Attachment in Practice

Dr Matt Woolgar
Consultant Clinical Psychologist
National Adoption & Fostering Service
South London & Maudsley NHS Foundation Trust
Senior Researcher, National Academy for Parenting Research, King’s College London
& Lecturer Children’s & Young People's IAPT UCL/KCL

matt.woolgar@kcl.ac.uk

http://www.nationaladoptionandfosteringclinic.com/
What are the clinical issues?

• National case seen in the Maudsley N&S Adoption & Fostering Service
• 7 yr-old LAC boy in pre-adoptive placement
• Thorough MDT assessment identifies complex mix of ADHD, Conduct Disorder & low mood, plus literacy problems
• MPH started: excellent response at home & school, with placement stabilised
Local CAMHS
(in one of Britain's largest cities...)

• Treatment discontinued in neurodevelopmental service:
  – “He is adopted, so I don’t need to see the child or read your report to know it is not ADHD but an attachment disorder”
  – MPH stopped & *discharged* from CAMHS because
    • No CD treatment without ADHD, or some other sort of ‘complexity’
    • Not at CAMHS threshold for CBT for depression and mood secondary to ‘attachment’
    • Don’t treat primary problem of ‘attachment disorder’

• Offered jazz based dance/music therapy in a voluntary organisation outside of NHS
# Mental Health in UK LAC, Ford et al 2007

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Birth family</th>
<th>High Risk</th>
<th>ONS LAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any disorder</td>
<td>8.5%</td>
<td>14.6%</td>
<td>46%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>3.6%</td>
<td>5.5%</td>
<td>11%</td>
</tr>
<tr>
<td>PTSD</td>
<td>0.1%</td>
<td>0.5%</td>
<td>2%</td>
</tr>
<tr>
<td>Depression</td>
<td>0.9%</td>
<td>1.2%</td>
<td>3%</td>
</tr>
<tr>
<td>Behavioural disorders</td>
<td>4.3%</td>
<td>9.7%</td>
<td>39%</td>
</tr>
<tr>
<td>ADHD</td>
<td>1.1%</td>
<td>1.3%</td>
<td>9%</td>
</tr>
<tr>
<td>ASD</td>
<td>0.3%</td>
<td>0.1%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Neurodevelopmental</td>
<td>3.3%</td>
<td>4.5%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Learning disability</td>
<td>1.5%</td>
<td>1.5%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>
Comparing ONS LAC data with our National Adoption & Fostering Service  
(Woolgar & Baldock, 2014)

<table>
<thead>
<tr>
<th>Disorder Type</th>
<th>ONS LAC</th>
<th>N&amp;S Adoption &amp; Fostering</th>
<th>CAMHS Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any disorder</td>
<td>46%</td>
<td>66%</td>
<td>31%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>11%</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>PTSD</td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Depression</td>
<td>3%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Behavioural disorders</td>
<td>39%</td>
<td>55%</td>
<td>4%</td>
</tr>
<tr>
<td>ADHD</td>
<td>9%</td>
<td>38%</td>
<td>12%</td>
</tr>
<tr>
<td>ASD</td>
<td>2.6%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Neurodevelopmental</td>
<td>12.8%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>Learning disability</td>
<td>10.7%</td>
<td>10%</td>
<td>3%</td>
</tr>
</tbody>
</table>
General CAMHS services for adoption & fostering

• CAMHS services under-identifying
  – Behavioural problems
  – Neurodevelopmental problems
    • ADHD
    • Global learning disability
    • Neurodevelopmental issues (e.g., tics etc)
    • Specific learning disability (e.g., dyslexia)
    • Anxiety, PTSD & depression
  – Over third had ‘attachment disorder/problems’ identified in CAMHS, but we saw only 4%
    • all under 5, all newly in placements… [and typically recovered over time]
A typical ‘attachment’ definition

• Quote from an attachment & adoption book for clinicians:
  
  'an attachment is a reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver’

• Is it?
The original definition

• A concept developed by John Bowlby
  – An **infant or child’s** strong, innate tendency to seek proximity to and contact with a specific figure in certain situations, *notably when frightened, tired or ill.*
  – One drive amongst many
  – Combines ethology [innate process] and cognitive models [representation, stability & development]
Defining attachment scientifically

- One biological behavioural system amongst many, with an ethological function to preserve the vulnerable & immature infant
- Activated by threat; overrides other behavioural systems
- Driven to seek safety & comfort from specific caregivers; then deactivates & other systems come back into play
- Different patterns of deactivation (e.g., on reunion in SSP) indicate quality of security in infants
- Some wider developmental consequences
- Infant’s perspective on caregiver quality
Attachment & neuroscience

• Attachment may be a universal & innate biological behavioural system residing in the brain, but
  – “attempts to locate a single, dedicated attachment circuit ... a bit like trying to find the real artichoke by peeling away all its leaves”. Coan, 2008

• A biological system – but complex.
• Distributed through various brain systems & characterised by temporary activation.
• Can’t see attachment quality in a brain scan
Measurement of attachment security in infancy - the Strange Situation

• Strange Situation (SSP): balances Exploration, Fear & Attachment systems
  – Exploration in a Fear-provoking situation mediated by attachment security

• Infant’s attachment to a Secure Base tested by increasing levels of stress
  – 1. A strange room
  – 2. A stranger
  – 3. Separation from the caregiver
  – 4. Being left alone

• Possible because development by 9 months of:
  – 1. Stranger fear
  – 2. Separation anxiety
Patterns of attachment organisation

- Attachment behaviours following reunion usually organised, & fall into one of 3 distinct & reliable patterns

- **A** AVOIDANT: *Minimises* the attachment relationship. Ignores/avoids mother (proximity/contact) on reunion. Often not upset by separation, and little distress on reunion. Does not use mother as a secure base. Takes little/no comfort from her presence. Minimal proximity seeking/contact maintenance, and impoverished play/exploration can be a defensive strategy to avoid it. About 25%

- **B** SECURE: Flexible, Secure Base behaviour predominates. Any distress during separations quickly resolves on mother’s return, by seeking her out as a secure base, taking comfort from her presence. Stays in proximity/contact until reassured and ready to return to (genuine, high quality) exploration/play. About 65%

- **C** AMBIVALENT/RESISTANT: *Maximisation* of the attachment relationship (ineffectively). Seeks contact/proximity with very strong protests/distress. But any effective secure base behaviour contradicted by angry resistance (e.g., hitting, squirming, increased distress on proximity). Often seeks, then rejects proximity/contact. A preoccupation with the mother on reunion delays/prevents return to play/exploration. About 10%
Disorganisation/Disorientation
If no organised attachment pattern

• Separate coding scheme in addition to A/B/C - ‘trumps’ it

• Origins: clinical samples, odd behaviour not fitting A/B/C pattern
  – No coherent strategy: e.g., mixed A & C strategies;
  – Odd behaviours: stilling/freezing, repetitions, stereotypies, confusion
  – Inexplicable unless fearful or disoriented, e.g., run out of door, hide etc.

• Proposed environmental causes:
  – a) Caregiver’s Frightening/Frightened behaviour
    Higher in Maltreating; depressed; substance abusing caregivers
  – b) Caregiver Unresolved regarding Loss or Trauma
    e.g., next child following still-birth
Some Definitions...
(see Boris & Zeanah, 2004 for further developments)

- **Insecure attachment** – the 35 to 40% of the population without a secure attachment pattern [includes A,C & D].
- **Disorganised attachment** [D] – an insecure attachment pattern that is *not organised*, about 15% of the population, but more frequent in maltreated and at-risk children
- **“Attachment disorder”** – very rare condition in which the attachment system has not properly developed due to extreme neglect in *infancy & early childhood*. No preferred attachment figure and no other explanations for presentation. 2 distinct forms.

***************

- **Disrupted attachment** – where an attachment has formed but been broken
- **Disordered attachment** – where the attachment system is thought to be working, but not optimally
Attachment & development

• Attachment theory speaks of a system active in infancy which has a legacy from ‘cradle to grave’
• How does it exert an influence?
• Where does the influence come from?
• What does it look like beyond infancy & into adulthood?
• What does attachment become?
Attachment in adulthood - I

• The AAI is NOT [!!!] a measure of attachment security analogous to SSP
  – A semi-structured interview about early experiences and emotionally charged events is coded from verbatim transcripts to give ‘current state of mind with regard to attachment experiences’ – mentalization???
  – Not the same as the behavioural attachment patterns which were about managing proximity & contact
Attachment in Adulthood - II

• Questionnaire measures such as ASQ etc are not measuring the same thing either, but romantic love, or other close relationships:
  – both feel safe when the other is nearby and responsive
  – both engage in close, intimate, bodily contact
  – both feel insecure when the other is inaccessible
  – both share discoveries with one another
  – both play with one another's facial features and exhibit a mutual fascination and preoccupation with one another
  – both engage in "baby talk“ (Hazan & Shaver, 1987)
Attachment and development

• Something develops
• Something leaves a legacy of something, in some way, in some domains, to some extent
• But the attachment system was only ever one system amongst many in infancy
• It never was, or will be, the only show in town...
• Developmental science loses track of it from middle childhood...
Developmental assessments

4 yr old boy in pre-adoptive placement

• 4yrs:
  – Reactive Attachment Disorder (RAD)
  – Oppositional Defiant Disorder (ODD)

• 9yrs
  – Specific, but not secure, attachments to parents evident, so no longer DAD or RAD
  – Autism Spectrum Disorder
  – ADHD
  – Normal IQ, but severe deficits in adaptive functioning & literacy
Breaking down Attachment Disorder
what’s love got to do with it..? A lot.

Attachment disorder - RAD

- Subtle neuro-psychological problems
  - Specialist assessment

- Social & Adaptive functioning
  - Social skills

- ASD
- ADHD
- ODD

- RAD

Recovered
[stability & love]

- Social skills
- School liaison
- Medication
- Parenting Intervention
Breaking down Attachment Disorder
what’s love got to do with it..?

Attachment disorder - RAD

- Subtle neuro-psychological problems
  - Specialist assessment
- Social & Adaptive functioning
  - Social skills
  - School liaison
- ASD
- ADHD
- ODD
- RAD
- Recovered
  - [stability & love]

Age 11 – Chromosomal abnormalities ??
Attachment Disorders
Prior & Glaser, 2006
Understanding attachment & attachment disorders

• Attachment disorder implies the failure to develop
  i) comfort-seeking attachment to
  ii) specific caregiver

RAD – inhibited seeking/accepting comfort
DAD – non-specific attachment relationships

• Lack of care (deprivation / neglect) or multiple changes in carers rather than frank abuse
• Distinguish presentation from effects of trauma / abuse
Reactive Attachment Disorder F94.1

ICD-10 RDC

• A. Onset **before the age of five years.**

• B. Strongly contradictory or ambivalent social responses that extend across social situations (but which may show variability from relationship to relationship).

• C. Emotional disturbance as shown by lack of emotional responsiveness, withdrawal reactions, aggressive responses to one's own or other's distress and/or fearful hypervigilance.

• D. Evidence of *capacity for social reciprocity and responsiveness as shown by elements of normal social relatedness in interactions with appropriately responsive non-deviant adults.*

• E. Does not meet criteria for pervasive developmental disorders (F84).
Emotionally withdrawn / inhibited

- Lack of social and emotional response
- Near absence of attachment behaviours, even in stress
- Emotion regulation problems
- A paucity of positive affect responses
- Hypervigilence & ‘frozen watchfulness’
- Gaze aversion, avoidance of contact & comfort
- Peer interactions impeded by negative emotional response
- Persistent but **reactive** to changes in caregiving
Disinhibited Attachment Disorder F94.2
ICD-10 RDC

• A. Diffuse attachments as a persistent feature during the first five years of life (but not necessarily persisting into middle childhood). Diagnosis requires a relative failure to show selective social attachments manifest by
  – (1) a normal tendency to seek comfort from others when distressed and
  – (2) an abnormal (relative) lack of selectivity in the persons from whom comfort is sought.

• B. Poorly modulated social interactions with unfamiliar persons. Diagnosis requires at least one of the following: generally clinging behaviour in infancy; or attention-seeking and indiscriminately friendly behaviour in early or middle childhood.

• C. The general lack of situation-specificity in the above features must be clear. Diagnosis requires that A and B above are manifest across the range of social contacts experienced by the child.
Indiscriminate Social/Disinhibited

- Disinhibited approach to strangers
- A lack of wariness
- Failure to check back with carer in unfamiliar settings
- Willingness to wander away from familiar caregiver
- May seek physical contact with strangers
- Age 2 – diffuse and clinging
- Age 4 – diffuse but attention-seeking / over friendly
- Strong links to institutional rearing – no opportunity to develop selective attachments
Prevalence

• Uncertain, but a rare disorder (Zeanah & Smyke, 2009)
  – 0/300 2 to 5 yr-olds in pediatric clinics
  – 0/24 impoverished children in Headstart program
  – 2/25 homeless children (both DAD, 0 for DSM)
  – 2/20 in maltreatment clinic (1 for DSM)
  – 2% in UK national Children Looked After study

• Higher rates for maltreatment (e.g., up to 35%, half comorbid RAD/DAD), but not RDC

• CAFT 38% with ‘Attachment Disorder’ @ referral – 4% diagnosed @ assessment
Prevalence Controversies

• A Danish study found a prevalence of RAD [excluding DAD] of almost 1% (2 cases) in normal community sample [in the world’s happiest nation] (Skovland et al, 2007)

• A rate of 1.5% (13) was reported for a community sample in Glasgow, with a ratio of DAD:RAD of 12:1 (Minnis et al, 2013)

• Who is measuring what? We don’t know – but it is rare
Prevalance

- “RAD is a rare disorder.... Even in disadvantaged samples of young children, the disorder seems to be rare.” Zeanah & Smyke (2009, p425)
- Disinhibited attachment symptoms (not frank disorders, which are likely to be rarer still) are “distinctly uncommon” (italics in original) in children not exposed to “profound and pervasive” institutional deprivation (Rutter, Beckett et al, 2009, p18)
- It is rare, and requires significant deprivation NOT abuse....
Attachment classification & attachment disorders (Rutter et al, 2009)

• Increasing evidence that RAD / DAD are not straightforwardly related to attachment security – some children shown to have secure attachments but also attachment disorder.

• Also DAD removed/renamed in DSM-5, and in ICD-11

• Rutter suggests that as RAD responds to improvements in the caregiving environment, i.e., reactive, it relates to attachment processes but DAD does not, and is probably more neurodevelopmental than attachment
DSM 5 RAD

• **A.** A consistent pattern of **inhibited, emotionally withdrawn** behavior toward adult caregivers, manifested by both of the following:
  • The child rarely or minimally seeks comfort when distressed.
  • The child rarely or minimally responds to comfort when distressed.

• **B.** A persistent social or emotional disturbance characterized by at least two of the following:
  • Minimal social and emotional responsiveness to others
  • Limited positive affect
  • Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

• **C.** The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
  • Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation and affection met by caring adults
  • Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care)
  • Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios)

• **D.** The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances inCriterion A began following the lack of adequate care in Criterion C).

• **E.** The criteria are not met for autism spectrum disorder.

• **F.** The disturbance is evident before age 5 years.

• **G.** The child has a developmental age of at least nine months.
DSM 5 RAD Unpacked

• Must be that child rarely seeks or responds to comfort when distressed [Criterion A]
• Not enough to be irritable/fearful, but have at least one of low social response & low positive affect [Criterion B]. Pathogenic care is neglect NOT maltreatment [Criterion C]
• Onset before 5 years still...[infancy & early childhood] – Zeanah suggests <3 years
• NO aggression!! It’s an internalising disorder
DSM 5 Disinhibited Social Engagement Disorder (DSED)

A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least 2 of the following:
   • Reduced or absent reticence in approaching and interacting with unfamiliar adults.
   • Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
   • Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
   • Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B. The above behaviors are not limited to impulsivity (as in attention deficit hyperactivity disorder) but include socially disinhibited behavior.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
   • Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
   • Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
   • Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in the above behaviors (#3) is presumed to be responsible for the disturbed behavior in #1 — e.g., the behaviors in #1 began after the care in #3.

E. The child has a developmental age of at least 9 months old.
DSM 5 DSED Unpacked

• DAD has become DSED – not an attachment disorder
• Socially disinhibited behaviour not specific to carers but strangers, so not attachment relationships [Criterion A]
• Specifically SOCIAL and not just the impulsivity of ADHD [Criterion B]
• Pathogenic care is Neglect, again, esp re. multiple caregivers, NOT maltreatment [Criterion C]
• An externalising disorder (overlap with ADHD??)
Recovery of RAD/DAD in foster care
(Smyke, Zeanah et al, 2012)

Inhibited behaviours [RAD] recovery rapidly in Foster Care to normal rates

Disinhibited behaviours improve in Foster Care but to an ‘intermediate level’
Impact of age at placement in foster care on RAD/DAD

Inhibited [RAD] symptoms show rapid improvement whatever age placed

Disinhibited [DAD] symptoms show rapid recovery only for early placement
‘The allure of rare disorders’ in maltreated children (Haugaard, 2004)

‘Although more common diagnoses, such as 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’

Chaffin et al, 2006 (APSAC)

These children’s problems are real & need effective diagnostic assessment just like any other child
Attachment

• Very often part of the formulation, but rarely the best primary diagnosis
• Very rarely leads us to treatment
• Can blind services to the nature of complexity in LAC
If problems left undiagnosed & untreated because not diagnosed?

17 year-old adopted girl (Woolgar & Scott, 2013)

• Presented with
  – Severe mood swings
  – Self-harm
  – Theft, aggression; running away; threatening behaviour
  – Associating with risky & inappropriate adults
  – Early & persistent school [& work] failure

• Existing “diagnosis”
  – Attachment disorder only (not a recognised diagnosis...)

• Previous treatment
  – None, as no local CAMHS provision for ‘attachment disorder’ – family left without any support
Assessment

• History
  – Conduct problems
    • ODD then CD
  – ADHD
  – Depressed mood
  – Self-harm

• Assessment
  – Low mood
  – Low self-esteem
  – Learning disability
  – Reading disorder
  – Charming & easily engaged
  – No attachment disorder now or ever any evidence for it
Missed opportunities for evidence-based interventions

- ODD/CD from 4 years
- ADHD
- Depressed mood
- Educational support for reading / low IQ

- Complex presentation & developmental course, with accumulating risks
- All obscured by general, impersonal & incorrect diagnosis of ‘attachment disorder’ – which also allowed services to avoid helping the family

- Failure to see the individual child
- Brother done well & at university... differentially susceptible siblings – same good adoptive parenting
Outcome

• Celebrated 18th birthday by running away

• Found 3 days later by police investigating another matter, bleeding & agitated

• Taken to A&E, admitted and assessed by adult services - in the ‘here and now’

• Went out as a child with ‘attachment disorder’, sent home as an adult with a personality disorder diagnosis
Placement stability

• In 2009 10% of children had ≥3 placements in 12 months [decreasing yearly; NI 62]

• But, 67% of young people living longer-term in state care [≥2.5 years], lived in same placement for previous 2 years [increasing yearly; NI 63]

Foster children are less secure to birth parents than control children (CAI)
(N=101 – in placement >6 months)

χ² (1)= 15.65, p<.001
χ² (1)= 28.01, p<.001
**But** – foster children show near normal security to their current foster carers (N=51)
Implications for foster care

• Not a specific intervention, the radical effect of ‘ordinary’ foster care (plus some stability) – big effect size for
  – RAD/DAD
  – Attachment security

• What can we do to support standard foster care & enhance carer sensitivity now & on a large scale [while we wait for a tiered & modular approach based on emerging interventions, personalised to child’s needs]?
Fostering Changes

National UK role out of an evidence based (RCT), attachment sensitive, group program for Foster Carers based on social learning theory
Impact of Fostering Changes Programme on Carer Defined Behaviour problems
Impact of Fostering Changes Programme on Attachment Relationship

Before | After
--- | ---
No Training | Training
48 | 
51 | 
53 | 54
REFERENCES


