Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems

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Although the term attachment disorder *is ambiguous, attachment therapies are increasingly used with children who are maltreated, particularly those in foster care or adoptive homes. Some children described as having attachment disorders show extreme disturbances. The needs of these children and their caretakers are real. How to meet their needs is less clear. A number of attachment-based treatment and parenting approaches purport to help children described as attachment disordered. Attachment therapy is a young and diverse field, and the benefits and risks of many treatments remain scientifically undetermined. Controversies have arisen about potentially harmful attachment therapy techniques used by a subset of attachment therapists. In this report, the Task Force reviews the controversy and makes recommendations for assessment, treatment, and practices. The report reflects American Professional Society on the Abuse of Children's (APSAC) position and also was endorsed by the American Psychological Association's Division 37 and the Division 37 Section on Child Maltreatment.*

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The terms *attachment disorder*, *attachment problems*, and *attachment therapy*, although increasingly used, have no clear, specific, or consensus definitions. However, the terms and therapies often are applied to children who are maltreated, particularly those in the foster care, kinship care, or adoption systems, and related populations such as children adopted internationally from orphanages. Some children who are maltreated described as having attachment-related conditions show genuine and occasionally extreme behavioral and relationship disturbances and may be at risk for placement failures and other adverse outcomes. A number of attachment-based treatment and parenting approaches have been developed that purport to help these children. Attachment therapy is a young and diverse field, and the benefits and risks of many attachment-related treatments remain scientifically undetermined. Controversies have arisen about a particular subset of attachment therapy techniques developed by a subset of attachment therapy practitioners, techniques that have been implicated in several child deaths and other harmful effects. Although focused primarily on specific attachment therapy techniques, the controversy also extends to the theories, diagnoses, diagnostic practices, beliefs, and social group norms supporting these techniques, and to the patient recruitment and advertising practices used by their proponents. The controversy deepened after the death of 10-year-old Candace Newmaker during a therapy session in 2000 (Crowder & Lowe, 2000), and a number of child deaths occurring at the hands of parents who claim that they acted on attachment therapists' instructions (Warner, 2003). Criminal charges have been brought against some attachment therapists and against parents who claimed to be using what is known as *attachment parenting*. State legislative actions banning particular treatment techniques have been proposed and passed (Gardner, 2003; Janofsky, 2001). Professional organizations have published warnings (American Academy of Child and Adolescent Psychiatry, 2003). Despite these actions, and others, some of these concerning practices have remained entrenched within networks of attachment therapists and foster or adoptive parents who advocate their use.

As a professional society concerned with the welfare of maltreated children, the American Professional Society on the Abuse of Children (APSAC) has a direct interest in this area. In response to concerns about these issues, this Task Force was charged by the APSAC Board of Directors with examining current practices related to the theory, evidence, diagnosis, and treatment of children described as having attachment-related conditions and problems and with making recommendations for action to the Board. The Task Force also included members appointed from the American Psychological Association's Division on Child, Youth and Family Services. In this article, the Task Force will (a) present our summary and analysis of positions taken by critics and proponents of some of the controversial attachment therapies and (b) make recommendations for indicated and contraindicated assessment, treatment, and professional practices related to children described as having attachment disorders.

BACKGROUND

Research on Accepted and Noncontroversial Attachment Interventions

It is important to note that not all attachment-related interventions are controversial. There are many noncontroversial interventions designed to improve attachment quality that are based on accepted theory and use generally supported techniques. Traditional attachment theory holds that caregiver qualities such as environmental stability, parental sensitivity, and responsiveness to children's physical and emotional needs, consistency, and a safe and predictable environment support the development of healthy attachment. From this perspective, improving these positive caretaker and environmental qualities is the key to improving attachment. From the traditional attachment theory viewpoint, therapy for children who are maltreated and described as having attachment problems emphasizes providing a stable environment and taking a calm, sensitive, nonintrusive, nonthreatening, patient, predictable, and nurturing approach toward children (Haugaard, 2004a; Nichols, Lacher, & May, 2004). Moreover, generally accepted theory suggests that because attachment patterns develop within relationships, correcting attachment problems requires close attention to improving the stability and increasing the positive quality of the parent-child relationship and parent-child interactions. Indeed, in a review of more than 70

Authors' Note: APA Division 37 (Child, Youth and Family Services) and the Section on Child Maltreatment have endorsed this report and its recommendations. This does not imply endorsement by the American Psychological Association as a whole or endorsement by any of the Association's other Divisions or Sections.

studies of interventions designed to improve early childhood attachment, those interventions that most increased parental sensitivity were also the most effective in improving children's attachment security (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2003). In these types of attachment security interventions, the focus is primarily on the parent-child relationship and teaching positive parenting skills rather than on the individual child's pathology. Such parent-child relationship approaches would likely tend to favor maintaining children in their homes and families (either biological, kinship, foster, or adoptive) over removing children to institutional care.

Comparing findings across studies has resulted in the initial identification of some approaches that appear more effective than others. In their meta-analytic review, Bakermans-Kranenburg et al. (2003) identified common characteristics found among more successful approaches. Shorter term, more focused, and goal-directed interventions tended to yield better results than broadly focused and longer term interventions. This was true irrespective of the level of problems in the family and irrespective of whether the program was delivered to prevention (nonclinical) or intervention (clinical) populations. Broadly focused and more extensive interventions sometimes produced negative effects. Other keys to effectiveness identified by Bakermans-Kranenburg et al. included maintaining a focused, goal-directed, behavioral approach targeted at increasing sensitive parental behaviors and including fathers and mothers in the intervention. These findings echo those of similar meta-analytic reviews summarizing a large body of randomized outcome trials testing interventions for childhood disorders in general. Across studies, interventions that are focused, goal-directed, and behavioral typically yield better results (Weisz, Weiss, Han, Granger, & Morton, 1995). Consequently, it appears that many characteristics of effective attachment interventions are the same characteristics found among many effective child interventions in general (e.g., including parent skills training, goal-directed, behavioral focus, etc.—see Patterson, Reid, & Eddy, 2002). Thus, the arguments sometimes offered by proponents of controversial attachment therapies that "traditional therapies don't work with these children" appear counter to the available evidence if the traditional therapies are evidence based.

Controversial Theories of Attachment Disorder and Corresponding Controversial Treatments

Proponents of controversial attachment therapies often offer alternative conceptualizations of attachment problems among foster and adoptive children and children who are deprived or traumatized. Many of these conceptualizations include a central focus on the concept of suppressed rage to explain children's behavior (Cline, 1991). The rage theory appears to be rooted almost exclusively in clinical observation rather than in science or traditional attachment theory and is not considered well supported by most attachment researchers (Sroufe, Erickson, & Friedrich, 2002). In contrast to traditional attachment theory, the theory of attachment described by controversial attachment therapies is that young children who experience adversity (including maltreatment, loss, separations, adoption, frequent changes in child care, colic, or even frequent ear infections) become enraged at a very deep and primitive level. As a result, these children are conjectured to lack an ability to attach or to be genuinely affectionate with others. Suppressed or unconscious rage is theorized to prevent the child from forming bonds with caregivers and leads to behavior problems when the rage erupts into unchecked aggression. The children are described as failing to develop a conscience and as not trusting others. They are said to seek control rather than closeness, resist the authority of caregivers, and engage in endless power struggles. From this perspective, children described as having attachment problems are seen as highly manipulative in their social relations and actively trying to avoid true attachments while simultaneously striving to control adults and others around them through manipulation and superficial sociability. Children described as having attachment problems are alleged by proponents of the controversial therapies to be at risk for becoming psychopaths who will go on to engage in very serious delinquent, criminal, and antisocial behaviors if left untreated.

Proponents of controversial attachment therapies commonly assert that their therapies, and their therapies alone, are effective for children with attachment disorders and that more traditional treatments are either ineffective or harmful (see, e.g., Becker-Weidman, n.d.-b; Kirkland, n.d.; Thomas, n.d.-a). Proponents believe that traditional therapies fail to help children with attachment problems because the prerequisite of establishing a trusting relationship with the child is impossible to accomplish with these children. In contrast to traditional theories, the controversial treatments hold that children with attachment problems actively avoid forming genuine relationships, and consequently relationship-based interventions are unlikely to be effective (Institute for Attachment and Child Development, n.d.). Proponents of the controversial therapies emphasize the child's resistance to attachment and the need to break

down the child's resistance (Institute for Attachment and Child Development, n.d.). According to proponents, children with attachment disorders crave power, control, and authority; are dishonest; and have ulterior motives for ostensibly normal social behaviors. The child with attachment disorders is described by these proponents as completely self-centered, often exhibiting a sense of grandiosity, lacking conscience, and posing a danger to other children and, ultimately, to society itself. They are labeled within some treatment or parent communities as simply "RAD's," "RAD-kids" or "RADishes." Thus, the conceptual focus for understanding the child's behavior emphasizes the child's individual internal pathology and past caregivers, rather than current parent-child relationships or current environment. If the child is well behaved outside the home, it is conceptualized as successful manipulation of outsiders, rather than as evidence of a problem in the current home or current parent-child relationship (Thomas, n.d.-a). Proponents of this viewpoint may describe the presenting problem as a healthy family with a sick child. This perspective may appeal to some. As Barth, Crea, John, Thoburn, and Quinton (2005) noted "attachment therapies may be attractive because by locating the blame for the child's current difficulties with prior carers, they appear to relieve adoptive and foster parents of the responsibility to change aspects of their own behavior and aspirations" (pp. 262-263).

Because children with attachment problems are conjectured to resist attachment or even fight against it, and to control others to avoid attaching, the child's character flaws must be broken before attachment can occur. As part of attachment parenting, parents may be counseled to keep their child at home, bar social contact with others besides the parent, favor home schooling, assign children hard labor or meaningless repetitive chores throughout the day, require children to sit motionless for prolonged periods of time, and insist that all food and water intake and bathroom privileges be totally controlled by the parent (for an example of some of these types of recommendations, see Federici, 2003). We should note that the term *attachment parenting* may have various meanings. In a less controversial context, the term refers to practices of maintaining close physical contact and proximity between mothers and newborns, which is argued to promote healthy attachment. This is not the meaning discussed here. Here, the term refers to practices similar to the controversial attachment therapies, except that the actual practices are delivered by parents, often in consultation with therapists, rather than by therapists themselves. In these practices, children described as being attachment disordered are expected to comply with parental commands "fast and snappy and right the first time," and to always be "fun to be around" for their parents (see, e.g., Hage, n.d.-a). Deviation from this standard, such as putting off chores, incompletely executing chores, or arguing, is interpreted as a sign of attachment disorder that must be forcibly eradicated. From this perspective, parenting a child with an attachment disorder is a battle, and winning the battle by defeating the child is paramount.

Many of the controversial attachment therapies also hold that the child's rage must be "released" for the child to function normally (for a critique of this theory, see Sroufe et al., 2002). A central feature of many of these therapies is the use of psychological, physical, or aggressive means to provoke the child to catharsis, ventilation of rage, or other sorts of acute emotional discharge. To do this, a variety of coercive techniques are used, including scheduled holding, binding, rib cage stimulation (e.g., tickling, pinching, knuckling), and/or licking. Children may be held down, may have several adults lie on top of them, or their faces may be held so they can be forced to engage in prolonged eye contact. Sessions may last from 3 to 5 hours, with some sessions reportedly lasting longer. In the Newmaker case, a technique called *rebirthing* was used to simulate the psychological death of the angry unattached child to allow the child to be psychologically reborn (Lowe, 2000). This technique involved the child being held down by several adults, rolled up in blankets, and being instructed to fight her way free. In rebirthing and similar approaches, protests of distress from the child are considered to be resistance that must be overcome by more coercion. Rebirthing has been repudiated by many practitioners, including those who recommend other controversial techniques (Federici, n.d.). Similar but less physically coercive approaches may involve holding the child and psychologically encouraging the child to vent anger toward her or his biological parents.

Coercive techniques, such as scheduled or enforced holding, also may serve the intended purpose of demonstrating dominance over the child, and provoking catharsis or ventilation of rage. Establishing total adult control, demonstrating to the child that he or she has no control, and demonstrating that all of the child's needs are met through the adult, is a central tenet of many controversial attachment therapies. Similarly, many controversial treatments hold that children described as attachment disordered must be pushed to revisit and relive early trauma. Children may be encouraged to regress to an earlier age where trauma was experienced (Becker-Weidman, n.d.-b) or be reparented through holding sessions, diaper-

ing, or scheduled sessions where older children are nursed using pacifiers or baby bottles (see, e.g., Ward, n.d.).

The question of whether releasing rage or encouraging regression is beneficial is largely untested but ought to raise concerns. When tested experimentally, encouraging physical ventilation of anger has been found to increase levels of anger and aggression toward others, not diminish them (Bushman, 2002). Furthermore, children who cope with abuse or trauma by expressing or ventilating anger appear to show poorer adaptation, not better (Chaffin, Wherry, & Dykman, 1997). Similarly, although many well-supported treatments for traumatic stress–related disorders (e.g., gradual exposure-based therapies) involve talking about or revisiting traumatic events, there are fundamental differences between exposure techniques and the kinds of catharsis promoted by controversial attachment therapies. The gradual exposure-based techniques supported in the empirical literature all emphasize maintaining control over and coping with emerging emotions connected to the trauma using newly learned adaptive skills (Deblinger & Heflin, 1996), rather than emphasizing ventilation of overwhelming emotion, emotional discharge, or revisiting supposed "preverbal" or unconscious traumatic events.

Some controversial attachment therapies offer predictions that children with attachment disorder will grow to become violent predators or psychopaths unless they receive the controversial treatments. At least one attachment therapy Web site has argued that Saddam Hussein, Adolph Hitler, and Jeffrey Dahmer, among others, were examples of children who were attachment disordered who "did not get help in time" (Thomas, n.d.-b). These prognostications appear to fuel a sense of urgency about these children and have been invoked by some attachment therapists to justify application of aggressive and unconventional treatment techniques (Hage, n.d.-b)). However, it is critical to note that there is no empirical scientific support for the idea that children with attachment problems grow up to become psychopaths or otherwise prey on society. Much of what is known about predicting serious violent adult criminality suggests that while some violent adult criminals have a life-course persistent behavior pattern, the future predictive specificity of any childhood condition or trait appears to be quite limited (National Institute of Mental Health, 2001). In other words, although a few children with early or serious behavior problems persist on a trajectory toward severe violence, most do not. Consequently, predictions that children who are described as having an attachment disorder will grow to become psychopaths or violent criminals should be viewed with some skepticism given the results of related research. Until sound research is conducted to test these prognostications, they must be considered speculative and without scientific foundation.

ASSESSMENT AND DIAGNOSIS

As we have noted earlier, the term *attachment disorder* has no broadly agreed-on or precise meaning. The term is not part of any accepted standard nosology or system for classifying behavioral or mental disorders, such as the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) or *International Classification of Diseases* (*ICD*). Officially, there is no such disorder. However, neither is the term completely arbitrary. It refers to a fairly coherent domain of severe relational and behavioral problems. Understanding what is meant by *attachment disorder* first begins by understanding the narrower, more tightly defined, and better accepted diagnosis of reactive attachment disorder or RAD, which is described in the *DSM-IV* (American Psychiatric Association [APA], 1994).

Reactive Attachment Disorder (RAD)

According to the *DSM*, the core feature of RAD is severely inappropriate social relating that begins before age 5 years. The style of social relating among children with RAD typically occurs in one of two extremes: (a) indiscriminate and excessive attempts to receive comfort and affection from any available adult, even relative strangers (older children and adolescents may also aim attempts at peers) or (b) extreme reluctance to initiate or accept comfort and affection, even from familiar adults and especially when distressed (APA, 1994). RAD is one of the least researched and most poorly understood disorders in the *DSM*. There is very little systematically gathered epidemiologic information on RAD. In its absence, much of what is believed about RAD is based on theory, clinical anecdotes, case studies, and extrapolated from laboratory research on humans and animals. Similarly, the course of RAD is not well established. Long-term longitudinal data on the outcomes of children diagnosed with RAD have not been gathered (Hanson & Spratt, 2000).

It appears difficult to diagnose RAD accurately. No generally accepted standardized tools for assessing RAD exist, and several interview procedures in the literature misdiagnose inappropriately high numbers of children as having RAD who, in fact, appear to have only mild to moderate symptoms (O'Connor, Rutter, Beckett, Keaveney, & Kreppner, 2000). In addition, several other disorders share substantial symptom

overlap with RAD and, consequently, are often comorbid with or confused with RAD. For example, disorders such as conduct disorder, oppositional defiant disorder, and some of the anxiety disorders, including posttraumatic stress disorder (PTSD) and social phobia, all share some features with RAD. Symptom overlap can lead to a failure to diagnose RAD correctly when it is present, and to overdiagnose RAD when it is not present.

RAD also is distinct from, but may be confused with, several other neuropsychiatric disorders involving severe and pervasive problems with social relatedness, such as autism spectrum disorders, pervasive developmental disorder, childhood schizophrenia, and some genetic syndromes. In addition, some children simply have temperamental dispositions toward either rapid social engagement on one hand or shyness and social avoidance on the other, and neither of these normal variants in social behavior should be confused with an attachment disorder. Some children simply learn odd social habits because of living in institutions or other unnatural environments, and these behaviors may mimic psychiatric disorders. Because of these diagnostic complexities, careful diagnostic evaluation by a trained mental health expert with particular expertise in differential diagnosis is a must (Hanson & Spratt, 2000; Wilson, 2001).

Exact prevalence estimates for RAD are unavailable. Some have suggested that RAD may be quite prevalent because severe child maltreatment, which is known to increase risk for RAD, is prevalent, and because children who are severely abused may exhibit behaviors similar to RAD behaviors. However, this logic is flawed, and the Task Force believes it is questionable to infer the prevalence of RAD based on the types of behavior problems exhibited by children who are abused or neglected. Although RAD may underlie occasional behavior problems among children who are severely maltreated, several much more common and demonstrably treatable diagnoses—with substantial research evidence linking them to a history of maltreatment—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.

A history of maltreatment should not imply any disorder. Many children who are maltreated cope well. Even those experiencing severe maltreatment may evidence very few or transient behavioral or emotional problems as a consequence of their abuse (e.g., Kendall-Tackett, Williams, & Finkelhor, 2001). Many emerge without any long-term mental disorder, let alone a disorder as severe as RAD. Resilience to trauma and adversity is not limited to the extremely healthy or robust. Rather, resilience is a common and relatively normal human characteristic (Bonanno, 2004). Thus, reliance on rates of child abuse and/or neglect or problem behaviors should not serve as a benchmark for estimates of RAD. According to the *DSM*, RAD is presumed to be a "very uncommon" disorder (APA, 1994), although it is a disorder currently drawing considerable attention and interest.

Attachment Disorders as a Broader Classification

The first standardized diagnostic criteria for RAD came in the third version of the *DSM*. These criteria were refined in subsequent editions of the *DSM* (APA, 1980, 1994). A largely similar definition was included in the *ICD-10* (World Health Organization, 1992), although pathogenic care was not a diagnostic requirement. Some clinicians have begun to identify a broader group of novel attachment disorders diagnoses beyond the confines of RAD, largely through anecdotal reports. As of yet, formal nosologies such as the *DSM* or *ICD* systems have not recognized an attachment disorder beyond RAD. The children's advocacy organization Zero to Three (1994) included some expanded categories by describing a number of variants of "relationship disorders" on Axis II. Despite the limitations noted in the RAD diagnostic criteria, the lack of an acceptable alternative leads to its application in practice to children who do not fully meet the criteria. Consequently, in practice, a child described as having RAD may actually fail to meet formal diagnostic criteria for the disorder, and consequently the label should be viewed cautiously.

Recognizing the limitations of the formal RAD criteria, alternative diagnostic criteria have been proposed to describe broader disorders of attachment, including those by Lieberman and Pawl (1988, 1990) and by Zeanah, Mammen and Lieberman (1993). Zeanah's research group went on to describe a range of attachment disturbances including disorders of nonattachment, secure base distortions, and disorders of disrupted attachment (Boris, Zeanah, Larrieu, Scheeringa, and Heller, 1998; Zeanah & Boris, 2000). In the absence of consensual and officially recognized diagnostic criteria, the omnibus term *attachment disorder* has been increasingly used by some clinicians to refer to a broader set of children whose behavior is affected by lack of a primary attachment figure, a seriously unhealthy attachment relationship with a primary caregiver, or a disrupted attachment relationship (e.g., Hughes, 1997; Keck, Kupecky, & Mansfield, 2002). As Zeanah and Boris (2000) argued, clinical experience suggests that disorders of attachment do exist beyond the confines of RAD. However, the exact

parameters of the disorders are not yet established. It is important that clinicians remain cognizant of these diagnostic uncertainties so that the diagnosis of "attachment disorder" is not improperly reified and more precise validity sacrificed.

Potential Misapplications of Attachment Disorder Diagnoses

Attachment-related problems may be underdiagnosed, overdiagnosed, or both simultaneously. In general, rare conditions may be missed by some clinicians simply because of unfamiliarity. They also may be overdiagnosed by proponents. There are no studies examining diagnostic accuracy among the increasing numbers of children who are maltreated being described by clinicians as having an attachment disorder. It is not clear how many children described as having attachment disorders suffer from actual disorders of attachment, from transitory sequelae of maltreatment, from stress related to shifts in placements or cultures, or from other disorders with shared characteristics. The simple fact that a child may have experienced pathogenic care, or even trauma, should not be taken as an indication of an attachment disorder or any other disorder. It also is important to bear in mind that a child entering the child welfare system, foster care, adoption, or other settings is almost invariably experiencing acute stress. Behavior problems or relationship problems shown during periods of acute stress do not automatically suggest any disorder. This is a particularly important point for evaluating children in cross-cultural or international adoptions. Different cultures have different normative social behaviors, which could easily be misconstrued as a disorder. For example, failure to make eye contact is included on some checklists as a sign of attachment disorder; however, this may be a normative social behavior in many cultures (Keating, 1976). Establishing that an attachment disorder, or any other stable disorder, actually exists requires some familiarity with the child's long-term behavior, including behavior in multiple settings, and should not be limited to behaviors occurring with a foster or adoptive parent. Assessments based on a single point in time snapshot of the child may be particularly vulnerable to misdiagnosis.

Practitioners working with children who are maltreated must be vigilant to avoid what some have called the "allure of rare disorders" (Haugaard, 2004a). Mental health and related fields have a long history of diagnostic fads, when rare or esoteric diagnoses become fashionable and spread rapidly through the practice world, support groups, and the popular press. Rarely have these fads resulted in real clinical or scientific progress, and occasionally they have resulted in demonstrable harm. For example, recent history in the child abuse field has seen the rise and fall in popularity of diagnoses such as dissociative identity or multiple-personality disorder and concepts such as repressed memory. Although fashionable only a few years ago, some scientists now question whether these phenomena actually exist at all, and it is now generally accepted that neither is nearly as prevalent as proponents once suggested. Arguably, both of these diagnostic fads harmed some patients (Dardick, 2004). Just as it is important not to miss the presence of an uncommon condition in a child, it also is important not to diagnose an uncommon and dramatic disorder when the diagnosis of a common but less exciting disorder is more appropriate. Although more common diagnoses, such as attention-deficit/hyperactivity disorder (ADHD), conduct disorder, PTSD, or adjustment disorder may be less exciting, they should be considered as first-line diagnoses before contemplating any rare condition, such as RAD or an unspecified attachment disorder. The standard diagnostic aphorism that "when you hear hoof beats, think horses, not zebras" is important to bear in mind for a number of reasons. First, more prevalent conditions are less likely than rare conditions to be misdiagnosed; their criteria are better established and agreed on, sound assessment procedures are more widely available, and classification accuracy is always higher with more prevalent (i.e., higher base rate) conditions. Second, the appropriate intervention for a common disorder is likely to be different from that for an uncommon disorder. Finally, there are richer literatures and better established evidenced-based treatments for more common conditions. For example, scientifically well-supported and effective treatments exist for ADHD, oppositional-defiant disorder, and PTSD (Kazdin, 2002).

Many of the controversial attachment therapies have promulgated quite broad and nonspecific lists of symptoms purported to indicate when a child has an attachment disorder. For example, Reber (1996) provided a table that lists "common symptoms of RAD." The list includes problems or symptoms across multiple domains (social, emotional, behavioral and developmental) and ranges from *DSM-IV* criteria for RAD (e.g., superficial interactions with others, indiscriminate affection toward strangers, and lack of affection toward parents), to nonspecific behavior problems including destructive behaviors; developmental lags; refusal to make eye contact; cruelty to animals and siblings; lack of cause and effect thinking; preoccupation with fire, blood, and gore; poor peer relationships; stealing; lying; lack of a conscience; persistent

nonsense questions or incessant chatter; poor impulse control; abnormal speech patterns; fighting for control over everything; and hoarding or gorging on food. Others have promulgated checklists that suggest that among infants, "prefers dad to mom" or "wants to hold the bottle as soon as possible" are indicative of attachment problems (Buenning, 1999). Clearly, these lists of nonspecific problems extend far beyond the diagnostic criteria for RAD and beyond attachment relationship problems in general. These types of lists are so nonspecific that high rates of false-positive diagnoses are virtually certain. Posting these types of lists on Web sites that also serve as marketing tools may lead many parents or others to conclude inaccurately that their children have attachment disorders.

THE ATTACHMENT THERAPY CONTROVERSY

The attachment therapy controversy has centered most broadly on the use of what is known as "holding therapy" (Welch, 1988) and coercive, restraining, or aversive procedures such as deep tissue massage, aversive tickling, punishments related to food and water intake, enforced eye contact, requiring children to submit totally to adult control over all their needs, barring children's access to normal social relationships outside the primary parent or caretaker, encouraging children to regress to infant status, reparenting, attachment parenting, or techniques designed to provoke cathartic emotional discharge. Variants of these treatments have carried various labels that appear to change frequently. They may be known as "rebirthing therapy," "compression holding therapy," "corrective attachment therapy," "the Evergreen model," "holding time," or "rage-reduction therapy" (Cline, 1991; Lien, 2004; Levy & Orlans, 1998; Welch, 1988). Popularly, on the Internet, among foster or adoptive parents, and to case workers, they are simply known as "attachment therapy," although these controversial therapies certainly do not represent the practices of all professionals using attachment concepts as a basis for their interventions.

The controversy was spurred by a series of child deaths. Transcripts of sessions at the facility implicated in the death of Candace Newmaker revealed a child begging to be released and complaining of suffocation before dying during the procedure. The death of Krystal Tibbets at the hands of her parents reportedly involved similar "compression" techniques employed at the suggestion of therapists. Some proponents of these techniques have dismissed children's protests of distress during the treatment by arguing that children with attachment disorders are "manipulative" and merely "feign discomfort" (Corrigan & Powell, 2002). Parents' assuming total control of the child's eating and drinking, and forcing excessive fluid intake, were implicated in one fatality, again allegedly at the instruction of therapists. The practice of some forms of these treatments has resulted in professional licensure sanctions against some leading proponents of the controversial attachment therapies. There have been cases of successful criminal prosecution and incarceration of therapists or parents using controversial attachment therapy techniques and state legislation to ban particular therapies. Position statements against using coercion or restraint as a treatment were issued by mainstream professional societies (American Psychiatric Association, 2002) and by a professional organization focusing on attachment and attachment therapy (Association for Treatment and Training in the Attachment of Children [ATTACh], 2001). Despite these and other strong cautions from professional organizations, the controversial treatments and their associated concepts and foundational principles appear to be continuing among networks of attachment therapists, attachment therapy centers, caseworkers, and adoptive or foster parents (Hage, n.d.-a; Keck, n.d.). As Berliner (2002) noted, parents and caseworkers may turn to these treatments out of desperation. For many foster or adoptive parents, the reality of foster or adoptive parenting may be quite discrepant from their expectations. Children may be emotionally distant or difficult to manage. On rare occasions, children may be violent. In some cases, radical treatments advertising dramatic successes may appeal to these parents. Although criticism of the controversial attachment therapies has been widespread in mainstream professional and scientific circles, efforts to disseminate these criticisms and concerns to the lay public have been minimal, and most foster or adoptive parents are probably unaware of the risks and poor foundation for some treatment claims.

Controversial attachment therapies are viewed by many in the mainstream professional and research communities as presenting a significant physical and psychological risk to children with little evidence of therapeutic benefit. Critics have long argued that these treatments are not based on sound or accepted theory, are inconsistent with the general principles of effective clinical practice, and are reminiscent of other unsound and sometimes dangerous fad or cult therapies that periodically arise in the mental health treatment and self-help arenas. Critics argue that most of these children have never received state-of-the-art, evidence-based traditional treatments, so pro-

ponent's claims that "traditional therapies don't work" are not well founded. Furthermore, they argue that using holding therapy or similar techniques to force children who were severely maltreated to have close, confining physical contact is more likely to exacerbate their difficulties than to help. In addition, critics note that holding therapy and those attachment therapies that seek to demonstrate dominance and control over the child may duplicate the dynamics of abuse experiences and reinforce rather than ameliorate relationship problems.

It is argued that holding therapy or other physically coercive therapies may present a physical risk to the child and others because of the use of physical force. Children have been injured while being restrained, and parents or therapists may be hit, kicked, or bitten. Although the exact number of child deaths related to the controversial treatment or parenting techniques is uncertain, six or more have been alleged by some attachment therapy critics (Advocates for Children in Therapy, n.d; Mercer, Sarner, & Rosa, 2003) and are noted in the policy statement by the American Academy of Child and Adolescent Psychiatry (2003). Critics argue that the dire predictions and negative conceptualizations of children central to controversial attachment therapies or attachment parenting, combined with their practitioners' isolation from the mainstream fields of child development, child maltreatment, and child psychology, create a fertile ground for abusive practices to develop. Critics of controversial attachment therapies or attachment parenting have pointed to the child deaths as the predictable result of combining (a) a belief in coercive techniques, (b) negative conceptualizations of children with RAD, (c) the isolated culture surrounding these practice and parenting communities, (d) desperation over very real child behavioral or emotional problems, (e) a false sense of pessimism about the child's long-term future, and (f) a false sense of futility about safer alternative approaches. Critics note that one of the highest profile deaths occurred at the hands of practitioners who were well-recognized attachment therapy trainers. Therefore, explanations that the deaths involved only isolated rogue practitioners who were simply not knowledgeable or skilled in these techniques seem unlikely. Deaths allegedly due to attachment parenting may be more difficult to assess and sometimes involve disputes over what was and was not actually recommended by the therapists. However, even if the deaths did involve misapplication of treatment techniques, or misapplication of parenting recommendations, critics argue that any psychological treatment or parenting approach that is so volatile that it can result in child death if done imperfectly is simply too dangerous under any conditions, particularly when there is no scientific evidence of benefit and when safer treatments are available.

Critics dismiss the anecdotal reports or testimonials offered on Web sites about the controversial attachment therapies or endorsements offered by former patients. They note that even quackery or demonstrably harmful treatments have their passionate adherents and can proffer many satisfied patients who describe stories of miraculous cures. This type of evidence simply cannot be considered persuasive from a scientific perspective. Critics further note that obtaining and using client testimonials in public advertising may violate established professional ethical standards (American Psychological Association, 2002, p. 9).

On the other hand, proponents of holding therapy and other controversial attachment therapies argue that the techniques present no physical risk to the child, parent, or therapist if done properly, and dismiss the concerns raised by critics as misunderstandings based on scattered and unrepresentative vignettes that have been taken out of context. They dispute that holding therapy involves coercion or involuntary restraint. Proponents describe their approach to holding as gentle or nurturing rather than coercive or humiliating (Keck, n.d.). Moreover, proponents may argue that nontraditional and intensely physical and emotional techniques, such as holding, reparenting, or catharsis, are required to help the children they describe as having attachment disorders. The primary evidence offered by proponents to support these arguments is anecdotal report, patient testimonials, therapist observations, and their own clinical experience of appearing to achieve success in cases where prior treatments have failed.

All agree that the series of child deaths is tragic; however, there is disagreement as to the cause. Proponents of controversial attachment therapies suggest that the practices that caused the deaths of these children were either misapplications of attachment therapy techniques, atypical practices, the result of parents misusing certain practices, the application of techniques that simply are not a part of most attachment therapy protocols anymore, or are misrepresentations by parents who are abusive attempting to defend or excuse their own abusive behavior by blaming it on therapists. In other words, proponents argue that these child deaths had nothing to do with holding or other controversial attachment therapies as they are currently practiced. Proponents suggest that critics are misrepresenting what attachment therapy actually involves (Cascade Center for Family Growth,

n.d.). Proponents correctly point out that most critics have never actually observed any of the treatments they criticize or visited any of the centers where the controversial therapies are practiced. Other proponents have suggested more personal reasons for critics' positions, suggesting that critics are motivated by their own "unresolved issues" or are simply psychologically uncomfortable with strong emotions (Institute for Attachment and Child Development, n.d.).

This polarization is compounded by the fact that attachment therapy has largely developed outside the mainstream scientific and professional community and flourishes within its own networks of attachment therapists, treatment centers, caseworkers, and parent support groups. Indeed, proponents and critics of the controversial attachment therapies appear to move in different worlds. Moreover, the sides do not agree on the rules for determining the risks and benefits of psychological treatments or how questions about risks and benefits should be resolved. Critics tend to rely on the well-established and accepted principles of clinical science. Central to the clinical science perspective is testing outcomes using rigorous scientific research designs and methods that control for well-known confounds such as spontaneous recovery, the placebo effect, patient expectancy effects, investigator effects, and other forces that may influence the perceived outcomes of any clinical intervention. Critics tend to rely on scientific peer-review of research findings, publishing results in the scientific literature for wider scrutiny and review, and independent replication of findings before labeling a treatment as efficacious with an acceptable level of risk.

Proponents, although not necessarily averse to science, appear to rely more on their own personal experience for determining what is beneficial, emphasizing what they see clinically and qualitatively and the testimonials of their clients (see Hage, n.d.-b). They operate more as advocates and believers than as skeptics or scientists. Most literature on controversial attachment therapies has not been vetted through any recognized scientific, independent peer-review process. Even less scientifically rigorous outlets such as published books and treatment manuals are difficult to find. Much of the available information is found on the Web sites of organizations or centers that deliver the treatment, or in-house and self-published materials. These Web sites often appear to serve as marketing tools and providing information about the treatments used. Critics have noted that these Web sites make exaggerated claims of effectiveness without adequate supporting scientific evidence and promote the diagnoses of attachment disorders with overly broad lists of indicators. Some proponents have claimed that research exists that supports their methods, or that their methods are evidence based, or are even the sole evidence-based approach in existence, yet these proponents provide no citations to credible scientific research sufficient to support these claims (Becker-Weidman, n.d.-b). This Task Force was unable to locate any methodologically adequate clinical trials in the published peer-reviewed scientific literature to support any of these claims for effectiveness, let alone claims that these treatments are the only effective available approaches. Most of the data offered on these Web sites is so methodologically compromised that the Task Force believes it could not support any clear conclusion. For example, perhaps the most widely cited study in the holding therapy literature, and possibly the only empirical study on the topic available in a mainstream peer-reviewed journal, suffered from a number of major limitations. The study used a very small sample (12 in the treatment group, 11 in the comparison group), participants were self-selected into treatment and comparison groups, and the statistical analysis did not include any direct test of group differences in change over time (Myeroff, Mertlich, & Gross, 1999).

Critics have questioned the ethical appropriateness of directly advertising controversial approaches to groups of foster parents, adoptive parents, caseworkers, and other lay audiences who usually do not have the training or background to evaluate the credibility of the claims made. It is argued by critics that any practice that is this controversial or volatile should not be marketed directly to the lay public, and that making claims of exaggerated or exclusive benefit is inconsistent with established ethical standards and the available scientific evidence. Presumably, most proponents do not agree with these concerns. Proponents seem to place great importance on their view that they are treating or parenting children who are seriously disturbed, and that they have special personal knowledge about these children and the struggles involved in raising them that outsiders and critics do not. Proponents emphasize that unless one has actually attempted to parent a child with an attachment disorder, it is impossible to fully grasp the situation.

Ultimately, continued separation between the worlds of attachment therapy and mainstream clinical science is not conducive to resolving these differences or promoting safe and effective clinical practices. The Task Force believes that the ultimate benefit of children will be best served by increased dialogue and information sharing between child abuse professionals, scientific researchers, and the attachment therapy

community. Nonetheless, the Task Force believes that it is important to take a stand on harmful or questionable practices and theories, while encouraging increased dialogue and research in these areas. The following practice recommendations are made by the Task Force:

RECOMMENDATIONS

1. Recommendations regarding diagnosis and assessment of attachment problems
   a. Attachment problems, including but extending beyond RAD, are a real and appropriate concern for professionals working with children who are maltreated and should be carefully considered when these children are assessed.
   b. Assessment guidelines
      (1) Assessment should include information about patterns of behavior over time, and assessors should be cognizant that current behaviors may simply reflect adjustment to new or stressful circumstances.
      (2) Cultural issues should always be considered when assessing the adjustment of any child, especially in cross-cultural or international placements or adoptions. Behavior appearing deviant in one cultural setting may be normative for children from different cultural settings, and children placed cross-culturally may experience unique adaptive challenges.
      (3) Assessment should include samples of behavior across situations and contexts. It should not be limited to problems in relationships with parents or primary caretakers and instead should include information regarding the child's interactions with multiple caregivers, such as teachers, day care providers, and peers. Diagnosis of RAD or other attachment problems should not be made solely based on a power struggle between the parent and child.
      (4) Assessment of attachment problems should not rely on overly broad, nonspecific, or unproven checklists. Screening checklists are valuable only if they have acceptable measurement properties when applied to the target populations where they will be used.
      (5) Assessment for attachment problems requires considerable diagnostic knowledge and skill, to accurately recognize attachment problems and to rule out competing diagnoses. Consequently, attachment problems should be diagnosed only by a trained, licensed mental health professional with considerable expertise in child development and differential diagnosis.
      (6) Assessment should first consider more common disorders, conditions, and explanations for behavior before considering rarer ones. Assessors and caseworkers should be vigilant about the allure of rare disorders in the child maltreatment field and should be alert to the possibility of misdiagnosis.
      (7) Assessment should include family and caregiver factors and should not focus solely on the child.
      (8) Care should be taken to rule out conditions such as autism spectrum disorders, pervasive developmental disorder, childhood schizophrenia, genetic syndromes, or other conditions before making a diagnosis of attachment disorder. If necessary, specialized assessment by professionals familiar with these disorders or syndromes should be considered.
      (9) Diagnosis of attachment disorder should never be made simply based on a child's status as maltreated, as having experienced trauma, as growing up in an institution, as being a foster or adoptive child, or simply because the child has experienced pathogenic care. Assessment should respect the fact that resiliency is common, even in the face of great adversity.
2. Recommendations regarding treatments and interventions
   a. Treatment techniques or attachment parenting techniques involving physical coercion, psychologically or physically enforced holding, physical restraint, physical domination, provoked catharsis, ventilation of rage, age regression, humiliation, withholding or forcing food or water intake, prolonged social isolation, or assuming exaggerated levels of control and domination over a child are contraindicated because of risk of harm and absence of proven benefit and should not be used.
      (1) This recommendation should not be interpreted as pertaining to common and widely accepted treatment or behavior management approaches used within reason, such as time-out, reward and punishment contingencies, occasional seclusion or physical restraint as necessary for physical safety, restriction of privileges, "grounding," offering physical comfort to a child, and so on.
   b. Prognostications that certain children are destined to become psychopaths or predators should never be made based on early childhood behavior. These beliefs create an atmosphere conducive to overreaction and harsh or abusive treatment. Professionals should speak out against these and similar unfounded conceptualizations of children who are maltreated.
   c. Intervention models that portray young children in negative ways, including describing certain groups of young children as pervasively manipulative, cunning, or deceitful, are not conducive to good treatment and may promote abusive practices. In general, child maltreatment professionals should be skeptical of treatments that describe children in pejorative terms or that advocate aggressive techniques for breaking down children's defenses.

d. Children's expressions of distress during therapy always should be taken seriously. Some valid psychological treatments may involve transitory and controlled emotional distress. However, deliberately seeking to provoke intense emotional distress or dismissing children's protests of distress is contraindicated and should not be done.
e. State-of-the-art, goal-directed, evidence-based approaches that fit the main presenting problem should be considered when selecting a first-line treatment. Where no evidence-based option exists or where evidence-based treatment options have been exhausted, alternative treatments with sound theory foundations and broad clinical acceptance are appropriate. Before attempting novel or highly unconventional treatments with untested benefits, the potential for psychological or physical harm should be carefully weighed.
f. First-line services for children described as having attachment problems should be founded on the core principles suggested by attachment theory, including caregiver and environmental stability, child safety, patience, sensitivity, consistency, and nurturance. Shorter term, goal-directed, focused, behavioral interventions targeted at increasing parent sensitivity should be considered as a first-line treatment.
g. Treatment should involve parents and caregivers, including biological parents if reunification is an option. Fathers, and mothers, should be included if possible. Parents of children described as having attachment problems may benefit from ongoing support and education. Parents should not be instructed to engage in psychologically or physically coercive techniques for therapeutic purposes, including those associated with any of the known child deaths.

3. Recommendations for child welfare
   a. Treatment provided to children in the child welfare and foster care systems should be based on a careful assessment conducted by a qualified mental health professional with expertise in differential diagnosis and child development. Child welfare systems should guard against accepting treatment prescriptions based on word-of-mouth recruitment among foster caregivers or other lay individuals.
   b. Child welfare systems should not tolerate any parenting behaviors that normally would be considered emotionally abusive, physically abusive, or neglectful simply because they are, or are alleged to be, part of attachment treatment. For example, withholding food, water, or toilet access as punishment; exerting exaggerated levels of control over a child; restraining children as a treatment; or intentionally provoking out-of-control emotional distress should be evaluated as suspected abuse and handled accordingly.
4. Professionals should embrace high ethical standards concerning advertising treatment services to professional audiences and especially to lay audiences.
   a. Claims of exclusive benefit (i.e., that no other treatments will work) should never be made. Claims of relative benefit (e.g., that one treatment works better than others) should only be made if there is adequate controlled trial scientific research to support the claim.
   b. Use of patient testimonials in marketing treatment services constitutes a dual relationship. Because of the potential for exploitation, the Task Force believes that patient testimonials should not be used to market treatment services.
   c. Unproven checklists or screening tools should not be posted on Web sites or disseminated to lay audiences. Screening checklists known to have adequate measurement properties and presented with qualifications may be appropriate.
   d. Information disseminated to the lay public should be carefully qualified. Advertising should not make claims of likely benefits that cannot be supported by scientific evidence and should fully disclose all known or reasonably foreseeable risks.

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