



Institute for Science in Medicine

**WHITE PAPER**

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**ATTACHMENT THERAPIES  
AND  
ASSOCIATED PARENTING TECHNIQUES**

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Attachment Therapies and associated parenting techniques have been disapproved by professional organizations, but continue to be recommended by Internet sites and in print and video forms, and to be chosen by parents, especially adoptive parents. Child injuries and deaths have been associated with these methods, which are without an acceptable evidence basis. Policy changes are needed to help lessen the popularity of these ineffective and potentially harmful treatments.

Relevant policy-makers are found in both public and private organizations. Some state and local governments and agencies have funded training in Attachment Therapies and paid for the treatment itself. These governmental entities have promoted the use of Attachment Therapies by means of policy set for child protective services, court-appointed special advocates (CASAs), guardians *ad litem*, foster parents, and so on. In the private sector, adoption agencies, organizations, and foundations have helped promote the use of Attachment Therapy by setting influential policies, particularly in terms of their screening of potential adoptive parents, the content of their pre-adoption education as required by the Hague Convention, and the nature of their post-adoption services. Both public and private sectors have influenced the use of Attachment Therapy through policies determining the provision of treatment for special needs adoptees and foster children. To some extent, however, both public and private health insurance groups have discouraged the use of such treatments by refusing reimbursement for their use.

## **Background**

### **Definition and Description**

Attachment Therapy (AT) is the term for a range of unconventional, non-evidence-based mental health interventions for children. What AT methods have in common is the assumption that most, if not all, childhood mental health disturbances are caused by failure of normal development of emotional attachment to caregivers. In addition, AT proponents claim causes of attachment that contradict its long-observed natural history. AT advocates believe that emotional attachment of young children to caregivers is caused (1) prenatally, by communication of mother and fetus, and (2) through two “attachment cycles”, the first involving experience of total dependence on an adult for food and physical care, and the second involving adult limit-setting. These posited causes of attachment are implausible in light of the evidence that infants do not show attachment to caregivers until at least six months of age, and that pleasant social interactions with responsive adults, rather than physical gratification, are responsible for the development of attachment.

AT practitioners also share the belief that re-enactment of typical episodes of early infancy can recapitulate and repair failed attachment development. AT practitioners and parents carry out these re-enactments by physically holding or restraining children, by feeding older children by spoon or by baby bottle and preventing them from obtaining food by themselves, and by requiring children to gaze into the eyes of parents or therapists, in the mistaken belief that eye contact causes attachment rather than following it.<sup>1</sup>

Most of the attention paid to AT methods has focused on Holding Therapy (HT), a method that uses physical restraint and intrusive physical contact as well as verbal provocation. HT was historically the first form of AT, beginning in the 1960s. It was based on the belief that rage at separation from a birth mother, or at other early experiences, prevented the development of attachment to caregivers; provoking rage by restraint, painful prodding of the torso, and the shouting of insults and demands at the child was thought to remove this rage by a process of catharsis. The 2000 death of a 10-year-old girl, Candace Newmaker, in a different but related treatment by HT practitioners, led to some degree of rethinking of this form of AT.<sup>2</sup>

AT methods are often accompanied by a range of non-evidence-based adjuvant treatments such as QEEG, Craniosacral Therapy, and Tomatis Sound Therapy (e.g., [www.mentalhealthgeorgia.com](http://www.mentalhealthgeorgia.com)). In addition, parents seeking treatment for their children's present or predicted problems are advised to use methods proposed by a foster parent who has been much associated with AT practitioners, Nancy Thomas.<sup>1</sup> The parents themselves may employ these methods, which may be referred to as Nancy Thomas Parenting (NTP), or children may be placed in "therapeutic foster care" or "respite care" where the methods are used. NTP techniques include limiting the amount and types of foods given to children, forbidding children to obtain food or drink for themselves, making toilet facilities available only with adult permission, removing furniture and items of comfort from bedrooms, placing locks or alarms on bedroom doors and food storage areas, and so on. Adults practicing NTP methods refuse information to children in foster care who want to know when they will see their parents. Children are required to do excessive chores and exercise. The adults also rock and gaze into the eyes of children of all ages, while bottle-feeding them or hand-feeding them caramels, a candy that according to Thomas replicates the experience of milk sugars in breast-feeding.

Children being treated with AT and NTP are commonly home-schooled, removing some of the normal community buffers that may work to prevent abusive treatment and often limiting their academic progress. In addition, if they fail to comply with parental wishes they may be placed in "respite care" for a weekend or longer, and are threatened with abandonment in the form of disrupted adoption or placement in residential treatment; these tactics are described by AT proponents as "loving at a distance."<sup>3,4</sup>

One version of HT, advocated by the American psychiatrist Martha Welch<sup>5</sup> and the Czech psychologist Jirina Prekopova,<sup>6</sup> is carried out by parents, who may or may not have a therapist present as a coach. In this form, small children are held on the parent's lap, facing the parent and embraced by the parent's arms. The children initially fight the restraint and scream while the parent speaks of a broad range of emotions toward the child. After an hour or more, the children are said to relax, gaze into the parent's eyes, and express love for the parent. Somewhat older children may lie across the parent's lap, and the largest children may be supine on the floor with the parent lying on top of them. Welch recommends daily holding for all children, although she originally presented this method as a treatment for autism. Prekop recommends the method for autistic children, for children she describes as "little tyrants", and for general improvement of family relationships. It is not clear whether either Welch or Prekop encourages the use of NTP methods.

## Diagnoses and Treatment Goals

AT, especially its HT form, was originally used with autistic children. Today, most of the children subjected to forms of AT are adopted and therefore would be expected by AT proponents to have difficulties associated with attachment. AT practitioners diagnose the treated children as suffering from Reactive Attachment Disorder (DSM-IV-TR 313.89), and popular material in print and on the Internet states that Reactive Attachment Disorder should be treated by AT (e.g., [www.reactiveattachmentdisordertreatment.com](http://www.reactiveattachmentdisordertreatment.com)). However, that material also refers to symptoms of a posited disorder, Attachment Disorder (AD), which are in fact different from symptoms of RAD. Checklists for parental diagnosis of AD include frightening symptoms like a love of “blood and gore,” “crazy lying” that will obviously not be believed, an aloof and unloving attitude, destructive and violent behavior, cruelty to animals and younger children, failure to make eye contact except when lying, and so on (see [www.thelittleprince.org](http://www.thelittleprince.org)). These symptoms are said by AT proponents to result from a failure of attachment to caregivers, and, if untreated, to culminate in serial killing. (In contrast, symptoms of RAD according to DSM-IV-TR involve either clinging and excessive fear of separation from a caregiver, or age-inappropriate friendliness to strangers.) AD is also diagnosed by means of a questionnaire for parents, the Randolph Attachment Disorder Questionnaire, to be discussed later.

The primary goal of AT is to create emotional attachment of a child to an adult caregiver. Observable goals that are thought to indicate the development of attachment are obedience to the adult, respectful and grateful behavior toward the adult, and the display of affection on the adult’s terms. In contradistinction to conventional views of developmental change in attachment, these behaviors and attitudes are not expected to change with age.

## Evidence for Effectiveness

However implausible AT might seem in terms of conventional perspectives on attachment, if there were systematic evidence supporting these treatments, they would have to be accepted as appropriate. (Indeed, the entire structure of attachment theory would have to be altered.) No such systematic evidence basis exists, nor is it likely to exist, for several reasons. To test the effectiveness of a treatment, it must first be possible to demonstrate intervention fidelity by showing that a manual or other form of guidance are followed by practitioners. As will be discussed later, AT practitioners learn from each other and choose their own techniques from a range of AT possibilities. In addition, their idiosyncratic uses of adjuvant treatments, including proprietary methods that are not evidence-based, and their recommendation of NTP methods to be used outside the treatment sessions, leave it completely unclear whether any two children have actually received the same therapy. This is especially a problem because many of today’s practitioners state that they do not use coercive HT, but the published research has been almost entirely on HT methods.

Although HT proponents have claimed an evidence basis for their methods, none of the few published studies involves randomized controlled trials, blinding of evaluators to treatment or diagnosis, or independent replications. In one case,<sup>7</sup> a simple before-and-after assessment of children by their parents was used, with reports of efficacy biased by unblinded parental evaluations and by the failure to control for normal rapid developmental change during childhood. A second publication<sup>8</sup> was based on a dissertation whose conclusion was very modest, but the pub-

lished work made strong claims about differences between a treated group and another group that had applied for treatment but did not appear, for reasons that were unclear but potentially highly confounding. (This paper was briefly listed as a RCT by a Cochrane review several years ago.)

A method strongly resembling HT, originally called “holding time” but now referred to as “prolonged parent-child embrace” (PPCE), was tested by means of before-and-after treatment evaluations by parents using the RADQ and another instrument and by means of comparisons of parent reports to normative data.<sup>9</sup> As parents provide the restraint in this method, there is no possibility that they can be blinded to the treatment. Although these authors reported positive outcomes, they noted that a number of confounding variables, plus regression to the mean, could have had an effect on the results. They did not mention the effect of using unblinded parent reports rather than professional observations.

A report by British researchers<sup>10</sup> described positive results of HT, but in fact was based on surveyed opinions of caregivers rather than on objective measures of child mood and behavior.

A method called Dyadic Developmental Psychotherapy (DDP) appears to have some relationship to HT, but the connection is not clear. This treatment, originated by Daniel Hughes, an author who in the 1990s stated approval of HT in some cases,<sup>11</sup> employs physical holding in ways described as “nurturing holds”. Publications authored or co-authored by Arthur Becker-Weidman have claimed that DDP is an evidence-based therapy,<sup>12</sup> but this claim has been rejected on the grounds that the supportive research is nonrandomized and subject to various confounding variables, that there is no independent replication of the study, and that evaluation was unblinded.<sup>13</sup> An additional serious problem is that in the original study treatment appears to have included HT methods, as evidenced by material referenced in the publication and said to have been recommended for parents to read. If DDP does not include HT methods, this study would appear to be irrelevant to DDP efficacy because of the evidence that HT was a part of the treatment; if it is relevant, then it must be that DDP includes HT techniques.

## **Assessment Methods**

One problem characteristic of research on AT is the frequent use of the Randolph Attachment Disorder Questionnaire (RADQ) by AT proponents. Some American practitioners, especially those who advocate the use of “holding therapy” for children diagnosed with Reactive Attachment Disorder, choose as a diagnostic test the Randolph Attachment Disorder Questionnaire (RADQ), an instrument self-published by Elizabeth Randolph.<sup>14,15</sup> The validating information claimed for the RADQ by Randolph has never been published in any peer-reviewed journal, and the one related article in a peer-reviewed journal<sup>16</sup> concluded that scores on the RADQ did not correlate with any validated test for childhood emotional disturbance. Beyond that, however, it is notable that Randolph herself stated plainly in her self-published work that the RADQ was *not* intended as a test for Reactive Attachment Disorder, but instead was an assessment of a different, suppositious disorder (AD) never described in any peer-reviewed publication. Whatever Randolph intended to test, in any case, she failed to guard against bias in her results by herself doing both the job of subjective diagnosis and that of performing and scoring the test. Although her publication includes a report of an analysis of variance on the test results, it does not state how many false positives or false negatives occurred. This raises the question whether there were no

such false results, simply because both the original diagnosis and the test result were in each case formulated by Randolph, who agreed with herself strongly in her assessment of each child; this of course is a far cry from having test scores that are validated by their agreement with an independent diagnosis. The RADQ should be excluded as a possible diagnostic tool for Reactive Attachment Disorder first on the showing of its own developer, who did not intend it to do that job, and second on the basis of its complete lack of conformity to normal guidelines for test development. That neither false positives nor false negatives have been reported is a statement not of the effectiveness of the test, but of a failure to consider a basic testing issue.

Helen Minnis, a Scottish psychiatrist, has been working for a number of years to try to develop such an assessment, but although she has created evaluative methods, she has no standardized brief test. In a 2009 paper with a group of colleagues,<sup>17</sup> Minnis described the complications and difficulties of this work, beginning with the lack of clarity in descriptions of the disorder:

*“Although the concept of RAD is encapsulated in psychiatric classification systems... the research base is scant, particularly in relation to school-age children... In this paper, we use the term RAD as in DSM to cover both the ‘inhibited’ and the ‘disinhibited’ phenotypes... The DSM and ICD systems both define RAD as being associated with early maltreatment and characterized by disinhibited behavior (indiscriminate sociability) or inhibited (withdrawn, hypervigilant) behaviors.”* (p. 931)

Minnis went on to point out that there is not much consensus about the effect of changes with age on RAD, and that one system includes attention-getting and aggression toward self and others among the symptoms. Minnis noted that research has indicated that children may show symptoms of RAD and also be evaluated as securely attached to caregivers.

Working with an extensive protocol rather than a brief test like the RADQ, Minnis looked for shared characteristics of children diagnosed with RAD. Minnis and her colleagues concluded that their findings “reinforce the conclusions from other literature that RAD is a phenomenon different in kind from attachment specific behaviors... RAD can perhaps be seen as one of the pervasive disorders of social impairment...” (p. 939) Minnis’s work suggests that a brief test diagnosing RAD is not going to be possible in the near future.

## **Adverse Events in AT**

A serious problem in assessment of the evidence basis for AT is the recognition of adverse events. Even a highly effective treatment would be compromised by unexpectedly frequent adverse events; a non-pharmaceutical mental health intervention would be expected to have no serious physical adverse events whatsoever, although exacerbation of mental illness in some cases might be possible. However, AT has been associated with child deaths, the best-publicized<sup>18</sup> occurring at the hands of practitioners, but a number of others caused by parents following AT or NTP advice. Such a Potentially Harmful Treatment<sup>19,20</sup> cannot be classified as evidence-based, no matter what the research reports.

HT had been classified as “promising” in two systematic research syntheses,<sup>21,22</sup> but this designation did not demand sophisticated research design or take note of adverse events that have

been associated with the treatment. One of the syntheses later revised<sup>23</sup> its classification for HT to “concerning”.

## **Education of AT Practitioners**

Examination of web sites such as that of the Association for Treatment and Training of Attachment in Children (ATTACH), [www.attach.org](http://www.attach.org), suggests that the majority of AT practitioners are licensed as social workers, with a small number of clinical psychologists and psychiatrists in addition. Licensure for all of these professions would be for general practice and would be dependent on academic credentials and supervised experience. In only a small number of cases would an academic institution have provided AT-related courses, although a number of AT-related doctorates have been awarded since 2000. AT practitioners have generally been trained in AT practices through continuing education courses presented by approved providers of CE credits for the American Psychological Association and the National Association of Social Workers. ATTACH has presented CE-conferring courses, and in addition has created the credential “registered attachment therapist,” based on attendance at courses given by AT practitioners. This credential, while irrelevant to licensing, is undoubtedly appealing to the public and has contributed to popular acceptance of the idea that only AT methods can help with childhood mental health problems that have been claimed to be based on attachment.

## **Professional Consensus**

HT has been rejected in a series of statements by psychologists and psychiatrists. The journal *Attachment and Human Development* dedicated an entire issue in 2003 to papers on this subject, of which only one suggested any acceptance of AT. The American Psychiatric Association, the U.S. National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, and the British Association for Adoption and Fostering have all approved resolutions rejecting HT; the American Psychological Association issued a statement but apparently confused HT with a related practice, “rebirthing”. The American Professional Society on Abuse of Children convened a task force whose report rejected HT and the adjuvant treatment methods mentioned earlier – one of the few statements about AT that considered the adjuvant methods.<sup>24</sup>

Despite a resolution in 2005 rejecting HT on behalf of the National Association of Social Workers, the social work profession has continued to be supportive of the treatment. A 2002 social work textbook on the use of DSM-IV-TR contained a chapter presenting the Welch version of HT as a suitable treatment for Reactive Attachment Disorder and referencing many HT advocates;<sup>25</sup> this chapter, co-authored by the book’s editor, was replaced in a later edition.<sup>26</sup> State social work groups have continued to seek training from AT-supporting organizations such as ATTACH. Several states, such as Georgia, paid for a program using AT/HT methods.<sup>27</sup>



## **Policy Concerns**

AT is a potentially harmful intervention without acceptable evidence for efficacy. AT is generally used for children who are incapable of informed consent and whose guardians may not be given sufficient accurate information to support decision-making.

The concept of emotional attachment of children to parents is as poorly understood by the public as it is fashionable. This situation, added to the existing susceptibility of the public to complementary and alternative medical (CAM) interventions, makes caregivers vulnerable to the claims of AT practitioners. The mass media have accepted and promulgated AT beliefs.

AT-based material about attachment, personality development, mental illness, and family relationships are easier to find on the Internet than accurate information, and sites presenting AT information are more user-friendly as well.

Mental health professionals, especially those licensed as social workers, often have little understanding of evidence bases for treatment or of established research and theory about attachment. Although professional groups have rejected various aspects of AT practices, none has committed resources to convincing the public or practitioners of evidence-based approaches to childhood mental illness. Professional groups permit approved providers of continuing education to present AT material without vetting by the larger groups.

Advocacy groups such as Focus on the Family are providing advertising for AT practices and are rarely contradicted or opposed in public. AT's parallels with fundamentalist beliefs about authority appeal strongly to a segment of the religious public.

Adoption caseworkers and agencies are strongly influenced by AT beliefs and practices. Many state and county child welfare departments, CASA workers, GALs, and even judges are influenced by AT beliefs and practices.

Public subsidies for special-needs adoptions, where the use of the funds is at the discretion of parents, are used to pay for AT.

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