

Reactive Attachment Disorder

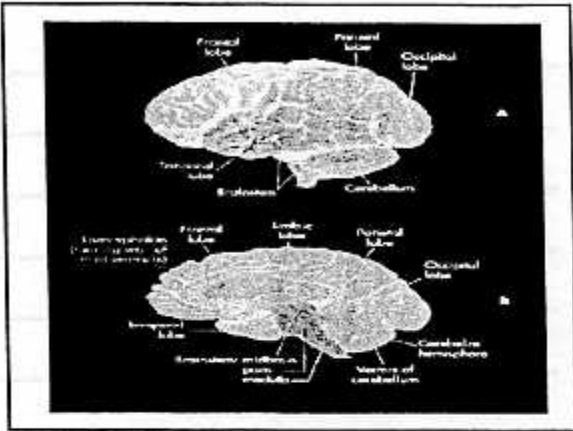
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What We Will Cover

- Developing Brain
- Types of Attachment
- Attachment Theory
- Treatment
- Strategies for Foster/Adoptive Parents
- Treatment Strategies for Borderline
- Case Studies

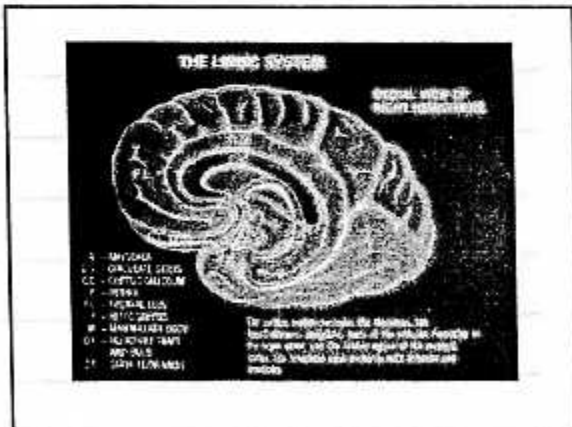
Brain

- Frontal Cortex – abstract thought
- Brain Stem- regulate heart rate, blood pressure, arousal state
- Limbic System – attachment, affect regulation, aspects of emotion
- Cortex – abstract cognition & complex language



Developing Brain

- Trauma (abuse/neglect) during preverbal years alters brain development & negatively impacts physical, cognitive, emotional, & social growth
- Early trauma interferes w/ development of limbic & subcortical systems



Brain cont.

- Irritability in limbic system may encourage the emergence of panic disorder & PTSD
- Extreme stress can result in reduced hippocampus volume which may lead to memory impairments & cause/effect thinking
- Chronic stress impairs connection between two hemispheres
- Left Hemisphere tells the event, right incorporates the subjective, social, and emotional meaning

Neurobiology

- Developmental experience determines the organizational & functional status of the mature brain.
- Parts of brain are different in regards to function, neurotransmitter networks, synaptic structure, and regional localization.
- All obey similar molecular rules.
- Designed to change in response to external signals. Key to survival.

Early Life Stress & Increased Sensitivity

- Early life stress induces long-lived hyper-reactivity of corticotropin-releasing factor (CRF) systems as well as alterations in other neurotransmitter systems, resulting in increased stress responsiveness. This is associated with neurobiological changes and underlie the increased risk of psychopathology.

DSM-IV Criteria

- A. Markedly disturbed and developmentally inappropriate social relatedness in MOST contexts, beginning before age 5 years.
- B. Not accounted for SOLELY by developmental delay (MR) & does meet criteria for PDD.
- C. Pathogenic care.
- D. Presumption that the care is responsible for the disturbed behavior.

Social Relatedness

- **Inhibited Type**
 - Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent & contradictory responses (e.g. child may respond to caregivers w/ mixture of approach, avoidance, & resistance to comforting, or frozen watchfulness)
- **Disinhibited Type**
 - Diffuse attachments as manifest by indiscriminate sociability w/ marked inability to exhibit appropriate selective attachments (e.g. excessive familiarity w/ relative strangers or lack of selectivity in choice of attachment figures)

Pathogenic Care

- 1) persistent disregard of the child's basic emotional needs for comfort, stimulation, & affection
- 2) persistent disregard of the child's basic physical needs
- 3) repeated changes of primary caregiver that prevent formation of stable attachments (e.g. frequent changes in foster care)

Attachment

- It is about a relationship. It is a bond that ties the child to the primary caregiver & allows the infant to seek and maintain physical closeness and connection to same. It is a lasting psychological connectedness between humans & an emotional affiliation that grows. It is person-specific, persistent, emotionally significant, & results in distress at separation.

Attachment Types

- **Secure** –Physical proximity & psychological availability. Parent will protect, find a solution, and live "happily ever after"
- **Insecure/Avoidant** – Avoids mother. May turn away or refuse eye contact. May ignore even after separation. Some prefer a stranger when needing comforting.
- **Insecure/Resistant** – Seek contact w/mother on reunion, but then push her away or turn away. Demonstrates no stranger preference, but may appear angry toward mother and stranger.

Attachment Types cont.

- **Disorganized/Disoriented** – Parent source of fear & reassurance. No clear strategy for responding to parent.
 - Hx of abuse/neglect, violence, unpredictability
 - Women-abuse substances & suffer domestic violence
 - Child creates disorganized, chaotic life narrative
 - Behavior is instinctive, impulsive
 - Behavior learned through imitation & experience

Disorganize/Disoriented cont.

- Responds to inaccurate impression of thoughts & feelings of others
 - Sensitive to hyperarousal & dissociation from stimulation
 - Safe & nurturing caregiving may generate feelings of anxiety & fear
 - Behavior = negative internal working model & vulnerable coping strategies
- Important – not mental illness -str ategies for protection

Treating RAD

- Traditional "talk" & behavior therapy unlikely to make a difference
- Attachment Therapy
- Narrative Therapy
- Object Relations Therapy
- EMDR

Object Relations

- Fairbairn – influenced by Freud & Melanie Klein
- Internal object-piece of psychic structure within personality
- External objects-those we relate to externally.
- Theory-internal object is affected by external object & will modify perception within the structure of the self.
- Object constancy = the nurturing & soothing mother as an internalized & constant object.

Object Relations cont.

- Splitting - Internal object splits-off or clumps together to form complex objects or mechanisms (defense mechanisms). The formation of complex objects is the core of how an individual relates, or reacts to self or the environment.

Rapprochement

- From Mahler's Developmental Stages (active approach behavior) 16-18 months and 22-24 months
- Most critical stage of the separation individuation process.
- Acutely heightened separation anxiety and active approaches to mother & almost constant concern with her whereabouts.
- Not able to be in contact with mom as much as in past. Mutual realization he can do more for himself. Mom's response to toddler's anxiety & frustrations are at greater intervals & toddler's defense to this crisis is an active approach.

RAD

- First three months consist of normal autistic phase From 1-5 months is symbiosis phase. According to Mahler this is when infant perceives that he resides within the nuclear orbit w/ mother. Mutual beneficial relationship in which he is the center. Mother is powerful extension of self. At 4-5 months up to 30-36 months begins Separation & Individuation. Achieved through progression & regressions, frustrations & satisfactions, conflicts & resolutions w/ mother. A sense of constancy & safety are key for this to occur in a healthy manner.

Attachment Theory

- John Bowlby & concept of "internal working model"
- Children form expectations of others & selves based on responsiveness and accessibility of primary attachment figure
- Later, approach new situations with preconceptions, interpretive tendencies, & behavioral biases
- Internal working model not necessarily permanent
- Mental representation develops with age
- Child is able to reassess experiences.

Attachment-Based Therapies

- Various models
 - Cradling to provide physical containment
 - Regression to rebirth
 - Allow to be at developmental age

Dyadic Developmental Psychotherapy

- Attachment Based Therapy
- Purpose – resolve dysfunctional attachment & develop healthy one
- Three Components
 - Educate parents
 - Teach parenting skills
 - Intensive emotional work with child

Treatment

- Experiential
- Regressive
- Affective Emphasis
- Confrontive
- Contractual

Narrative Therapy

- Family Attachment Center in Deephaven, MN
- Ages 3 to 21
- Two week intensive, 2-3 hours a day plus follow-up
- Parent as therapist
- Reframes life experiences – replaces original experience w/ predictability, nurturing, safety
- Stories used to store & recall life experiences
- Assists parent to step back from emotions & increase understanding of the adaptive nature of child's behavior. Increases empathy

Premise of N.T.

- Before language is developed understanding is by behavior
- Parents/therapists tell stories to communicate understanding of child's perspectives, emotions, beliefs
- Set strategy. Four types of narratives. May need to revisit an earlier narrative, or a single narrative may encompass two types.

Narratives

- Claiming – First person. From beginning child deserved love & care. Impart family traditions & history. Aim is to enhance attachment to parents.
- Developmental – First person. Progress through stages of development to current. Aim is to enhance attachment to parents.
- Trauma – Third person. Address trauma history to gain new understanding of life events. Goal is healing.
- Successful Child – Third person. Teach positive behavior for daily life

N.T. cont.

- Narratives are given at emotional, intellectual, & developmental level of child.
- Follow-up may include day treatment, individual or family therapy, continuing narratives at home etc.
- May use audio or tactile neuro-stimulation techniques in the background or jointly w/ narrative
- Problem behavior is never directly addressed. Focus is on shifting or altering internal working model.

EMDR Eye Movement Desensitization & Reprocessing

- Shapiro's hypothesis: Facilitates accessing of traumatic memory network, so information processing is enhanced; new associations occur between traumatic memory & more adaptive memories/information
- Client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus Thought to result in complete information processing, eliminating of emotional distress, allow cognitive insights.

**EMDR cont.
3-Pronged Protocol**

- 1) Past events resulting in dysfunction are processed & associated w/ adaptive information
- 2) current circumstances that elicit distress are targeted, & internal & external triggers are desensitized
- 3) imaginal templates of future events are incorporated to assist in acquiring adaptive skills

EMDR – Possible Negative Effects

- Distressing & unresolved memories may emerge
- May experience reaction not anticipated including a high level of emotion or physical sensation
- Subsequent to session, the processing of incidents/material may continue, & other dreams, memories, feelings may emerge

EMDR Process

- Brief interrupted exposure - Simultaneous focus on image of event, associated negative belief, & attendant physical sensation
- Mindfulness – just notice & let whatever happens happen
- Free association – during processing, client asked to report any new insights, associations, emotions, sensations, images that become conscious
- Repeated access & dismissal of traumatic imagery. Practice controlling & dismissing disturbing stimuli.

EMDR cont.

- When unresolved trauma is triggered by stimulation of one of the stored information elements, the child may experience the affect & physical sensations of original trauma. Cross-network information processing assisted via external bilateral brain stimulation
- Emotional distress accompanying disturbing thought disappears as eyes move spontaneously & rapidly.

What Can A Foster Parent Do?

- Depends on age of child. Need to held, rocked, cuddled.
- Praise for doing and being
- Calm control when misbehaves
- What function does the behavior serve?

Monitoring Behaviors (foster parent cont.)

- What function does the behavior serve?
- What is the emotional age?

Responses (foster parent cont.)

- Structure, routine, predictable, repetitive = security. Even leisure time can be structured.
- Reduce changes, surprises, tension, & chaos. Boring is good!
- Child may need a list of all things coming up OR this may cause increased worry. Parent must adjust the external because the child cannot yet adjust the internal.

Teach Behaviors (foster parent)

- Do not say what not to do, teach them what TO DO
- Assume nothing
- Keep expectations realistic and do not expect changes overnight or over a year.

Differential Diagnoses

- RAD
- ADHD
- PDD
- Borderline Personality Disorder
- Conduct Disorder/Antisocial Personality Disorder

Borderline

- Hallmark traits – lack of identity, pervasive emptiness, excessive anger, inability to regulate emotions.
- Source of SX – thought to be caused by the dynamic, ambivalent & powerful struggle between SMP vs. individualization during rapprochement phase. Dependence vs. independence. Therefore resides predominately within the rapprochement subphase. Constant push-pull behavior. A kind of "I hate you, don't leave me" or "I run away, come rescue me" dynamic.

Borderline cont.

- Object constancy not acquired. Continue to seek maternal nurturing. Becomes chronic & compulsive. Object fragmentation (splitting) occurs with person oscillating between need to emotionally refuel AND the need to express intimacy in age appropriate manner.
- When young engaged in push-pull behavior. Child ran from mother & expected to be caught into safety of her arms. Child wishes for both dependence & independence.

Borderline Therapy

- Need to apply heat & skillful use of development tools. Balance of acceleration & breaking.
- Office is a holding environment in which T. can reshape the psychic structures. If one overwhelms the client w/ negative affect, the Therapeutic alliance breaks & cannot be repaired.
- In holding environment one must set limits, boundaries, and be consistent
- Transitional Space – Applying heat to ambiguous situations to assist with generalizing.
- Dialectical Behavior Therapy

DBT

- Marsha Linehan – University of Washington, Seattle
- Dialectical-derived from classical philosophy. Refers to form of argument in which an assertion is first made about a particular issue (the thesis), the opposing position is then formulated (the antithesis) and finally a synthesis is sought between the two extremes.
- Keys are acceptance on one hand & change on the other.
- Behavioral in that, without ignoring the past, it focused on present behavior & current factors which are controlling the behavior

DBT cont.

- Hierarchical structure of treatment goals
 - Reduce parasuicidal Bx (self-injury or life threatening)
 - Reduce Bx that interfere w/therapy/treatment
 - Reduce Bx that reduce the quality of life
 - Increase Bx skills
 - Decrease & deal w/ PTSD responses
 - Enhance self-respect
 - Any other goals set by therapist

DBT Theory

- Not empirically validated
- Invalidating environment
- Emotionally vulnerable
- Doesn't learn to understand & trust self
- Behavior oscillates
- Consequence – dysregulation of emotions

Three Dialectical Dilemmas

- Emotional vulnerability vs. Unrealistic goals & expectations
- Unrelenting crisis vs. Inhibiting negative affect
- Active passivity vs. Apparent competence

DBT Therapy

- Empirically validated in two trials by Linehan
- Randomized controls. Over one year.
 - 1991- compared effectiveness of DBT relative to treatment as usual. Reduced suicidal & parasuicidal behavior, kept patient in therapy, gains made over usual treatment group.
 - In press-DBT added to standard community psychotherapy. No difference with client staying in therapy. But DBT clients reported less anger, had fewer parasuicidal episodes, less episodes of medical treatment, fewer psychiatric in-patient days.

DBT - Four Primary Modes

- Weekly psychotherapy
- Weekly 2 ½ hour group skills training
- Telephone contact
- Therapist consultation

Weekly Psychotherapy

- Explore in detail a particular problematic behavior or event from past week. Includes identification of problem, chain of events leading up to it, brainstorming alternative solutions, & examining what kept the client from using the more adaptive solution.
- Between & during session, therapist actively teaches & reinforces adaptive behaviors. Emphasis is on teaching how to manage emotional trauma rather than reducing or taking them out of the trauma.

Group Skills Training Four Major Group Skills

- Mindfulness – derived from Buddhist meditation.
- Interpersonal effectiveness – effective ways of achieving one's objectives w/ others
- Emotion modulation – changing distressing emotional states
- Distress tolerance skills – how to put up with these if they can't be changed for the time being

Telephone Contact

- Individual therapist is available by phone between sessions
- Therapist sets clear limits on contact
- Calls after self-injury are not acceptable. After ensuring immediate safety, no further calls are allowed for next 24-hours. Avoids reinforcing self-injury.
- Not for psychotherapy – give help & support in applying skills to real life situation between sessions & avoiding self-injury
- Can call to repair relationship if client feels she has damaged her relationship w/ therapist.

Therapist in DBT

- Therapists receive DBT from each other at regular therapist consultation
- Essential to prevent burn out.

Working Assumptions

- Patient wants to change & is trying her best at any particular time
- Behavior pattern is understandable given her background & present circumstances. Life may not be worth living, but solution is to make it worth living.
- She may not be responsible for the way things are, but it is her personal responsibility to make them different.
- Client cannot fail DBT.

Stages of Therapy & Treatment Targets

- Pretreatment – assessment, commitment, orientation
- Stage 1 – focuses on parasuicidal/suicidal behaviors, therapy interfering behaviors, behaviors that interfere w/ quality of life. Develop skills to resolve these problems
- Stage 2 – Deal w/ PTSD. If flashbacks occur before this stage deal w/ using distress tolerance techniques
- Stage 3 – Self-esteem & individual treatment goals

Reinforcement

- Relationship with therapist is main reinforcer.
- Patient carries a diary card to record targeted maladaptive behaviors between sessions.
- Initially in each session these are dealt with by carrying out a detailed behavioral analysis.

Now for the question!!

- Who is the famous literary figure who most certainly had a reactive attachment disorder as a child that grew up to have an antisocial personality disorder?

Secure Attachment

- Piglet sidled up to Pooh from behind.
- "Pooh," he whispered.
- "Yes, Piglet?"
- "Nothing," said Piglet, taking Pooh's paw.
- "I just wanted to be sure of you."

- A.A. Milne Winnie-the-Pooh
