What Is “ATTACHMENT”?  
- Differs from “bonding”  
- “Attachment” is characterized by a special bond that forms primary caregiver – infant relationships  
- Three (3) key components in an “attachment” 
  - Enduring emotional relationship with specific person  
  - Relationship characterized by safety, comfort, soothing and pleasure  
  - Loss (or threat of loss) of this person = DISTRESS

“ABCs of Attachment”  
A - ATTUNEMENT  
B - BALANCE  
- Healthy physiological state  
C - COHERENCE  
- Internal world capable of adapting to constant environmental changes  
- Caregiver(s) are responsible for setting this foundation

(Siegel & Hartzell, 2003)
What Is Important for Healthy Attachment to Occur?

The primary relationship
- This sets the “template” for future

Quantity and quality of interactions
- Directly relate to neurochemical activities in the brain
- Help to “organize” brain systems

What Is Important for Healthy Attachment to Occur?

Timing
- First 3 years

Critical Period
- First year of life is essential

Attachment

Normal attachment is an organized, cascading, neuro-developmental pattern that establishes the foundation of the future experiences of self (bodily states, emotions, and self regulation) and of relationships to others (care giving, comfort and safety)

It requires ‘appropriate parenting’, which is consistent nurturance plus predictable safety and structure (the yin/yang of parenting).
Neurobiology of the Developing Mind

- Attachment is an ‘experience dependent’ development
- A huge number of genes encode the timing and details of the circuits
- Experience ‘activates’ specific neuronal connections and creates new synapses
- Mostly right hemisphere activity – facial expression, perception of emotion, ‘relational communication’

- Brain differentiation requires genetic information and proper experiences, allowing normal self-regulation, relatedness, language and memory … in short, an organized mind
- Importance of orbitofrontal cortex, a coordinating region between limbic system (emotional brain) and associational system regions of the neocortex (achieving proper context)

Normal Cycle of Dyadic Attunement

- States of attunement … interrupted by periods of disruption … followed by repair of mutually coordinated attunement
- Each cycle brings greater complexity in:
  - Regulating affective states
  - Leads to greater confidence in learning/exploration
  - Experiencing genuine feelings without fear of danger ensuing … in both partners
Normal Cycle of Dyadic Attunement

- If genuine feeling states are thus tolerated in dyadic attunement, it leads toward a genuine child, rather than the defenses against genuine feelings, such as denial, withdrawal, lying, stealing, conning, aggression, etc. ... all the symptoms we see in serious attachment disorders.

Normal Cycle of Dyadic Attunement

- Fear of danger disorganizes the mind, whereas secure dyadic attachment reorganizes the mind ... an evolutionary solution to danger, where the child learns to regulate fear.

But ...

- If fear of danger comes from the dyad itself, as with caregivers dysregulation (often triggered by the child’s genuine feeling states), then we may spiral into the destructive cycle of RAD and all its difficult expressions.

Summary of Normal Dyadic Development

In the first several years of life, the parent’s mind acts to constantly alter the child’s mind, developing neural circuits of increasingly sophisticated self regulation.
Attachment Disorders

➢ A broad arena of dysregulation of mood, behaviour and social relationships, following failure to form normal relationships with primary caregiver in early childhood
➢ The period of pathologic attachment is generally thought to be 6 mo. to 3 years
➢ Best to consider along a spectrum, from healthy ‘secure attachment’, to midrange ‘insecure or other undesirable forms’, through to non-attachment or disorganized attachment (RAD)

Attachment Disorders

➢ Disorganized attachment is the most severe form of attachment problems, where this biopsychosocial system becomes ‘disorganized’ in the same fashion as ‘disorganized schizophrenia’, where many domains of function are simultaneously disturbed. ‘Disoriented’ could also be used.
➢ The chief cause of this disorganization is ongoing neglect and trauma, i.e. ‘disorganized parenting’ … and hence ‘developmental PTSD’ usually present.

Diagnostic Criteria DSM iv

A. Markedly disturbed social relatedness
➢ Either failure to initiate or excessively inhibited (‘frozen’) children.
➢ Or, diffuse attachments/excessively familiar (walk off with strangers). Note the focus on one ‘boundary issue’.
Diagnostic Criteria DSM iv

B. Pathogenic care
- Persistent disregard for child’s basic emotional or physical needs … or no stable attachments (frequent moves or changes in parenting care)
- Note: inhibited or disinhibited type. Not accounted for by MR or PDD.

Presentation … Checklists

Infants
- Severe colic
- Failure to thrive (or anacritic depression)
- Failure to attach or bond
- Resistant to comforting, holding, etc.

Children
- Boundaries
  - Personal space
  - Strangers (frozen watchfulness to indiscriminate sociability)
- Rage
- Sleep

- Bizarre lying and stealing
- Hoarding food
- Sexual touch
- Manipulative
- Emotionally phony (‘as if’)

… some of which are the basis of Axis II diagnosis in adults
‘Disturbance of Attachment’ Interview

This is a semi-structured interview designed to be administered by clinicians to caregivers.

It covers 12 items or ‘boundaries’
- Having a discriminated, preferred adult (specificity and proximity)
- Seeking comfort when distressed
- Responding to comfort when offered
- Social and emotional reciprocity

‘Disturbance of Attachment’ Interview

It covers 12 items or ‘boundaries’ (continued)
- Emotional regulation
- Checking back after venturing away from the caregiver
- Reticence with unfamiliar adults
- Willingness to go off with relative strangers
- Self endangering behaviour

‘Disturbance of Attachment’ Interview

It covers 12 items or ‘boundaries’ (continued)
- Excessive climbing
- Hypercompliance (too good)
- Role reversal (parentified)
- Vigilance
Self Concept ... ‘Written In Stone’

I must be bad and my bad behaviour is who I am

Trust no one and survival depends on being in control

Self Concept ... ‘Written In Stone’

I do nothing right

I deserve to be hated

Others deserve my hate

Self Concept ... ‘Written In Stone’

I am good and loved and lovable

I trust the world and me in it

I am competent

I deserve a chance

I can forgive and attach to others

RAD Definition / Description

- Generally apparent in children before the age of five (5)
- Lack of consistent care and nurturing in early years
- Characterized by the inability to establish age-appropriate social contact and relationships with others
- There are two subtypes:
  - Reflecting the disinhibited attachment pattern
  - Reflecting the inhibited pattern
**RAD – PTSD Spectrum**

- Developmental PTSD = complex PTSD – DESNOS
- Overlap of symptoms include amnestic and dissociative episodes, alterations in relationship to self, distorted relationships, somatization and affective dysregulation
- Also share many overlapping symptoms with FASD, Depression/Bipolar and ADHD/ODD/CD
  - All share aspects of cognitive, mood and behavioural dysregulation thus diagnostic problems

**FASD Definition**

- An alcohol related birth defect
- FASD is not curable, but is 100% preventable
- Encompasses a specific “cluster” of abnormalities
- Caused by a mother’s drinking or substance consumption while in utero

**FASD Definition**

- Produces lifelong disabilities and neuropsychiatric dysfunction
- NOT genetic….if mother has FASD, she will not “pass it on” to her children as long as she does not drink…though there are obvious RAD implications for a mother with FASD without strong intervention
**FAS / FASD / ARBD / ARND**
- Confirmed alcohol exposure
- Facial anomalies – thin upper lip, short palpebral fissures, flat philtrum or midface
- Growth retardation – low birth weight or decelerating weight over time, low weight/height ratio
- CNS/ND abnormalities on PE – small cranial size, abnormal MRI findings, neurological hard or soft signs

**ARND / FASD (Includes Partial Syndrome)**
- Complex patterns of behavioural / cognitive abnormalities
- Inconsistent with developmental level
- Family history
- Environmental influences
- Other obvious diagnosis
  - Very impulsive
  - Moderate/severe learning difficulties

**ARND / FASD (Includes Partial Syndrome)**
- Other obvious diagnosis (continued)
  - Poor social perception
  - Poor abstraction and cause/effect
  - Poor ‘higher level’ receptive/expressive language
  - Poor verbal memory
  - Judgment attention
  - Executive function
Diagnosis of FASD Involves

- Case management coordinator
- MD trained in FASD diagnosis
- Psychologist (WISC/WIAT etc)
- Occupational Therapy (motor skills and sensory integration)
- Speech and Language (communication assessment)

Four Digit Diagnostic Code

Magnitude of expression of four basic features of FAS on a four point Likert scale (1 is ‘none’ and 4 is ‘extreme’)

- Growth deficiency
- FAS facial phenotype
- CNS damage/dysfunction
- Gestational exposure to alcohol

Why Is FASD a “Spectrum Disorder” …and Why Isn’t RAD?

- Symptomatology is along a wide continuum
- Varies (and can present differently) from individual to individual
- The threshold of alcohol exposure which results in fetal damage has not yet been determined…similarly, the threshold for unstable attachment/neglect/etc. is similar…it is not fully determined
- Potential changes for RAD in upcoming DSM
### Dual Diagnosis Issues (for both FASD and RAD)
- ADD
- ADHD
- Autistic
- Asperger's Syndrome
- Pervasive Developmental Disorder
- Conduct Disorder
- ODD
- OCD
- Learning Disabled
- Developmental Receptive Language Disorder
- Sensory Integration Dysfunction
- Others...

### FASD – RAD Common Features
- Both presume brain injury
- Both presume deficits in multiple domains of development
  - Cognitive
  - Emotional
  - Behavioural
  - Relational (family and peers)
  - Learning (social and academic)

- Both require bio-psychosocial-language-educational-OT approaches...an entire ‘village’ of ongoing support
Risk Factors (FASD has in common with RAD)
- Higher maternal age
- Lower SES and Ed levels
- Prenatal exposure to other substance including nicotine
- Custody changes

Risk Factors (FASD has in common with RAD)
- Paternal drinking/drugging
- Poor access to prenatal services
- Poor nutrition and chaotic environment (stress/abuse/neglect)

Thus many children have both FASD and RAD

Common Features
Both require ultra-dedicated caregivers
- 24/7 supervision
- Continuous ‘external brain’
- Ongoing advocacy in the face of criticism and lack of understanding
- Who can take good care of themselves, their marriage and their families, as well as the child in question
- Who understand ‘vicarious trauma’ and how/when it affects them
Common Features

Vital that neither diagnosis allows for
- ‘Giving up’
- ‘Why bother’
- The pessimism of ‘no useful treatment’

Both require improvement in the ‘attachment context’, RAD specifically but FASD in general, for
- The boundaries

Common Features

Both require improvement in the ‘attachment context’, RAD specifically but FASD in general, for
- The boundaries
- Communication
- Responsibility
- Social skills, etc

Common Features

All more likely to improve with better attachment...builds a better foundation which allows for more specific therapies to “work”
- Behavioural Therapy
- Speech and Language
- Occupational Therapy
- Special Education
DSM-IV and Other Criteria for FASD and RAD

- Quick review of specific DSM-IV criteria
- FASD along the continuum
- Theories re: Disorders of Attachment along the continuum
  - Bowlby
  - Ainsworth
  - Van der Kolk
  - Perry et al.

Prevalence of FASD and Co-Morbid RAD?

- No specific studies, other than anecdotal
- Higher rate of RAD in those with FASD than general populations
- Chicken and egg issue
- Neurological dysfunction in both
- Brain damage effects...may likely interfere with ability to develop healthy, reciprocal relationship(s)

Similar Effects of FASD and RAD

- For the Individual
  - Behaviorally
  - Neurologically and cognitively
  - Emotionally
  - Socially
  - Medically & physically
Similar Effects of FASD and RAD

- Within families
- Schools and Educational systems
- Treatment & therapy

Behavioral Effects and Issues

- Easily frustrated
- Respond immediately; no "Stop-Think-React"
- Emotionally labile
- Distractible
- Rigid
- Perseverative
- Oversensitive to stimuli
- Under-sensitive to stimuli

Behavioral Effects and Issues

- Demonstration of behavioural inconsistencies
- React to change
- Boundary issues
- Sexual acting out
- Lie, steal...legal issues
Neurological / Cognitive Effects

- Frontal Lobe issues
  - Need “external brain”
- Difficulty with short-term memory
- Often seizure disorders
  - Instructions must be clear, repetitious, short
- Difficulty with information processing
  - Predicting outcomes
  - May be state dependent

Neurological / Cognitive Effects

- Speech/Language Problems
  - Delays
  - Echolalia
  - Abnormal speech patterns
  - Articulation problems
- Difficulty retaining and utilizing information
- Retrieval difficulties

Neurological / Cognitive Effects

- Difficulty organizing & conceptualizing
- Difficulty with similarities and differences
  - Friend from stranger (safety)
  - Problem solving concerns
- Difficulty translating one modality to another
**Emotional Effects**
- Developmental and chronological age differ; emotionally immature
- Impulsive; disinhibited
- Look for immediate gratification; difficulty with delaying
- Fear failure and seem to sabotage success
- Emotionally rigid
- Depressed; isolated

**Emotional Effects**
- Often present with flat affect
- Can be irritable (especially as teens)
- Temper tantrums to rage
- Tendency to react rather than respond

**Social Effects and Issues**
- Delays in normal social development (i.e., separation anxiety may occur sometime between 6 and 8 rather than 6 months and 18 months)
- Socially immature; difficulties with peer group despite often being “peer driven”
- Immature social skills; difficulty learning inferentially
- Easily suggestible and influenced
- Require constant supervision
Social Effects and Issues

- May have difficulty internalizing modeled behaviors
- Lack stranger anxiety
- Feel different than others; often teased
- Can be argumentative due to lack of understanding
- Have difficulty “reading” people congruently; significant issues with relationships as a result
- Manage time poorly

Social Effects and Issues

- Communication difficulties
- Lack “feelings identification”
- Overall arrest in social development and social skills acquisition that may never reach adult maturity

“Concrete” Help and Change in Thoughts for Caregivers

From seeing child as
- Defiant/bad
- Oppositional ("won’t")
- Lazy
- Doesn’t try
- Fussy or demanding

To seeing child as
- Defended or challenged
- "Can’t"
- Tries hard
- Exhausted/"can’t start"
- Sensitive
- Is younger
“Concrete” Help and Change in Thoughts for Caregivers

From seeing child as
- Acting “babyish”/younger
- Attention-seeking
- Resistant
- Inappropriate
- Ignoring the “obvious”

To seeing child as
- Needing contact & support
- Doesn’t “get it”
- Not able to understand “proprieties”
- Requires many “re-teachings” and repetition

Some Overall Common Strengths

- Spontaneous
- Curious
- Affectionate
- Gentle & compassionate
- Loving
- Tactile; cuddly
- Perservation: persistent; focused; determined
- Sensitive
- Have a love for animals
- Many others

...though these strengths are often also weaknesses

Strategies

- Common strengths and difficulties
- Multi-modal approaches
- Individual versus group treatment
- Insight?????
Treatment of RAD: Love and Limits

Supports in the family for
- Predictable physical, emotional and psychological safety
- Calm consistent routines and limits
Caregivers mental health … via respite
- The diagnosis and treatment of vicarious trauma
- Ongoing psycho-education, so as to sustain the principles of attachment/attunement parenting within the forefront of daily life

Treatment of RAD: Love and Limits

All because healing requires parents of ‘RADishes’ to be
- Playful
- Loving
- Accepting
- Curious
- Empathic

Treatment of RAD: Love and Limits

All because healing requires parents of ‘RADishes’ to continuously sustain such attunement with the child, especially given the expression of genuine feeling states
- Terror
- Sadness
- Disgust
- Shame, etc.
- The array of defenses against genuineness (which originally caused fear of danger in the dyad)
**Treatment of RAD: Love and Limits**

Continues dyadic attunement, focus on the therapist’s or caregiver’s state of mind, establishing a healing pace and place

- Playful, loving, accepting, curious and empathic
- Attachment facilitating interventions (‘as if an infant in arms’)
- Shared subjective experiences
- Tolerating genuine feelings

**NOT rebirthing or coercive techniques**

(Theraplay/Dyadic Developmental Psychotherapy (Daniel Hughes Ph.D., 2005 and A. Becker-Weidman, 2006); Diana Fosha*, 2003 (AEDP))

**Medication Treatment**

- SSRIs appear to modulate limbic system, decreasing affective responses of anxiety, depression and fear
- Atypical Neuroleptics appear to modulate or smooth ‘state transitions'; helpful with rage, destructiveness, and impulsivity
- Clonidine helps regulate the ‘fight or flight’ tendencies of PTSD
- Adjunctive meds for co-morbid conditions or specific symptoms (sleep, ADHD, etc.)

**Bio-Psychosocial Treatment of FASD**

- Managing attachment and trauma complexities, keeping in mind the pyramid
- ‘The village’ becomes ‘the external brain’
- Skills in the social, communicational & adaptive living areas. Making choices/using judgment
- Behavioral management (structure, consistency, simplify, patience)
- Meds management of certain symptoms
- Always planning ahead
An “Inside Out “Approach
- Loss & trauma from childhood experiences requires understanding of past “connections”
  - “Leftovers lead to vulnerabilities”
- Passing of unresolved issues from generation to generation, perpetuating suffering
  - Childbirth stories
  - Life “narratives”

“Inside Out” Issues
When caring for children, our own triggers/leftovers become activated
- Bias one’s perceptions
- Alters decision-making
- Intrusive experiences (emotions, behaviors, perceptions, sensations, etc. without conscious awareness)
- Furthers disorganization and disorientation

“Inside Out” Issues (continued)
When caring for children, our own triggers/leftovers become activated
- Disconnected caregivers = Disconnected Child(ren)
- Creates obstacles to change/ movement (in therapy, communication, further bonding, etc.)
- Children become burdened by caregiver’s experiences
- Impacts attachment
CASA’s Trauma and Attachment Group (TAG) Program

TAG at CASA: Three Phases
- Trauma and Attachment Program Model

TAG at CASA: Three Phases
Stabilization
- Of disposition (PGO)
- Of symptoms of affect and behavioural dysregulation
- Altered consciousness (dissociated)
- Basic trust and attachment

TAG at CASA: Three Phases
Working through trauma
- Safe/unsafe place and how to transition between the two
- Building ‘realistic coherent life narrative’ (healthy context of all my life experiences)

Re-connection
- Family (foster/adoptive and ?bio)
- Peers (SS groups)
- Community and culture (activities)
TAG at CASA: Three Phases

Reconnection totally depends on the formulation of a coherent, realistic narrative, (the 'hoped for' end product of our treatment), where a child then genuinely knows where people and things fit into her life

Vs.

Still idealizing or demonizing past figures, especially bio family associated with 'offending parent(s)'

Trauma and Attachment Program Model: TAG I

- Psycho-education
- Stabilization
- Development of Safe/Holding Environment
  - Non-intrusive
  - "Setting the therapeutic stage"
- Basic introduction to therapeutic “themes”
- "Kit" work
- Ongoing dyadic observation and feedback

Trauma and Attachment Program Model: TAG II

- Ongoing psycho-education
- More “intrusive” strategies (specific therapeutic approaches re: attachment/trauma issues)
- Bodywork, internal processing/awareness, sensorimotor profiles/feedback work, expressive therapies (art journaling, etc.), play therapy (sandtray work)
- Ongoing specific dyadic “homework"
**Trauma and Attachment Program Model: TAG III**

- Parent support
- Continued psycho-education
- Therapeutic group re: parent process
- Ongoing individual and/or family therapy for continued assessment and/or follow-up
- Ongoing support with other “parties”
  - Children’s services, schools, FSCD, community programs, etc.

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**Strategies**

In order to:

- Reduce symptoms
- Improve sense of safety
- Develop a more realistic narrative (story)
- Develop a more healthy attachment style
- Improve self regulation
**Strategies**

- A “Safe Place” … imaginary, real, both
- Relaxation, visualization
- “Special Time”:
  - 1:1, FUN, unconditional, scheduled, consistent
- Communication, interaction
- Games, activities, exercises, “The Kit”
- Transitional object

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**What Can We Do?**

- Accept what is
- No quick fix
- It’s a process
- Strategies, not solutions

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**Therapeutic Strategies**

**Multi-Modal Approaches**

- **Kinesthetic**
  - Movement exercises
  - OT/Sensory processing and integration work
  - Brain Gym
Therapeutic Strategies
Multi-Modal Approaches

Visual
- Expressive therapies
- Token economies
- Psycho-drama/Art therapy
- Role playing

Auditory
- Music/Singing
- Relaxation (i.e., “safe place” development)

Incredible Years: The Parenting Pyramid
The Parenting Pyramid

Attachment / attunement strategies
- Various forms of verbal and non-verbal communication
- Play
- Touch
- Problem solving
- Sensory integration work, etc.

All promote the development of
- Self-regulation
- Problem solving
- Cooperation
- Self esteem
- Attachment

Parenting Pyramid

- Praise
- Encouragement
- Celebrations
- Rewards

Promote
- Social skills
- Thinking skills
- Motivation
**Parenting Pyramid**

- Clear limits
- Rules and routines
- Consistency

**Promote**

- Responsibility
- Predictability
- Obedience

**Parenting Pyramid**

- Ignoring
- Redirecting
- Time outs
- Setting consequences (natural and logical)

**Decreases**

- Annoying
- Even aggressive/destructive behaviors

**Parenting Pyramid**

- The bottom three layers of the Pyramid promote healthy development
- Whereas the top two layers decrease problem behaviors
- RULE: You cannot have much success with the top two layers (behavioral approaches) until you have established the bottom three layers (attachment/attunement/safety)
**Parenting Pyramid**

- And those that only know behavioral approaches, possibly not realizing they have an Attachment Disorder, then run the risk of ever harsher or more punitive approaches... even into unsafe conditions... sometimes very quickly, before it is realized by themselves or others ("the village")
- Knowledge here can prevent disaster

**Therapeutic Strategies**

- Important: Traditional psychological approaches to address behaviors are often not effective... could exacerbate problem
- "Takes a Village to Raise a Child" Approach
- Psychopharmacological/ Behavioral/ Psycho-educational
- Psycho-education using multi-modal approaches

**Case Example**
Case Example

- Bio-psycho-social approach
- Lifespan view

Case Presentation: Sandtray

Session 1
Case Presentation: Sandtray

Recommendations: Needs and Implications

- Increased understanding and education re: FASD and RAD with parents, professionals as well as the general community is needed regarding the bio-psycho-social needs
- Careful multi-disciplinary treatment planning for the FASD and RAD individual
- Specialized school placements and training for educators
Recommendations: Needs and Implications

- More effective supports to assist with the appropriate identifying and treatment of the youth's individual predisposition for symptoms of depression and suicidal ideation would benefit the caregivers.

- Need to provide support when requested for caregivers at SPECIFIC developmental stages for changes in the resources for those with FASD and RAD. Respite care and ongoing support for caretakers is necessary in maintaining proper individual and community supports, consistency, reduction of burnout, and overall understanding to manage and cope.

Reference

- Contact Information
- Source Material
Contact Information

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For Information on Upcoming Sessions in the Series:
www.fasd-cmc.alberta.ca

Please Take the Time to Fill Out the On-Line Evaluation

Thank You!