Letter to the Editor

It was with great interest that we read the report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems in the February *Child Maltreatment* journal. We appreciate and share the Task Force's dedication to children's safety and wholeheartedly agree with the statement that children's interests will be best served by "increased dialogue and information sharing between child abuse professionals, scientific researchers, and the attachment therapy community" (p. 85). To that end, as the consumers of therapeutic services, it is our hope that you will acknowledge the importance of our knowledge, experiences, and contributions.

Although we acknowledge and respect the Task Force's expertise in the area of child maltreatment, we wonder how many Task Force members have specific experience working with adoptive children and families. Attach-China/International Parents Network was formed precisely because so many parents of internationally adopted children were having difficulty in finding professionals who could provide the proper treatment for their children's problems. As with other professionals we have consulted, it may be important to consider what life is like in overseas orphanages as opposed to life in a dysfunctional family. These questions come to mind because of the report's criticism that attachment therapy's "conceptual focus for understanding the child's behavior emphasizes the child's individual internal pathology and past care givers, rather than current parent-child relationships or current environment" (p. 79).

According to Bessel van der Kolk, MD (1998), as many as 80% of abused and neglected infants and children develop disorganized and/or disoriented attachment relationships, which he defined as unpredictable approach-and-avoidance patterns toward mother, the inability to accept comfort from caregivers, rage at attachment figures, and pathological self-regulatory behaviors. Life in an orphanage is, by definition, neglect. Ratios of caregivers to infants are typically 25:1. Infants are often not held while fed, but bottles are propped. There is usually no availability of caregivers at night, when lights are turned out and doors closed. Infants are tied to cribs and potty seats, resulting in physical scarring around waist, groin, ankles and wrists, as well as emotional scarring of the psyche. Viewers of René Spitz's films on institutionalized children will understand the empty-eyed look that most infants from China have when they are abruptly handed over to strangers (their new adoptive parents) after 9 months or more of neglectful orphanage life. It would be a rare child, indeed, who would not be affected by these conditions.

The Task Force wrote,

> Although RAD may underlie occasional behavior problems among children who are severely maltreated, several much more common and demonstrably treatable diagnoses…may better account for many of these difficulties. Therefore, it should not be assumed that RAD underlies all or even most of the behavioral and emotional problems seen in foster children, adoptive children, or children who are maltreated. (p. 81)

We agree that the definition of *reactive attachment disorder* (RAD) is a major problem, as is the lack of broader definitions of *attachment impairment* along the attachment continuum. Although the diagnosis of RAD may be fitting for only the most extremely affected children, we believe that the broader category of attachment impairment applies to many more children. However, although the diagnoses along the continuum of attachment impairment are not yet fully delineated and defined, this does not mean that the difficulties these children experience can be better accounted for, or treated, by more familiar or more common diagnoses and treatments. It is the etiology of the symptoms that is important, not simply the group of symptoms. To choose a diagnosis and treatment based on how common they are, or how familiar we are with them, is like a Procrustean bed, making the patient fit our treatment, rather than our treatment fit the patient. Differential diagnosis between disorders with similar groups of symptoms has long been a concern within

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the field. Disorders such as attention-deficit/hyperactivity disorder (ADHD) and bipolar disorder can have very similar symptom groups yet are best treated completely differently.

Furthermore, to simply dismiss a cause-and-effect relationship between severe neglect and/or abuse and attachment impairment is to ignore widely accepted research by Spitz, Bowlby, and van der Kolk (Bowlby, 1969/1982, 1973, 1980; Karen, 1994; van der Kolk, 1989, 1994, 1998; van der Kolk, McFarlane, & Weisarth, 1996; van der Kolk, Pelcovitz, Roth, & Mandel, 1996; Spitz, 1952) and a growing body of research on how maltreatment affects the brain by Perry, Schore, Siegal, and others (Perry, 1994, 2000, n.d.; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Perry, Southwick, Yehuda, & Giller, 1990; Schore, 1999, 2003; Schwarz & Perry, 1994; Siegal, 1999, 2001). In "The0 Neuroarcheology of Childhood Maltreatment: The Neurodevelopmental Costs of Adverse Childhood Events," Bruce Perry, MD, PhD (2001), stated that

> It is much easier to influence the functioning of a developing system than to reorganize and alter the functioning of a developed system. Adverse childhood events, therefore, can alter the organization of developing neural systems in ways that create a lifetime of vulnerability. (para. 26)

Yes, if one hears hoof beats, think horses, not zebras. However, if one is in Africa, why wouldn't one think zebras? Although we have no statistics on how many children continue to demonstrate pathological behaviors after a year or more in their new homes, we do know from reading thousands of letters from parents describing the same behaviors that their early start in life continues to persist in affecting their ability to relate.

The report stated, "Critics [and by implication, the Task Force] argue that most of these children have never received state-of-the-art, evidence-based traditional treatments" (pp. 83-84). It is precisely because most of us have exhausted all traditional resources and treatments without finding sufficient help that we have turned to the Internet and parent networks. Many parents report that the majority of clinicians, pediatricians, and international adoption clinics they have consulted have no experience or understanding of adopted children's emotional health. The real tragedy in this is that effective treatment is often delayed for years while parents are encouraged to take a wait-and-see approach because children are resilient, or fruitlessly go from one traditional treatment to the next.

More adoption education for health care providers such as the Certificate Program in Adoption at Rutgers University is needed. It was at Rutgers that David Brodzinsky, PhD, studied adopted children, determining that the most common presenting symptoms in adopted children include hyperactivity, impulsiveness, oppositional and defiant behavior, aggression and anger, lying and stealing, hoarding behavior, and attachment difficulties. It certainly brings into question the report's criticism of attachment therapy's focus on the child's internal pathology and past caregivers.

As consumers, we cannot simply leave it up to "the professionals." That is an outmoded approach that overlooks the central role that adoptive parents must play along with therapists to support the healthy resolution of children's attachment issues. However, we completely agree with the Task Force's recommendations that clear guidelines be established, so that we can make a determination about what is safe, effective, and reliable when choosing a therapeutic modality.

Unfortunately, that is where the Task Force's report was most disappointing. Although the Task Force stated that "not all attachment-related interventions are controversial" the Task Force has lumped all interventions together, benign or otherwise. To equate the interventions of giving children chores with "hard labor" and reparenting and/or age regression (parenting children at their current emotional, not chronological, age) with humiliation, the Task Force does clinicians and consumers a disservice.

What we need are clear definitions of what constitutes good, nonabusive attachment therapy and parenting techniques. To say that all physically enforced holding is coercive suggests that all children, whether suffering from attachment impairment or not, know what is best for themselves. All parents who are doing an adequate job of parenting force their children to do many things they don't want to do, such as taking medicine or not running into the street. The Task Force report lacked differentiation between abusive holding (e.g., lying on top of a child and screaming at him or her) and loving, therapeutic holding (cuddling, kissing, and demonstrating that no matter how much the child provokes the parent to abandon them, the parent will stay). To only advocate traditional treatment methodologies, which parents have found to be ineffective, creates a vacuum in which fringe therapies can thrive, thus putting parents and kids at even greater risk.

In actuality, we agree with many of the Task Force's recommendations. We agree that there needs to be a broader and more specific definition of RAD and

attachment problems. We agree that there need to be valid and reliable assessment tools and scientific studies on which techniques are truly therapeutic. We agree that all attachment therapy should be based on empathy and include parent training in active listening and exploration of the parent's own relationship issues. It is our highest hope that there will be continued and expanded dialogue between the Task Force, respected attachment clinicians, and parents on how to best help our children and families.

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Cosigned by 109 additional adoptive parents

REFERENCES

Bowlby, J. (1969). *Attachment and loss: Vol. 1 attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol 2 separation*. New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol 3 loss*. New York: Basic Books.

Karen, R. (1994). *Becoming attached: First relationships and how they shape our capacity to love*. New York: Oxford University Press.

Perry, B. D. (1994). Neurobiological sequelae of childhood trauma: Post traumatic stress disorders in children. In M. Murburg (Ed.), *Catecholamine function in post traumatic stress disorder: Emerging concepts* (pp. 253-276). Washington, DC: American Psychiatric Press.

Perry, B. D. (2000). Traumatized children: How childhood trauma influences brain development. *Journal of the California Alliance for the Mentally Ill*, *11*(1), 48-51. Retrieved November 11, 2000, from www.ChildTrauma.org/ctamaterials/trau_CAMI.asp

Perry, B. D. (2001). The neuroarcheology of childhood maltreatment: The neurodevelopmental costs of adverse childhood events. In B. Geffner (Ed.), *For the cost of child maltreatment: Who pays? We all do* (pp. 15-37). San Diego, CA: Family Violence and Sexual Assault Institute.

Perry, B. D. (n.d.). *Violence and childhood: How persisting fear can alter the developing child's brain*. Child Trauma Academy. Retrieved November 20, 2000, from www.ChildTrauma.org/ctamaterials/trau_CAMI.asp

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and use-dependent development of the brain: How states become traits. *Infant Mental Health Journal*, *16*, 271-291.

Perry, B. D., Southwick, S. W., Yehuda, R., & Giller, E. L. (1990). Adrenergic receptor regulation in post-traumatic stress disorder. In E. L. Giller (Ed.), *Advances in psychiatry: Biological assessment and treatment of post traumatic stress disorder* (pp. 87-115). Washington, DC: American Psychiatric Press.

Schore, A. (1999). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Mahwah, NJ: Lawrence Erlbaum.

Schore, A. (2003). *Affect dysregulation and disorders of the self/affect regulation and the repair of the self*. New York: Norton.

Schwarz, E., & Perry, B. D. (1994). The post-traumatic response in children and adolescents. *Psychiatric Clinics of North America*, *17*(2), 311-326.

Siegal, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford.

Siegal, D. J. (2001). *The developing mind: How relationships and the brain interact to shape who we are*. New York: Guilford.

Spitz, R. A. (1952). *Grief—A peril in infancy* [Film]. Available from Archives of the History of American Psychology, The University of Akron, Polsky Building, LL10A, 225 South Main St., Akron, OH 44325-4302.

van der Kolk, B. (1998). The psychology and psychobiology of developmental trauma. In *Human Behavior: An introduction for medical students* (pp. 383-399). New York: Lippincott-Raven.

van der Kolk, B. A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimization, and masochism. *Psychiatric Clinics of North America*, *12*(2), 389-411. Retrieved February 4, 2002, from www.cirp.org/library/psych/vanderkolk/

van der Kolk, B. A. (1994). *The body keeps the score: Memory and the evolving psychobiology of post traumatic stress*. Retrieved February 7, 2002, from www.trauma-pages.com/vanderk4.htm

van der Kolk, B. A., McFarlane, A. C., & Weisarth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experiences on mind, body, and society*. New York: Guilford.

van der Kolk, B. A., Pelcovitz, D., Roth, S., & Mandel, F. (1996). Dissociation, somatization, and affect dysregulation. *American Journal of Psychiatry*, *153*(7), 83-94. Retrieved from ProQuest.