Center for Family Development

Arthur Becker-Weidman, Ph.D.
Susan Becker-Weidman, LSCW-R
Emily Becker-Weidman. Ph.D.

2410 W. Azeele Street, Unit 213
Tampa, FL 33609

Office: 716 636 6243
Fax: 716 636 6243

aweidman@gmail.com
center4familydevelop.com

New Jersey Office:
10 McKinley Street, Suite 12
Closter, NJ 07624

Office: 646 389 6550

emilybw@gmail.com
dremilybw.com

Mailing Address:
5692 Ferncrest Court, Unit D
Clarence Center, NY 14032

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

Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems. Child Maltreatment, 11 (1), 2006, pp 76-89.

This important document presents several recommendations regarding the evaluation and treatment of children with disorders of attachment. While the report itself is based on old, and in some cases outdated and incorrect information, the recommendations are valid and should be followed by all clinicians who work with children.

The Center for Family Development has reviewed this document and adheres to those recommendations. Our practice, policies, and procedures are all in compliance with the APSAC report's recommendations, and in some instances, go beyond what is recommended.

The Report recommends the following regarding the diagnosis and assessment of attachment problems (pg. 86):

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.

The Center for Family Development's assessment and evaluation process is a comprehensive evaluation of the child and family that considers strengths and weaknesses and that uses a variety of methodologies to gather information and evaluate the meaning of this data. Our assessment process is not limited exclusively to the assessment of attachment issues. Children who have chronic histories of maltreatment or institutional care may have a variety of issues that must be considered as part of a comprehensive assessment process. For this reason, we evaluate and screen for many issues including various mental health issues and diagnoses, sensory-integration issues, neuro-psychological issues, Fetal Alcohol Spectrum Disorder and the effects of prenatal exposure to alcohol and drugs, and various learning issues.

Our assessment includes a comprehensive review of documents including adoption summaries, school records, health records, and previous evaluations and reports. We interview the caregivers to get a full understanding of the child's current functioning, history, and concerns. As part of this interview we begin to assess the caregiver's capacity of provide an attuned and emotionally responsive environment.

The parent's reflective function and family of origin are important dimensions to be considered. The interview with the child includes a mental health assessment and the administration of several projective tests. We observe the child with the caregivers, and finally we use a variety of tests and measures to gather information from the child, caregivers, and teachers. The instruments commonly used include the following: Child Behavior Checklist (caregiver, child, and teacher versions), Vineland Adaptive Behavior Scales, House-Tree-Person Projective Test, Child Apperception Test, Behavior Rating Inventory of Executive Function (parent and teacher versions), Biography of parents, Day in the life of the Child narrative, Parent Stress Index, and, when indicated, we use a variety of structured observational methods and procedures such as the Ainsworth Strange Situation Protocol. Other tests and observational methods are used as indicated.

A more complete description of our assessment process and methodologies can be found in Becker-Weidman (2005) "The Logistics of Providing Dyadic Developmental Psychotherapy," In Creating Capacity for Attachment (Eds.) Arthur Becker-Weidman, Ph.D., & Deborah Shell, MA, Wood 'N' Barnes, OK: 2005, pp 43-56.

The Center For Family Development is a Registered Agency of The Association for the Treatment and Training in the Attachment of Children. All our staff are licensed mental health professionals and have received extensive training in the evaluation and treatment of children, differential diagnosis, and the evaluation and treatment of trauma-attachment disorders. All our staff receives ongoing training and supervision.

The Report recommends the following regarding treatment and interventions (pg. 86 - 87):

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.

Our Informed Consent Document addresses each of these recommendations. Dyadic Developmental Psychotherapy is an evidence-based treatment (See: Becker-Weidman, “Treatment for Children with Trauma-Attachment Disorders: Dyadic Developmental Psychotherapy,” March 2006 issue of Child and Adolescent Social Work. Becker-Weidman, “The Effective Treatment of Abused Children with Dyadic Developmental Psychotherapy,” in, Child Abuse and Its Impact, Frank Columbus, Ph.D. (Ed.) Nova Science Publishers, NY, In Press.). It is grounded in Attachment Theory and relies of the creation and maintenance of a safe and secure base from which the family can explore issues. Attunement, the reflective function, and developing and maintaining an emotionally sensitive and response environment are core features of the treatment and the parenting principals (See, for example, Miranda Ring, Ph.D., (2005), “For Parents,” in Creating Capacity for Attachment.).

Caregivers are always involved directly in treatment and are trained in attachment facilitating parenting methods that use an attuned sensitive and reflective approach. In no instances are coercive methods used.

Dysregulation is never sought and on those rare instances in which a child becomes dysregulated, the therapist works actively and sensitively to re-regulate the child.

Other sections of the APSAC recommendations address the child welfare system and ethical standards. The Center for Family Development supports those recommendations. Specifically, the report recommended the following for the child welfare system:

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.

The report recommended the following ethical standards.

Professionals should embrace high ethical standards concerning advertising treatment services to professional audiences and especially to lay audiences.

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 trail scientific research to support the claim.

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.

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.

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.

The Center's evaluation and treatment procedures and methodologies are all consistent with these recommendations. Our use of an evidence-based treatment, Dyadic Developmental Psychotherapy, is consistent with these recommendations. Evidence for the effectiveness of Dyadic Developmental Psychotherapy appears in a professional peer reviewed journal (previously cited).