factor to attachment problems. Larger studies on play therapy in children with and without the presence of primary attachment figures would be useful in determining the effectiveness play therapy with this population.

Commonalities in treatments which appear to be helpful are: including the parents in therapy to target the primary attachment relationship, helping the child shape more secure views of self and others, and limiting the child’s exposure to multiple caregivers.

O’Connor and Zeanah (2003), in their review of treatments for attachment disorders, recommend support groups for the adoptive parents of previously fostered or institutionalized children. Respite care is discussed as a potential intervention in families with a high level of stress related to the child’s behavior, with warning that the effects on the child of being sent away from the parent must be carefully assessed. The authors also recommend teaching parenting skills to this group to decrease dangerous behaviors, such as approaching strangers. However, they point out that the effects of psychoeducational interventions on the attachment relationship have not been well-studied in adopted children with attachment problems.

While even the few articles available on this issue provide some guidance for therapists working with fostered/adopted children with attachment problems, certainly no standard for treatment is apparent in the literature. No studies were available in which an intervention was applied and systematically measured. However, commonalities in treatments which appear to be helpful are: including the parents in therapy to target the primary attachment relationship, helping the child shape more secure views of self and others, and limiting the child’s exposure to multiple caregivers.

Practice Parameters

The American Academy of Child and Adolescent Psychiatry (2005) has developed practice parameters for the treatment of children with RAD. The authors of the parameters stress that the most important intervention is to advocate for the child to have a stable attachment figure. After the child is in a relationship with the potential for secure attachment, the therapist should utilize the parent–child dyad or use the parent as a therapeutic tool to facilitate positive caregiver–child interactions. Recommended treatment modalities include infant–parent psychotherapy and interaction guidance.

Conclusion

The two frequently used models in attachment treatment, psychotherapy and psychoeducation, appear to be quite different, but there is evidence that both may be useful tools in improving the status of children with attachment disorders. In psychoeducation, parents are educated about their child’s condition, taught how to physically care for and bond with their child, and are given tools to manage behavior problems. As the caregiver applies psychoeducational techniques, she becomes more competent in her parenting role, leading to more satisfactory, healthy interactions with her
child. In psychotherapy, the parent’s increased awareness of her own upbringing, as well as a corrective experience with the therapist, allows the parent to better meet her child’s physiological and psychological needs. There is some evidence that parent–child psychotherapy is more effective than psychoeducation at changing children’s negative internal representations, but more studies are needed to validate this finding. Both psychotherapy and psychoeducation foster trust and stability in a primary attachment relationship, creating a secure base for the child. In addition, both therapies target the parent’s internal representations of self and child, which if negative are detrimental to a child at any developmental stage. It seems feasible that both approaches promote parent–child attachment, but through different methods.

When using either psychoeducation or psychotherapy to treat a family with attachment problems, it is important that the advanced practice nurse consider the expected developmental norms for the child in treatment. Helping the parent understand normal attachment and development is an important aspect of both psychotherapeutic and psychoeducational models.

The combination of both methods used in conjunction is an effective method for improving disordered attachment styles in both parents and children. Combined treatment may produce increased benefit by targeting both parenting skills and parental psychological factors that affect the parent–child relationship. Further research is needed to determine whether combined treatment models are more efficacious than either psychotherapy or psychoeducation alone, as no studies have addressed this.

The evidence for intervening with foster and adoptive children with attachment disorders is extremely limited, with no controlled studies and only a handful of case studies. However, the literature supports that this population requires a different type of intervention than children with attachment disorder who are living with biological parents. Foster or adoptive parents may be providing a secure and loving home, but their children are still at great risk for the development of attachment problems. It is important to include the parents in the treatment intervention, as well as limit the child’s exposure to multiple clinicians. Interventions which target the underlying negative representations of both the child and the parent are recommended, especially teaching parents how to appropriately interpret and respond to their child’s often confusing cues. This will help the foster/adoptive child with attachment disorder begin to learn that their parent will respond to their needs and help them shape a view of the world as a safe place. More studies are necessary to determine whether play therapy and parent support groups are effective interventions with this population.

Limitations in applying the research on attachment interventions to clinical work include the lack of consistency in the populations studied and treatment interventions applied, and difficulty transferring information obtained in research into a clinically useful format. In addition, researchers need to evaluate the validity of the DSM-IV criteria for RAD versus clinical presentations of RAD and insecure attachments to help clinicians to choose an appropriate treatment. Studies that identify a child’s attachment status pre- and postintervention would be helpful in beginning to validate some of the treatments being utilized for attachment disorders. There are few studies to evaluate when recommending treatments for children with attachment disorders. However, researchers have made progress in advancing both psychoeducational and psychotherapeutic methods as appropriate interventions for both biological and foster/adoptive children with attachment disorders.

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