ADDRESSING *THEORY OF MIND* DEFICITS IN CHILDREN WITH ATTACHMENT DISORDERS

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Definition of Attachment

- The bonding *process* between infant and preferred caregiver(s), usually the mother, which satisfies innate needs of the infant for physical contact and proximity to ensure comfort, support, nurturance and safety *(Bowlby, 1969)*.

- The bonding process results in certain reciprocal behaviors from both participants which, when positively attuned, increases the infant's sense of security and predictability, while reinforcing the mother's sense that she knows her baby and can protect him/her. Over time, these patterns form "internal working models" of interaction.

- With continued bonding, the infant is able to develop a clear sense of self as separate from the mother and the confidence to venture out on his/her own.

What is *Reactive Attachment Disorder*?[1]

- ✓ A consistent pattern of inhibited, emotionally withdrawn behavior in which the child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection and nurturance.
- ✓ Evident before 5 years of age.
- ✓ Distinguished from Intellectual Disability or Autism Spectrum Disorders.
- ✓ Results directly from persistent disregard of the child's basic *emotional needs* for comfort, stimulation, and affection (i.e., neglect), *physical needs*, or *repeated changes of primary caregiver* that prevent formation of stable attachments. This is referred to as "pathogenic care.
- ✓ Identified more in children who have been maltreated or who have received inconsistent care.
- ✓ Shown to have a higher probability of developing disruptive or conduct-related disorders compared to children with DSED.

[1] **Criteria for DSM 5 (© 2013 American Psychiatric Association).**

What is *Disinhibited Social Engagement Disorder?*[2]

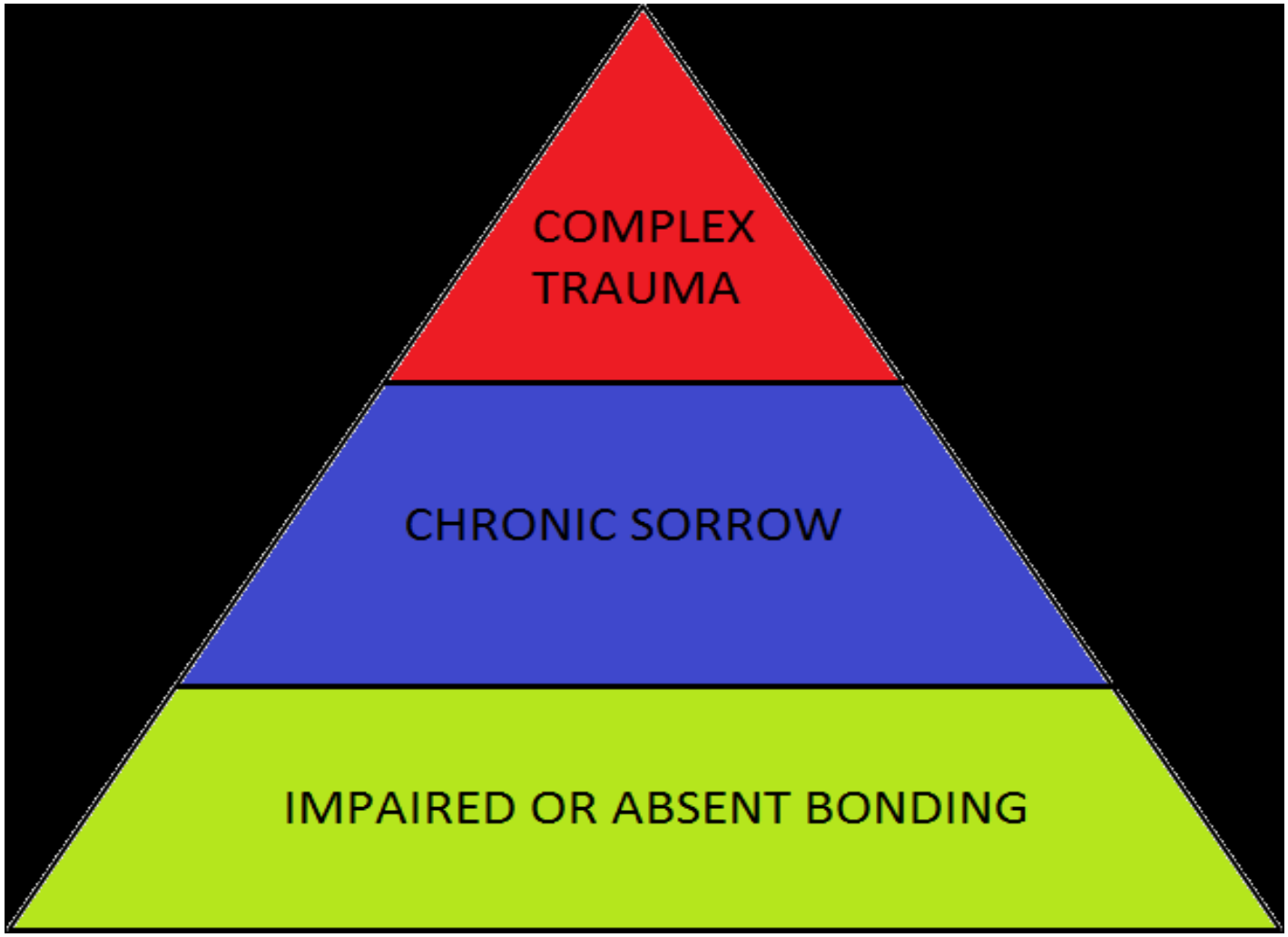
- ✓ A pattern of behavior in which the child actively approaches and interacts with unfamiliar adults.
- ✓ Reduced or absent reticence to approach and interact with unfamiliar adults.
- ✓ Overly familiar behavior (verbal or physical violation of culturally sanctioned social boundaries).
- ✓ Diminished or absent check back with adult caregivers after venturing away, even in unfamiliar settings.
- ✓ Willingness to go off with an unfamiliar adult with minimal or no hesitation.
- ✓ Identified more in children who have been adopted out of institutions and/or who have experienced persistent neglect.

[2] **Criteria for DSM 5 (© 2013 American Psychiatric Association).**

Considering a "Spectrum" for Attachment Disorders

- Most cases of attachment disorders are based on accounts of children adopted out of institutional care. These have formed the prototype for DSM-IV-TR & DSM 5, although we see similar disorders in foster children without institutional rearing.
- Although *Reactive Attachment Disorder* and *Disinhibited Social Engagement Disorder* have been found to be legitimate discrete categories, children with attachment disorders can oftentimes exhibit mixed features.
- Many children in out-of-home placement or adopted from foreign countries can manifest disturbances suggestive of RAD or DSED, yet there may be problems accessing data to support early pathogenic care.
- Children with underlining attachment disturbances are often first diagnosed as having Disruptive Behavior, Oppositional Defiant, or Attention Deficit/Hyperactivity Disorders, thus bypassing a critical etiological marker.
- Because attachment follows a developmental, neurobiological trajectory, treatment should address foundational issues before attempting to ameliorate later co-morbid disorders.

"The most effective intervention process would be to first address and improve self-regulation, anxiety, and impulsivity before the cognitive problems (self-esteem, guilt, shame) become the focus of therapy (*Perry, 2009*)"



Core Axioms

- Children who have experienced continued disruption in the formation of primary attachments require a unique set of approaches that will often appear *counter-intuitive* to what most care providers feel is normal or comfortable for them.
- The capability of the caregiver to regard the child as an individual with a mind, capable of intentional behavior and address the child's internal emotions, desires, physical states and distressful states results in the child's development of a *theory of mind* (ToM). As the child's ToM increases, so does secure attachment (*Meins, et al*).
- The organization of higher parts of the brain (limbic & cortical) relies on input from the lower parts of the brain (brainstem & diencephalon). If neural activity is regulated, synchronous, patterned, and of "normal" intensity, the higher areas will organize in healthier ways (*Perry, 2009*).

Problematic Internal Working Models for Youth with Attachment Disorders

#1: Because the youth had experienced an early lack of positive regard for emotional and physical states, he/she demonstrates impairment in the ability to identify, reflect on, and regulate emotions and body awareness.

#2: Because the youth had experienced early impairment in the formation of selective attachments, he/she demonstrates extreme difficulty in generalizing interpersonal strategies from person to person.

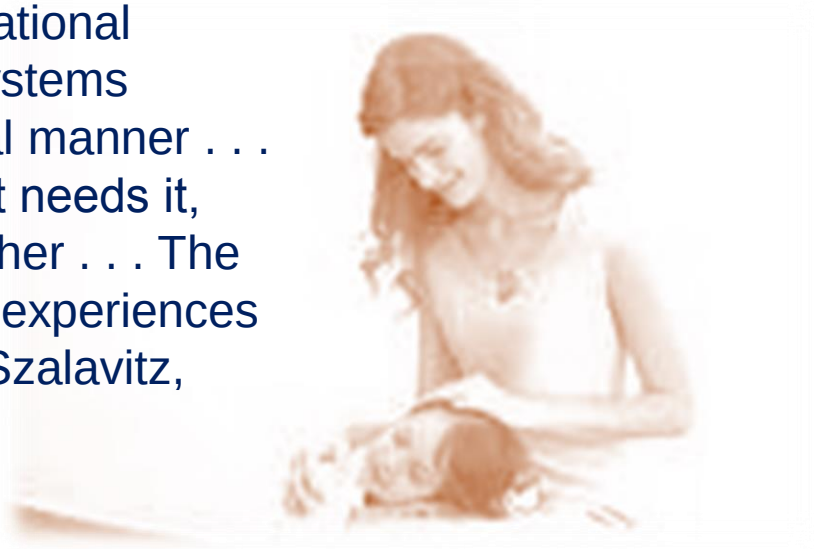
#3: Because the youth had experienced early pathogenic care around primary needs, he/she will often approach situations from a basic survival perspective.

#1: *Theory of Mind* Deficits

- Identifying uncomfortable or undesirable experiences: (ex.) hot, cold, tired, sick, scared.
- Attainment or continuation of comfortable or desirable states: (ex.) warmth, sleep, happy, laugh.
- Identifying antecedents of or reasons for experience or judgment: (ex.) hurt feelings, mad, naughty.
- Explanation of one's experience in terms of a physical symptom, an affect expression, or another psychological state: (ex.) feel bad, hurt, not happy, sad.

Establishing a Neurosequential Lens

"When Mama P. (foster parent) had rocked and held the traumatized and neglected children she cared for, she'd intuitively discovered what would become the foundation of our *neurosequential* approach: these children need patterned, repetitive experiences appropriate to their developmental needs, needs that reflect the age at which they'd missed important stimuli or had been traumatized, not their current chronological age . . . A foundational principle of brain development is that neural systems organize and become functional in a sequential manner . . . If one system doesn't get what it needs when it needs it, those that rely upon it may not function well either . . . The key to healthy development is getting the right experiences in the right amounts at the right time (Perry & Szalavitz, 2006)."



#2: Managing Personas

The King of Masks

#3: GRATIFYING BASIC NEEDS & SURVIVAL

- Lying / Storytelling / Concealing
- Stealing / Foraging / Hoarding
- Self-perception of Equal Power
- Running Away / AWOL
- Manipulation of Others

- Lack of Empathy or Remorse
- Aggression / Rage
- Fake sense of self
- Boredom / Impoverished Affect
- Neglect of self & possessions
- Overly-dramatic

CHALLENGES FOR HELPING PROFESSIONALS

- Resistance to undoing maladaptive attachment patterns increases with age due to continued reinforcement and over-reliance on internal working models of interaction, despite whether or not the behaviors appear to be serving the youth's best interests.

- With the onset of puberty, primitive attachment patterns can become eroticized and suddenly take on new dimensions including paraphilias, sexual addictions, and partner sexual aggression.

SUPPORT NEEDS BY LEVEL OF CARE

- FAMILY HOME:
  - **Psychoeducation on attachment disorders.**
  - Parents work as "tag team", but have liberal respite care available.
  - Structured environment through predictable routines and close physical bonds.
  - Individualized, daytime rituals which combine personal care and "grounding" words.
  - A supportive "village" whereby extended family members, natural supports, and teachers conduct therapeutic interactions.
  - Outpatient behavioral health w/ community rehab or therapeutic behavioral services. Focus should be parent-youth dyad.
  - Add Wraparound support if negative behaviors escalate.

SUPPORT NEEDS BY LEVEL OF CARE (cont'd)

- FOSTER HOME:
  - **Training on attachment disorders.**
  - Foster parents work as "tag team" and have respite care available on a scheduled basis.
  - Predictable routines and careful management of physical space and boundaries.
  - Individualized care that combines attention to emotions and physical state.
  - A consistent natural and professional support system that conducts therapeutic interactions.
  - Outpatient behavioral health w/ community rehab or therapeutic behavioral services. Focus should be caregiver-youth dyad.
  - Allow foster parents the freedom to ventilate frustration without feeling judged or fearful of facing removal of the youth.

SUPPORT NEEDS BY LEVEL OF CARE (cont'd)

- RESIDENTIAL TREATMENT:
  - **Training on attachment disorders.**
  - Assigned primary residential counselors based on youth's selective attachment.
  - Predictable routines and careful management of physical space and boundaries.
  - Individualized treatment that combines attention to emotions and physical state.
  - An informed and relationally-focused professional support system that conducts therapeutic interactions.
  - Intensive mental health and therapeutic behavioral services for community rehabilitation.
  - Frequent staffings and treatment plan reviews to adjust to shifts in attachment behaviors.

Building an Attachment-based Support Team (AST)

- Conduct a thorough evaluation of the child's ability to understand the environment, his/her own support-seeking behaviors, and which staff/family members get targeted for positive or negative behaviors. This should be the focus during the initial or "honeymoon" phase (usually 3 to 4 months).
- Construct a Safety Plan along the lines of negative attachment triggers and interpersonal interventions.
- Utilize Family Partner, Rehab Specialist, Therapist, Care Manager, ancillary supports (e.g., teachers, residential counselors, mentors, etc.). Participants do better when they are not triggered by the child's behaviors and when they themselves hold *autonomous* attachment representations.
- Support the child-caregiver relationship through the use of dyadic treatment.

Effective Approaches to Attachment Work

- Accelerated Experiential Dynamic Psychotherapy (*Fosha,2009*)
- Animal-assisted / Equine Therapies
- Neurosequential Model of Therapeutics (*Perry, 2009*)
- Parent-Child Interactive Therapy (PCIT)
- Problem-solving & Skill-building
- Theraplay®

QUESTIONS & ANSWERS