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Attachment

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Learning Outcomes

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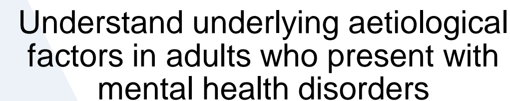
To understand different classifications of attachment, conditions that promote healthy attachment and the clinical relevance of failure to develop selective attachments.

To understand the relevance of attachment theory to emotional development, affect regulation and relationships across the lifespan

Basic understanding of assessment of attachment across the lifespan

Awareness of principles of interventions

Why should adult psychiatrists care about attachment



Understand how adults patients' early attachment patterns could explain aspects of how that patient presents and uses services, and how it can impact on their parenting

we need to consider what strengths, blocks, blind spots, unresolved issues, assumptions, vulnerabilities, 'hot buttons' and 'no go' areas we may each bring into the room with our patients

Definitions of attachment

An affectionate bond between two people that endures through time and space and serves to join them emotionally

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Why do we need Attachment?

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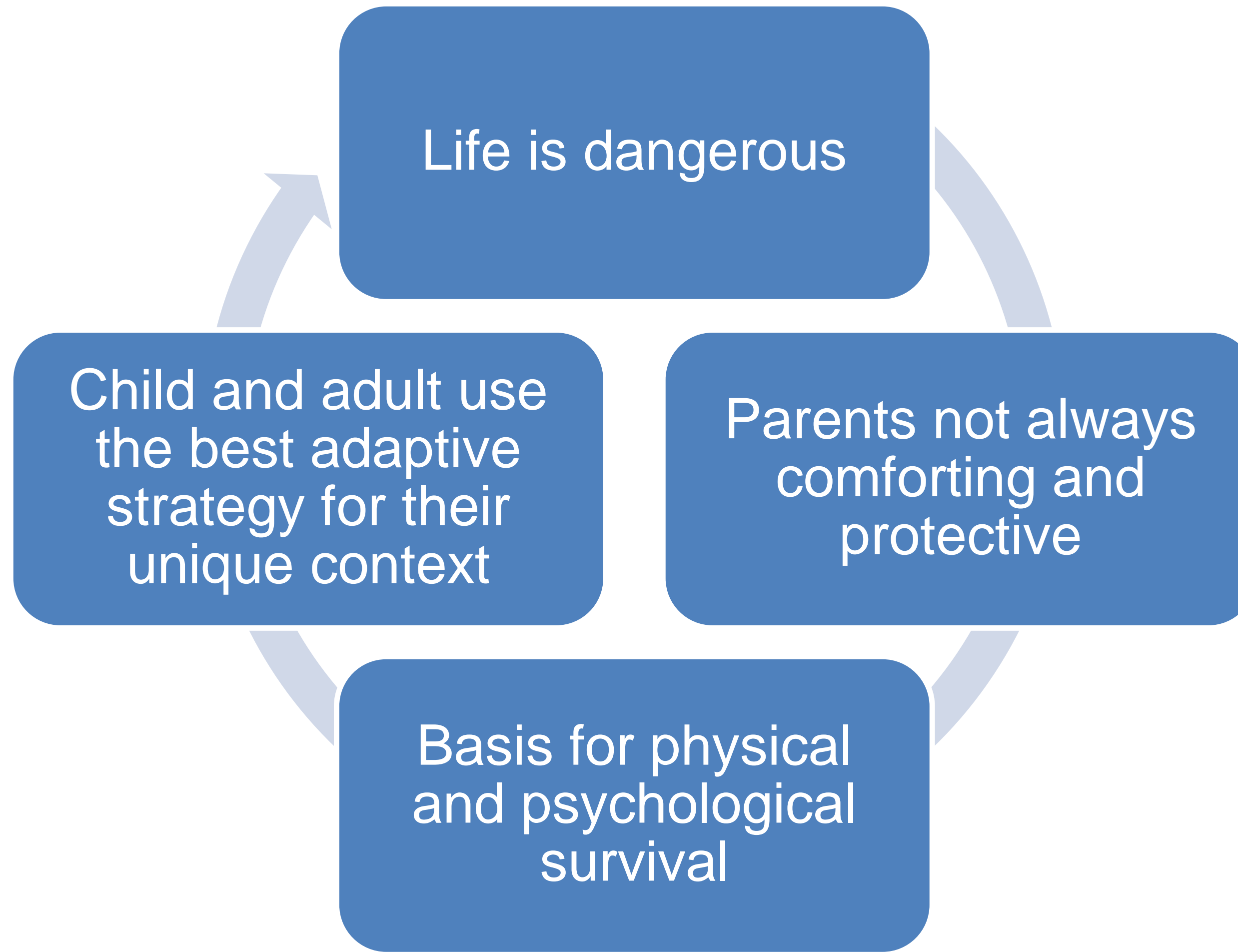

Purpose of attachment behaviours

It is through important attachment relationships that the child makes sense of herself, her emotions, other people and relationships

Underlying information processing patterns (particularly non-verbal) will be robust – how we see the world, others and ourselves

Early attachments affect the course of psychological and social development and mental health

What a ‘good enough’ attachment figure does

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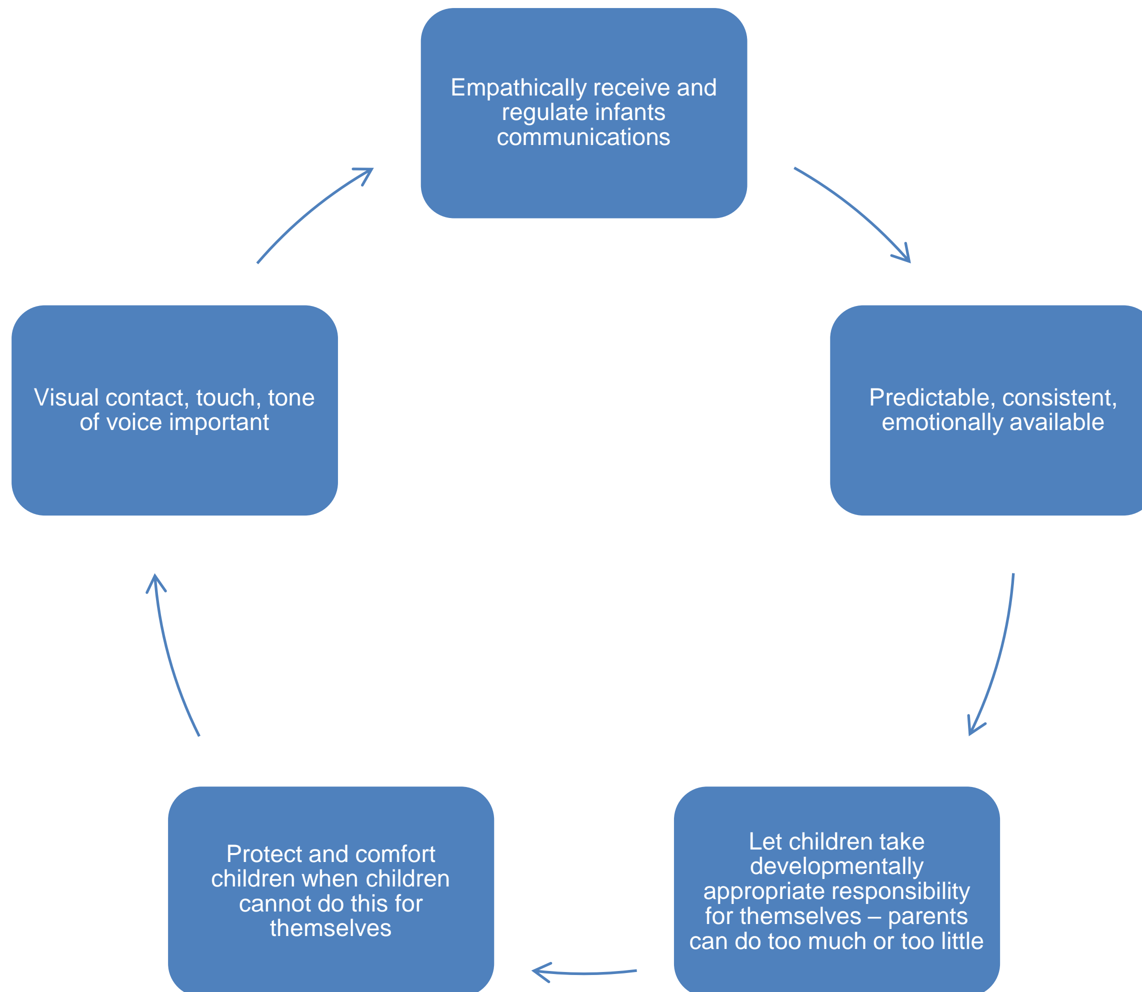
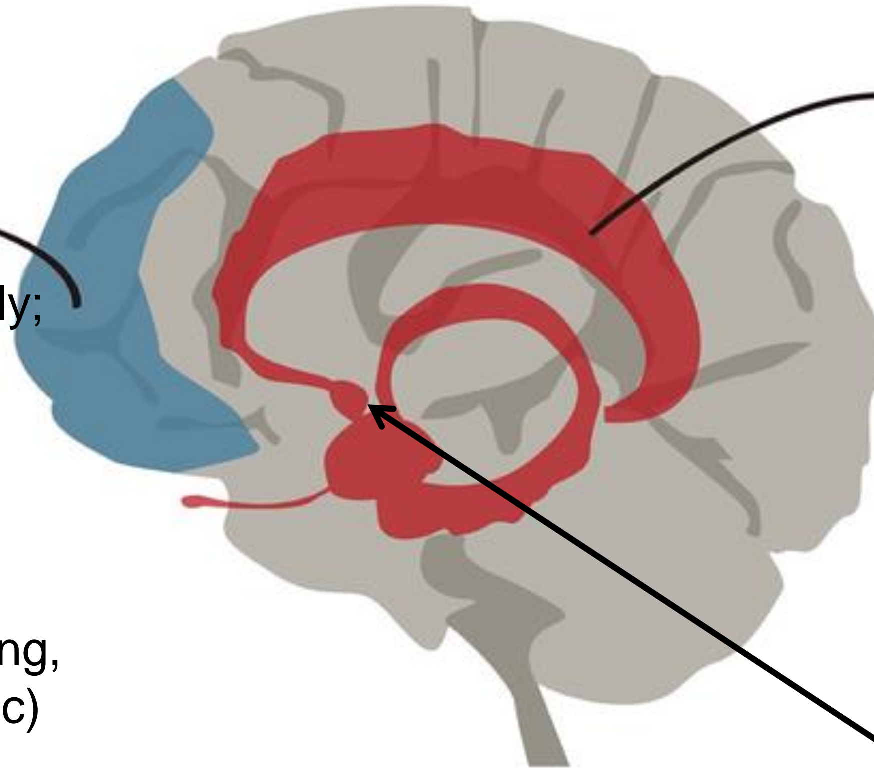


Brain Development

Prefrontal Cortex
(‘**Thinking Brain**’)

- Develops postnatally; does not mature till toddlerhood
- Involved in higher cognitive functions
  (e.g. logical thinking, consequences, etc)
- Control centre for managing arousal
- Entirely experience dependent; develops within relationships



Limbic System – (‘**Emotional Brain**’)

- First parts of the brain to mature; intact at birth
- Fight/Flight/Freeze (Arousal) Response – cascade response leading to physical reactions)
- The amygdala stores (pre-verbal) anger and anxiety experiences

Need to consider how cognitive ability and neurodevelopmental conditions interact with development trauma.

Neural Integration

Integrative communication between caregiver & child stimulates activation & growth of integrative fibres (Schore, '94)

Brain develops regulatory circuits during 1st five years of life

Integrative fibres enable co-ordination & balance of self-regulation – attention, behaviour, emotion & thinking

Repeated neglect, adversity or abuse can result in underdevelopment of some areas of the brain and in over-sensitivity of others. It can also result in poor integration between brain areas

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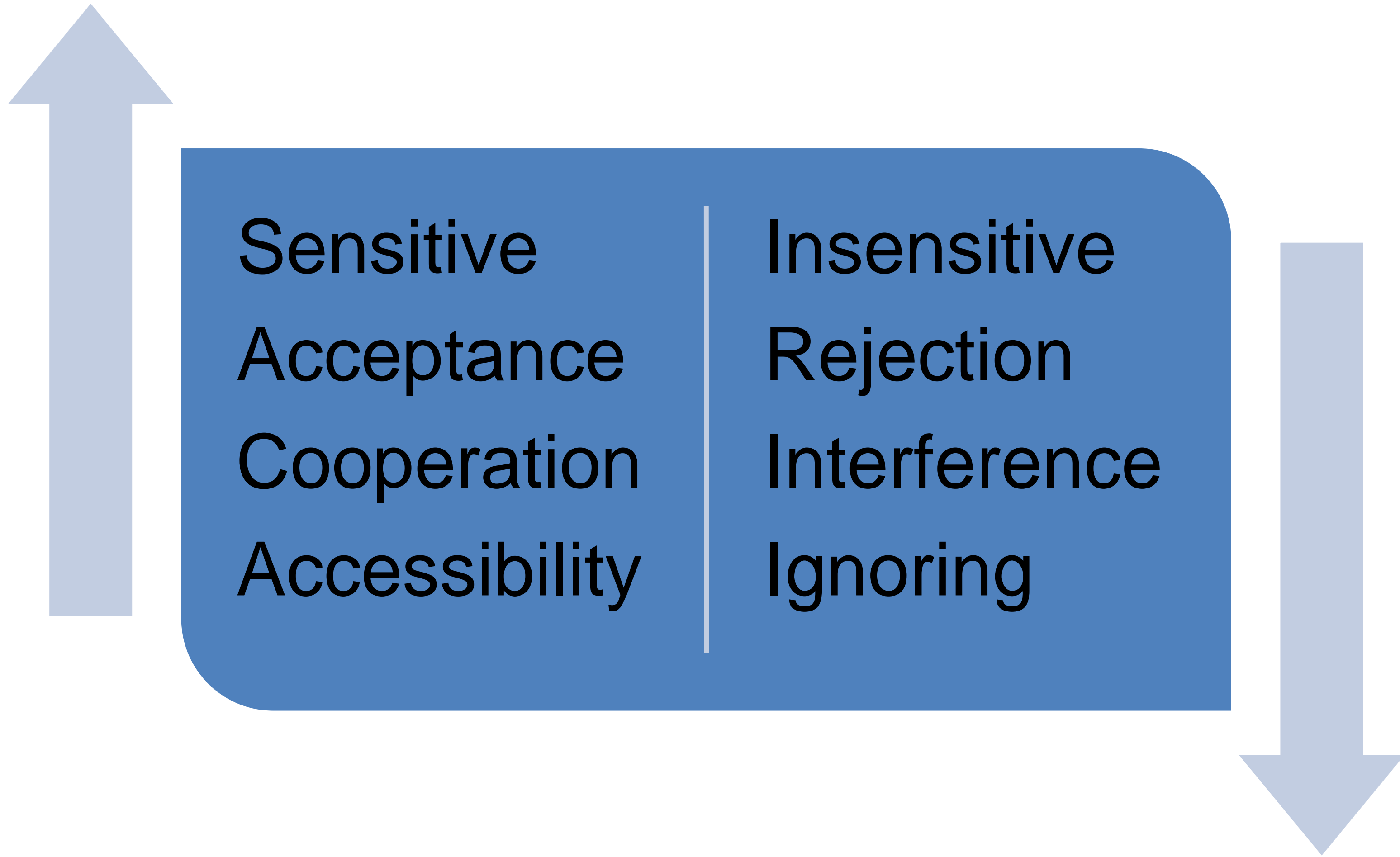

Sensitive

- parent meshes their response to infant's signals and communication to form a cyclical turn taking pattern of interaction

Insensitive

- Parent intervenes in an arbitrary way, these intrusions reflecting their own mood and wishes

Acceptance

- parent generally accepts the responsibility of child care, demonstrating few examples of irritation with the child.

Rejection

- Parent has feelings of anger and resentment that eclipse their affection for the child, often finding the child irritating and resorting to punitive control

Cooperation

- parent respects the child's autonomy and rarely exerts direct control

Interference

- parent imposes their own wishes on the child with little concern for the child’s mood or current preoccupations

Accessibility

- parent is familiar with their child's communication and notices them at some distance. Easily distracted by the child

Ignoring

- parent is preoccupied with their own activities and thoughts They often fail to notice child’s communication unless they become very obvious through intensification

Theoretical basis

- **Attachment theory (Bowlby 1951,1969,1988)**
  - Research and practice have confirmed its position as a most powerful and influential account of social and emotional development.
  - Bowlby asserted:
    - children are biologically prepared to contribute to attachment relationships,
    - a secure emotional base facilitates the development of self-esteem, empathy and independence,
    - attachment behaviours most obviously occur within the relationship between infants and parents between 6 months and 3 years.

- **Ainsworth et al (1978)**
  - Provided scientific evidence to support Bowlby's theory
  - Used the *Strange Situation* procedure to research child-parent interactions.
  - Identified three patterns of attachment: *insecure-avoidant, insecure-ambivalent* and *secure*.

Theoretical basis ctd…

- **Main and Solomon (1986 and 1990)**
  - Used strange situation test to add further category- disorganized

  - **Main and Goldwyn (1990)**
  - Suggested that parents' mental representations of their own childhood experiences determine their sensitivity to their child's attachment needs and influence the quality of their parenting.
  - Developed the Adult Attachment Interview to assess an adult's attachment experiences, the meaning to the adult of these experiences and their current internal working model.
  - **Crittenden (1985 – present)**
  - Also Ainsworth student –alternative model of attachment (Dynamic Maturational Model (DMM) to ABCD model, no disorganization, patterns extend into adulthood, range of assessment tools across the lifespan

Strange Situation Test

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Developed to assess attachment relationships between caregiver and child between 9 and 18 months

Developed by Mary Ainsworth

Child is observed playing for 20 minutes, during which time a sequence of events occur involving the carer and a stranger entering and leaving the room

The purpose is to raise the child's stress and so observe the activation of their attachment behaviour

The amount of exploration - i.e. how much the child plays throughout is also observed

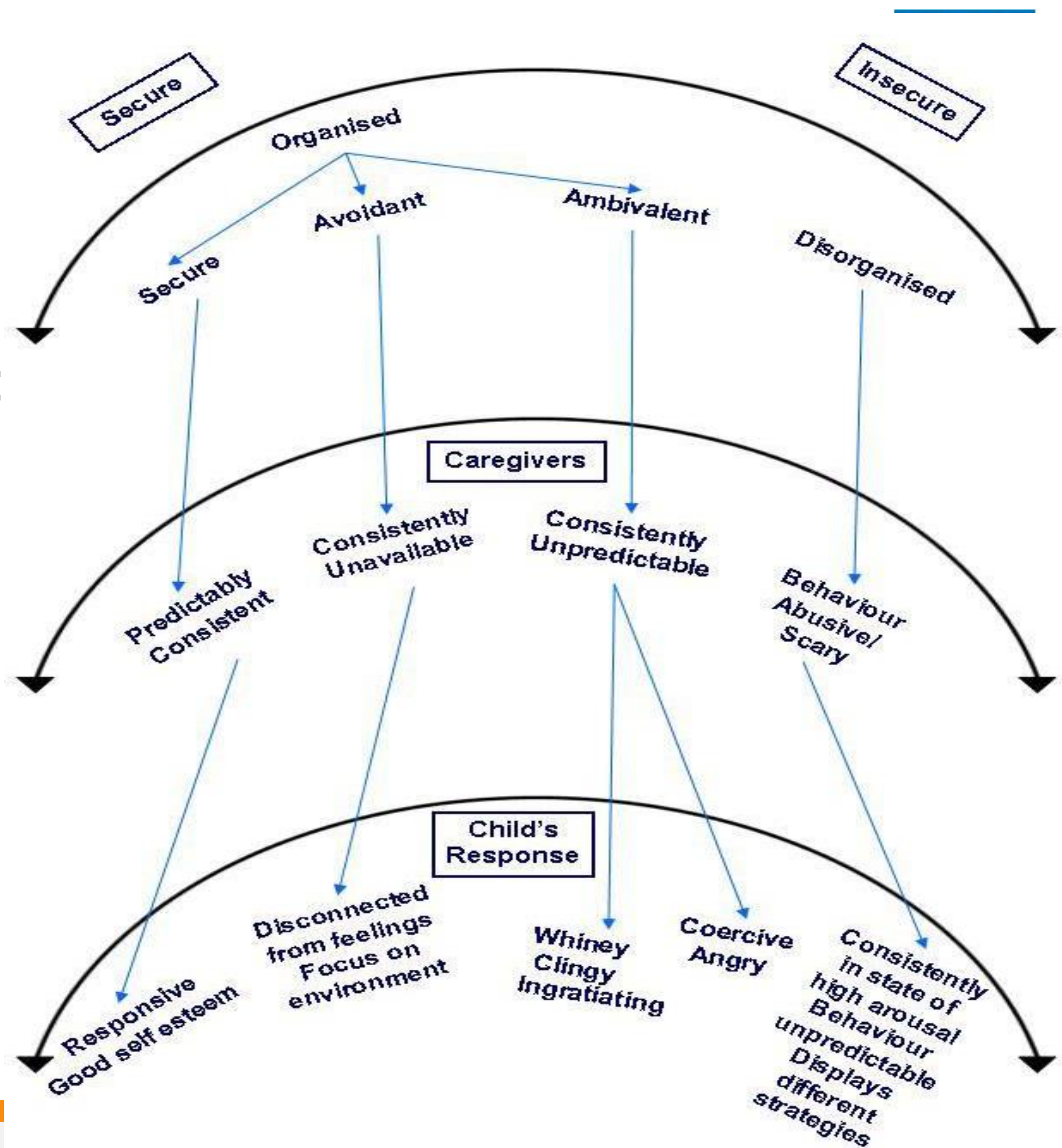
Categories of attachment behaviour on SST

- Ainsworth developed the following categories of attachment:
- Rates in non clinical populations
  - Secure (type B) -55-60%
  - Insecure –avoidant- (type A)-20%
  - Insecure- ambivalent /anxious (type C)- 10%
  - Disorganized – (type D)- later added by Main and Solomon -up to 15%
- These proportion are remarkable similar across cultures- secure is usually 55%-60% although rates of other types can vary slightly

Patterns of Attachment

Attachment can be classified into patterns of behaviour:

- Secure attachment pattern
- Insecure attachment patterns (3 types)
  - Ambivalent
  - Avoidant
  - Disorganised



Secure Attachment

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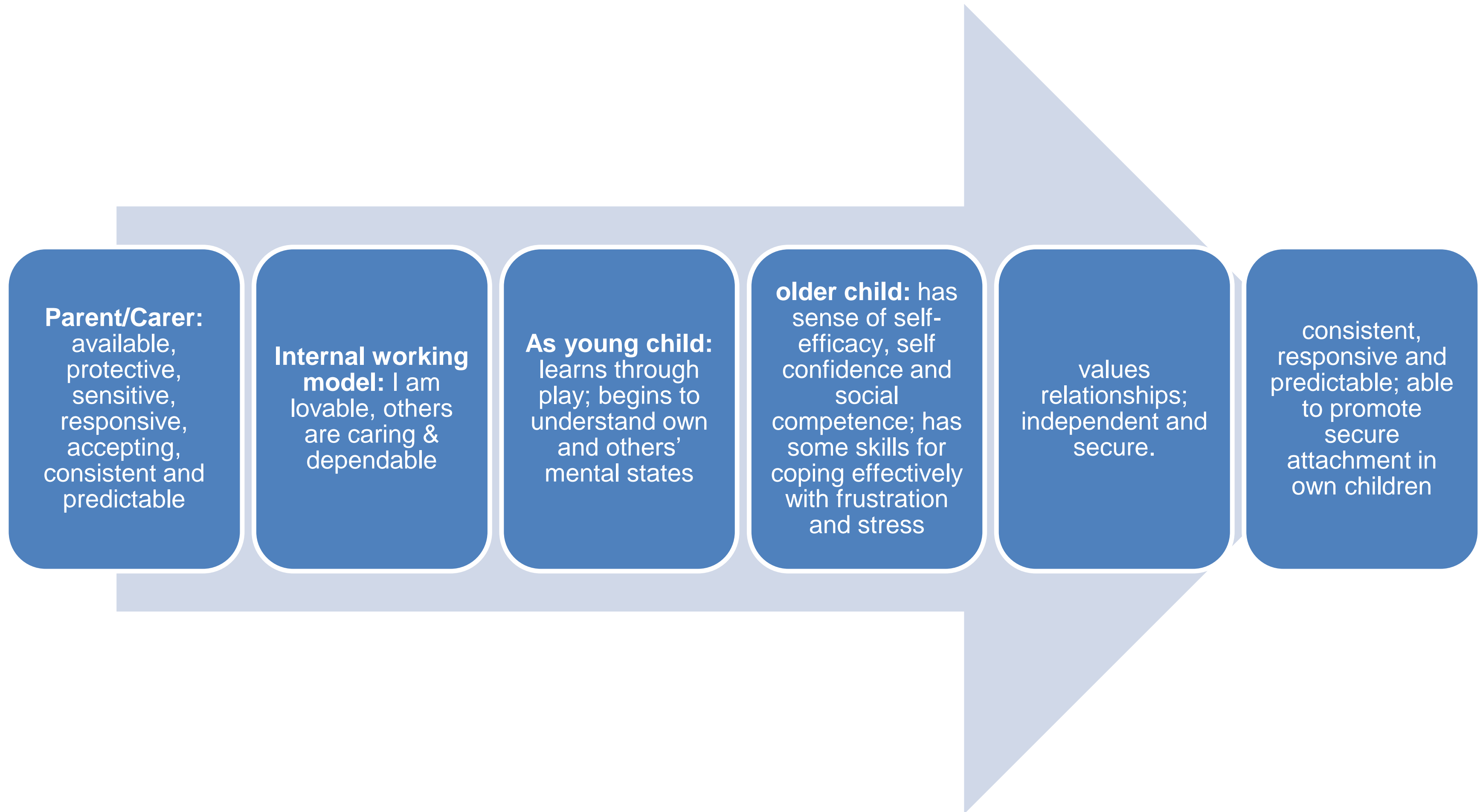
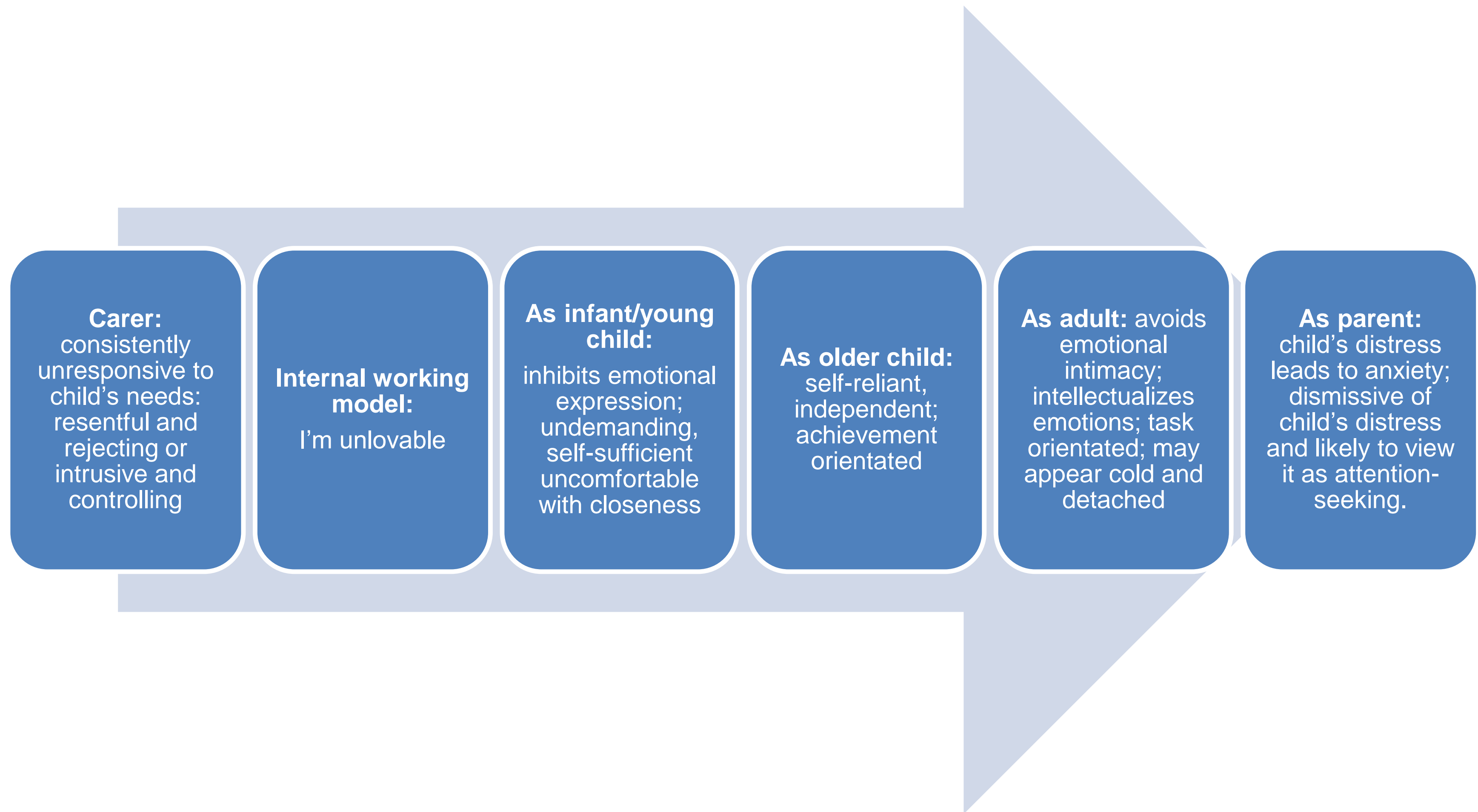


Insecure attachment



Insecure attachment-ambivalent

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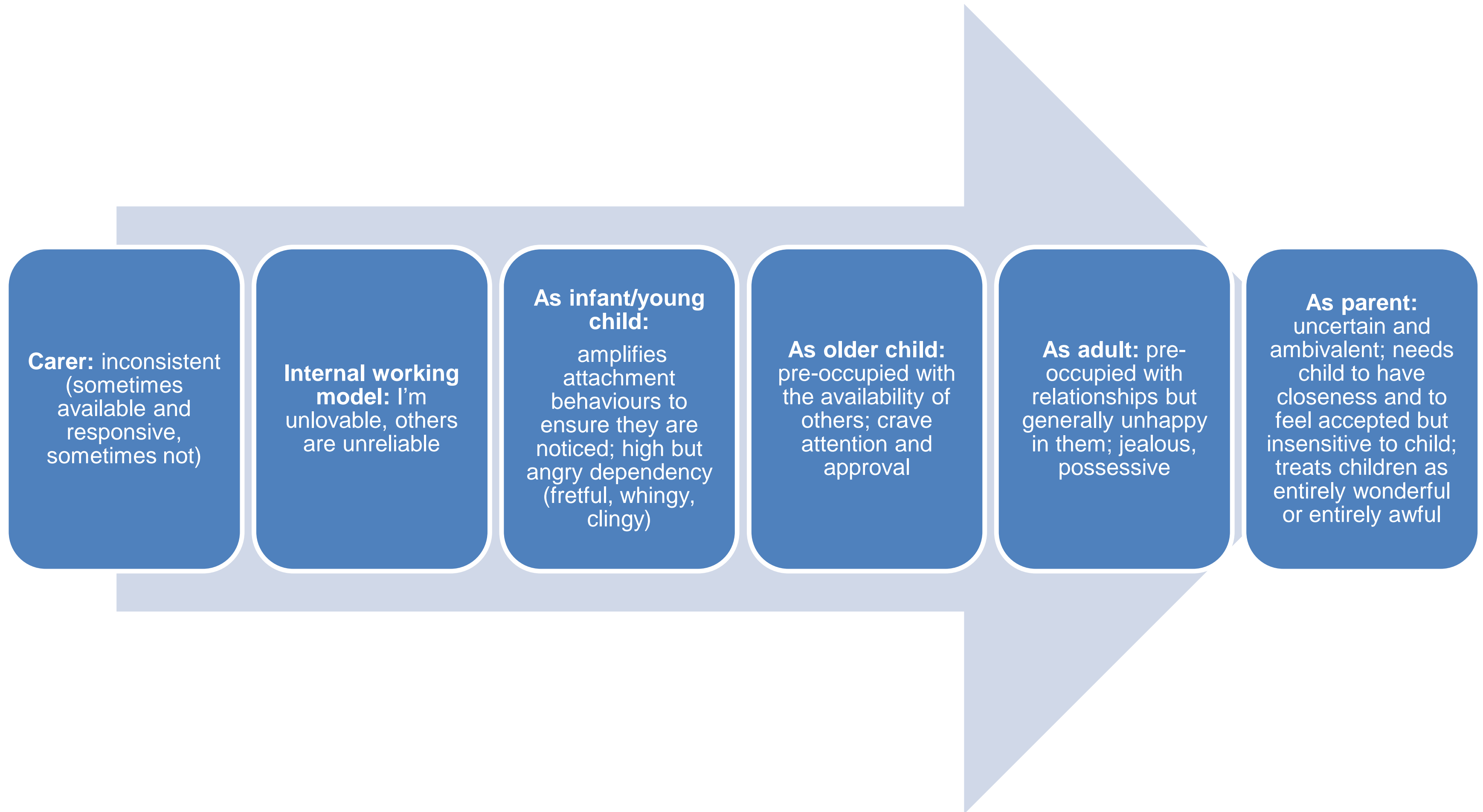

Disorganised Attachment

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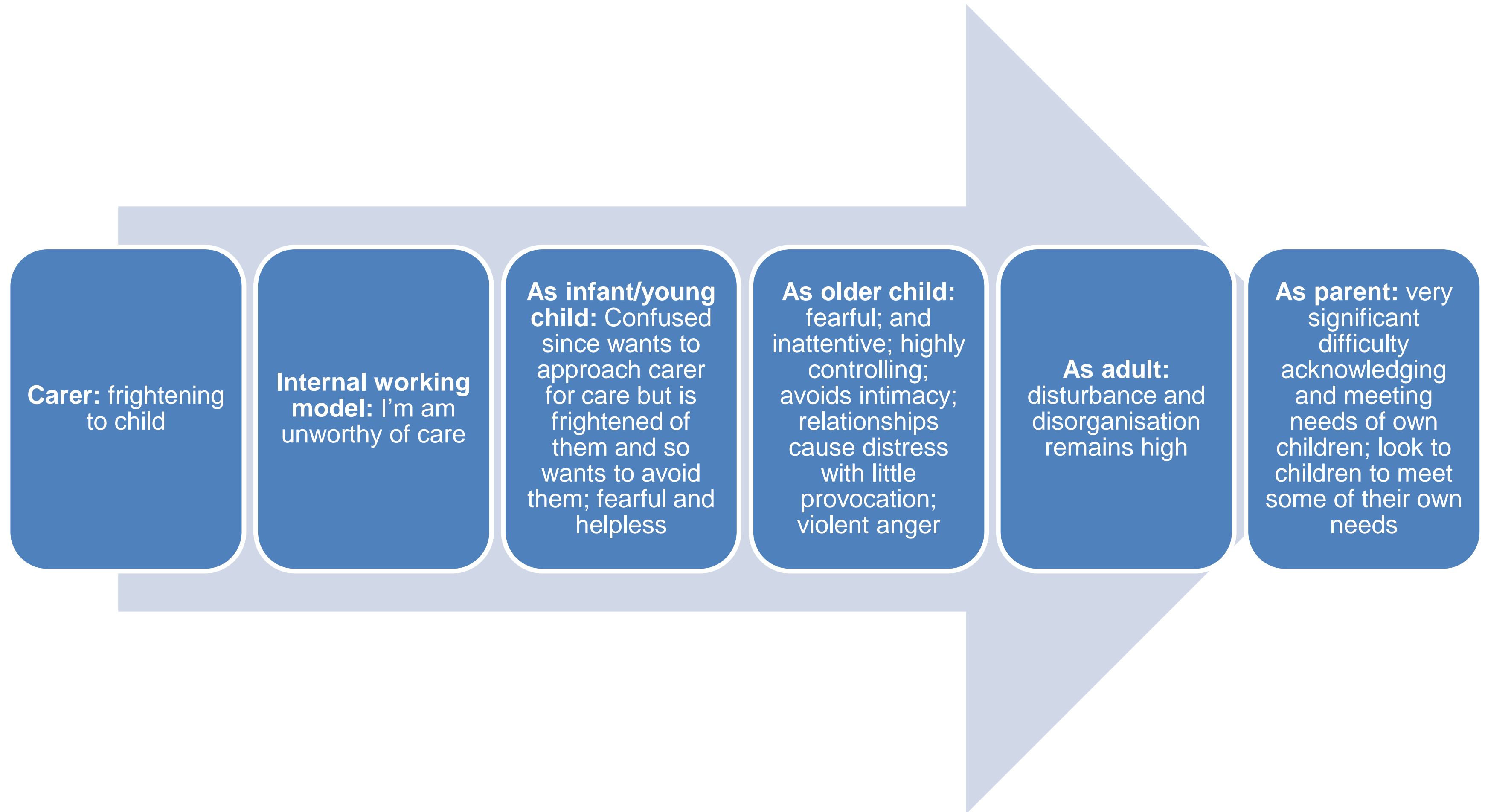

Features of disordered attachment

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Emotions

- Poor recognition of internal emotional states
- Labile
- Anxiety
- Angry outbursts
- Detached

Relationships

- clinging
- lack of discrimination; over friendly, or withdrawal
- Poor maintenance of relationships
- Need to be in control
- Aggressive interactions
- Ambivalence
- Poor eye contact
- Problems regulating physical closeness

Behaviour

- Inattentive
- Impulsive
- Poor concentration

Cognitive

- Fail to learn from mistakes
- Poor cause and effect thinking
- Executive functioning problems

Physical

- Enuresis
- Encopresis
- Sleep difficulties
- Problems regulating food intake

Disorganized attachment

- Infants with disorganized attachment on the strange situation test are more likely to show high levels of aggression in middle childhood
- This is likely to be a long lasting trait
- Rates of disorganised attachment are much higher in children who are looked after; or where there is a history of abuse/ trauma- possibly as high as 90%
- There may be an overlap between the concept of disorganised attachment and the diagnostic category of Reactive Attachment Disorder. (although some dispute that they are the same)

Differential diagnosis of attachment difficulties

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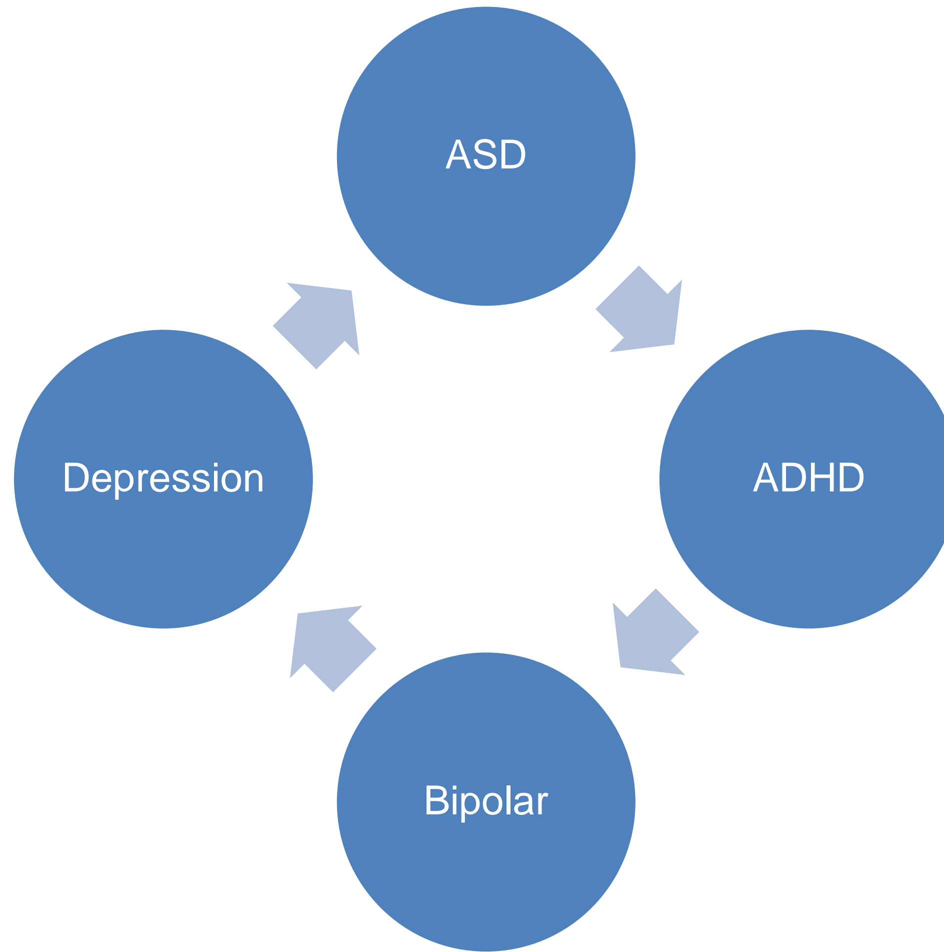

ASD vs Attachment

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Play

ASD tends to be related to intense interests, involve collecting/ordering; have high cognitive content. Children with attachment disorders may lack play skills but interests tend to be more usual.

Relationships

Children with ASD may show one sided interaction, unaware of other's perspective. Children with attachment disorders- might lack social skills but do not have unusual types of interaction; can be highly attuned to other's reactions.

Communication

specific communication deficits of ASD, e.g. echolalia, literal understanding, unusual voice tone not usually seen in attachment disorder.

Assessment in children

- Focused observations of child and carer. Strange situation test. Adaptations have been developed for slightly older children
- Structured assessment may be used, e.g. Story Stems, MCAST-play based methods designed to access attachment representations
- Structured interviews for older children (7 upwards) and adolescents.- e.g. School aged Assessment of Attachment (SAA)

Most of the above are predominately used in research; clinical assessment tends to rely on history taking and general observations

Assessment in adults

- Mainly structured interviews-self report questionnaires also exist
- Most widely used- Adult Attachment Interview AAI- (George, Kaplan and Main 1984)
- Semi structured interview- lot of research validity both with ABCD and DMM methods
- Aims to elicit adult representations of their attachment experiences.
- Interview codes content and coherence of discourse, and underlying information processing
- Categories are autonomous; dismissing; preoccupied; unresolved

AAI Categories

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Autonomous

- value attachment relationships, describe them in a balanced way
- Discourse is coherent and internally consistent

Dismissing

- memory lapses.
- Minimize negative experiences
- deny impact on relationships
- Positive descriptions may be contradicted.

Preoccupied

- Have continuing preoccupation with own parents
- Incoherent discourse.
- Have angry or ambivalent representations of the past

Unresolved

- evidence of trauma or unresolved loss or abuse

Therapeutic interventions for children

- A range of approaches have been developed.
- None are, or attempt to be, a substitute for good quality care at home. They can only be an extra.
- All professional attachment interventions emphasize the central importance of carers and largely describe therapeutic work with, and through parents, long-term substitute carers or adoptive families.

Principles of care giving for children with disrupted attachments: Looked after children

- Information giving
- Co regulation of emotions
- Limit setting, discipline with empathy
- Claiming behaviours
- Help child build narrative about their experiences
- Carer coping and self care

Care giving for children with disrupted attachments: Looked after children

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Information giving	Co regulation of emotions	Limit setting, discipline with empathy
Claiming behaviours	Help child build narrative about their experiences	Carer coping and self care

Carer characteristics: Looked after children

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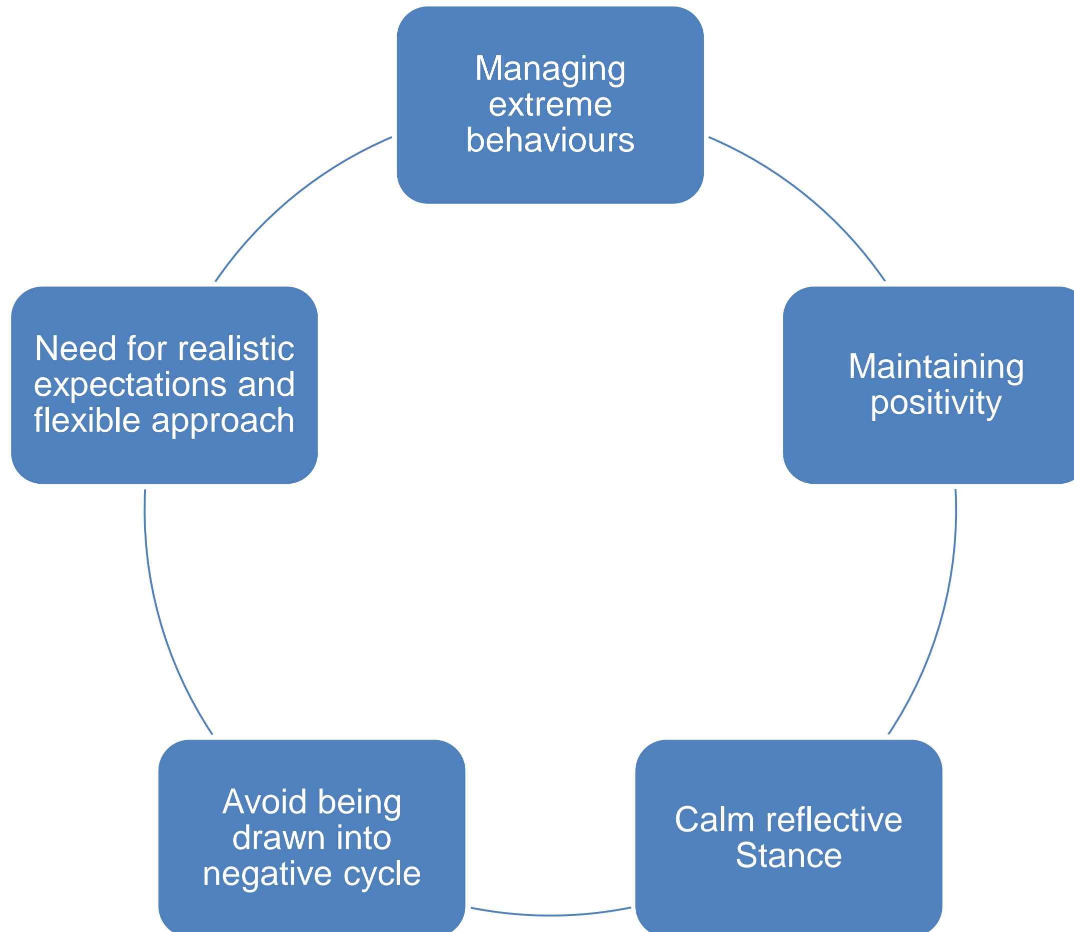

Therapeutic Interventions

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- Parent-Child Game
- Parenting Education- understanding about effects of early disrupted attachment on current behavior
- Adapted Webster Stratton groups
- Video interaction guidance
- Attachment groups for carers
- Relationship Play Therapy-theraplay
- Dyadic Developmental Psychotherapy

Evidence for interventions

- Not a lot of clear evidence about therapeutic interventions.
- Some evidence to suggest that behavioural based interventions can increase parental sensitivity especially with young children
- But harder to address parents' own attachment representations
- In older children, a range of CAMHS interventions may be useful for addressing problem areas such as increased arousal, social problem solving, coping with frustration, closer family relationships- but studies do not generally show a change in attachment status of the child
- Studies favour- short term interventions with clear focus.

Prognosis

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insecure attachment patterns are best thought of as risk/ vulnerability factors for later problems, rather than predictive factors

Little evidence about links between infant attachment patterns and later adult psychopathology

Some studies have shown that those adults with preoccupied/ ambivalent attachment-have higher rates of mood disorder, anxiety and borderline personality disorder

Disorganized attachments in young children- associated with later high levels of aggression in middle childhood/adolescence, and possibly predict a higher level of mental health difficulties in later life.

Studies have shown link with more hostility in later adult relationships

Prognosis

Psychiatric in patients- shown to have higher rates of disorganized attachment than controls

Difficult to know if continuity of problems is due to continuity of environment

Extreme disturbances of attachment are like be associated with history of abuse and /or trauma as children as well

We do know that attachment patterns in parents- closely mirror those of their infants (or can get reversal patterns)

consequences are broader than mental health difficulties but can affect quality of adult relationships, parenting, employment, criminality, drug use, etc.

Changes to Attachment: ICD 11

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ICD10

Categorised under: 'Disorders of social functioning with onset specific to childhood and adolescence'

Two main subcategories: 'Reactive attachment disorder' and 'Disinhibited attachment disorder of childhood'

RAD: fearfulness and hypervigilance, poor social interaction with peers, aggression towards self and others, misery, and growth failure in some cases

ICD11

Categorised under: 'Disorders specifically associated with stress'

Two main subcategories: Reactive attachment disorder' and 'Disinhibited social engagement disorder'

RAD: doesn't offer specific symptoms, just that it occurs in context of grossly inadequate childcare

MCQ 1

1. The biological basis of attachment behaviour is:
    - A. The child developing relationships with other children
    - B. The mother wanting to protect her child from any harm
    - C. The child seeking proximity to the attachment figure
    - D. The mother's instinct to rear children
    - E. All of the above

Answer

- E

MCQ 2

2. Attachment theory has been developed by:
    - A. Freud
    - B. Bowlby
    - C. Skinner
    - D. Piaget
    - E. Klein

Answer

- B

MCQ 3

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3. ‘Institutional deprivation” occur in the context of which ICD 11 diagnosis?:
   - A. Generalised anxiety disorder
   - B. Phobic anxiety disorder
   - C. PTSD
   - D. Reactive attachment disorder
   - E. Paranoid personality disorder

Answer

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- D

MCQ 4

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4. Select a feature that does NOT form part of Reactive Attachment Disorder (ICD 11) but points towards Pervasive Developmental Disorders:
   - A. Abnormal pattern of social responsiveness that improves if child is placed in normal rearing environment
   - B. Aggressive responses towards their own or other's distress
   - C. Restricted, repetitive interests and behaviours
   - D. Strongly contradictory social responses
   - E. None of the above

Answer

- C

MCQ 5

5. Reactive Attachment Disorder of early infancy and childhood (DSM V) and Reactive Attachment Disorder of (ICD 11) share common diagnostic criteria. Which of the following is NOT a diagnostic feature in ICD 11:
   - A. Developed before age of 5 years
   - B. Does not turn to primary caregiver for comfort
   - C. Does not display security seeking behaviour
   - D. Does not respond when comfort is offered
   - E. None of the above

Answer

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- E

MCQ 6

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6. Which of the following features is NOT part of Disinhibited Social engagement Disorder (ICD11):
   - A. Approaches adults indiscriminately
   - B. Exhibits over familiar behaviour with strangers
   - C. Features develop within first 5 years of life
   - D. Occurs in context of grossly inadequate childcare
   - E. Abnormal speech development including echolalia

Answer

- E

MCQ 7

7. Which of the following cognitive age ranges must a child reach to develop an attachment relationship:
   - A. 2-5 months
   - B. 7-9 months
   - C. 2 years
   - D. 5 years
   - E. 7 years

Answer

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- B

MCQ 8

8. What is the procedure called that assesses a child's attachment behaviour:
   - A. Novel Situation Test
   - B. Attachment Assessment Procedure
   - C. Strange Situation Procedure
   - D. Mother - Infant Attachment Battery
   - E. None of the above

Answer

- C

MCQ 9

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9. Symptoms of Reactive Attachment Disorder have to be present before which age:
   - A. 3 years
   - B. 9 months
   - C. 18 months
   - D. 8 years
   - E. 5 years

Answer

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- E

MCQ 10

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10. The current hypothesis is that Attachment Disorders develop as a result of:
    - A. Children having been brought up by a single parent
    - B. Children having had limited opportunities to form selected attachments
    - C. Children having received a vegetarian diet
    - D. Children having intrinsic difficulties in forming secure attachments
    - E. Children having a specific gene mutation

Answer

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- B