

DBHS Practice Protocol

DISTURBANCES AND DISORDERS OF ATTACHMENT



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
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Title

Disturbances and Disorders of Attachment

Goal (What Do We Want to Achieve Through the Use of this Protocol?)

To delineate standards set forth by the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) for the approach to and treatment of the full range of attachment-related disturbances and disorders.

Target Population(s)

Children enrolled in the RBHA/TRBHA systems that require treatment for attachment-related disturbances or disorders.

Definitions

[Attachment \(relationship\)](#)

[Attachment Behavior](#)

[Bonding](#)

[Child and Family Team](#)

Background

Disorders of attachment are conditions increasingly recognized in children and were described as early as the 1930's with institutionalized children. Despite this long history of recognition, there is no universally agreed upon definition of Attachment Disorder.

Conceptually, there is agreement that these disorders represent deviations from the normative patterns of relationship development. Current diagnostic classification systems (e.g. DSM-IV TR, ICD-10) describe two subtypes of Reactive Attachment Disorder, Inhibited Type and Disinhibited Type, both of which are characterized by behaviors in children that indicate the absence of a discriminate attachment figure. Thus, these disorders actually represent disorders of nonattachment. That is, the child has not developed a "focused attachment" to any specific person, despite having achieved a level of cognitive functioning at or beyond the 7-9 month range, when such attachments are expected and developmentally possible.

The absence of such a relationship for a very young child places his/her future development in serious jeopardy. Infant-caregiver relationships are the crucial foundation for early development. Because human beings have evolved a tenacious propensity towards developing attachment relationships, the absence of such a relationship is uncommon and appears to occur primarily in extreme circumstances of care that deprive children of the opportunity to co-create a relationship with at least one specific and special adult caregiver. Examples of circumstances which interfere with the opportunity for attachment relationships include institutional care where shifts of staff are responsible for the infant's care vs. specific individuals and the occurrence of multiple placements of young children who come into the child welfare system.

Recent literature on attachment disorders that is not yet reflected in the DSM or ICD classification systems propose a variety of behavioral patterns that represent significant and

unhealthy imbalances in a child's ability to use his/her attachment figure as a "secure base." These behavioral patterns include the tendency to venture from the adult for exploration in a manner that is reckless or self-endangering, without the opposing tendency to check back or seek proximity to the caregiver, or patterns of exploratory inhibition where the child is excessively clingy, fearful or hyper-compliant with the attachment figure.

There have been recent concerns in the literature regarding the over-diagnosis of Reactive Attachment Disorder and the failure to consider other more commonly encountered clinical conditions, including other aberrations of attachment patterns, post-traumatic stress disorder, disorders of affect (depression, anxiety) and pervasive developmental disorders.

While disorders marked by the absence of an attachment relationship are rare, severely problematic attachment relationships are thought to be relatively common among very high-risk children age 12 to 48 months.¹ An attachment relationship may become derailed when parental emotional and/or physical availability and inadequacies in caregiver-child interactions are the rule rather than the exception for the child.

Children who have had insecure attachment relationships are at higher risk for developing social adjustment problems, including difficulty with forming peer relationships and exhibiting antisocial behaviors. They are also at higher risk for poor academic performance due to a lack of persistence and poor problem-solving skills.

Recommended Processes and Procedures

Assessment Considerations

Disorders of attachment develop during the early years of childhood. There is a greater likelihood for attachment disorders the more a child experiences transitions and multiple placements and in institutional settings where shifts of staff are responsible for the infant's care vs. specific caregivers.

*ADHS' Behavioral Health Assessment: Birth to Five*² is designed in part to help discern conditions associated with deficiencies in attachment and must be used for children within this age group. Comprehensive assessment should seek an accurate history of the child's relationships with primary caregivers and needs to occur over time and across settings and caregivers. The period of child development when focused attachments are expected to occur is between 7 to 9 months of age. It is important for the clinician to consider an upper limit of 10-12 months of age to account for individual differences and the potential for developmental competencies to be delayed. Therefore, a diagnosis of Attachment Disorder is not recommended for a child who has yet to reach a developmental level that is commensurate with the end of the first year of life. For assessment purposes, it has been suggested that the following domains of infant behavior are most relevant to the question of attachment-related problems: showing affection, comfort seeking, reliance for help, cooperation, exploration, controlling behavior, reunion responses and response to strangers.

¹ Boris, NW, Hinshaw-Fusilier, SS, Smyke, AT, Scheeringa, MS, Heller, SS & Zeanah, CH (2004). *Comparing Criteria for Attachment Disorders: Establishing Reliability and Validity in High-risk Samples*. Journal of the American Academy of Child and Adolescent Psychiatry, 43(5).

² <http://www.azdhs.gov/bhs/provider/forms/pm3-9-2.pdf> & <http://www.azdhs.gov/bhs/provider/forms/instqdb5.pdf>

Some examples of behavioral signs of disturbed attachment in young children include the following³:

- Lack of affection interchanges across a range of social settings
- Lack of comfort seeking when hurt, frightened, or ill
- Excessive dependence on caregiver or inability to seek and use supportive presence of attachment figure when needed
- Pervasive lack of compliance with caregiver requests or fearful overcompliance to caregiver instructions
- Failure to check back with caregiver in unfamiliar settings after venturing away
- Failure to reestablish interaction after separation including active ignoring/avoiding behaviors

Although there is limited consensus on the prevalence of these disorders, it is clear that there is increased vulnerability in children from low socioeconomic groups and in families in which caregivers cannot respond adequately to the basic needs of their children. Repetitive changes of primary caregivers hinder the formation of stable attachments. Recognition must therefore be given to the premise that the more a child experiences transitions and multiple placements, the greater the likelihood for attachment disturbances. Given the association between many conditions associated with disorders of attachment, and involvement with the child welfare system, the Child and Family Team, or Clinical Liaison if a team has not yet been established, may need to enlist assistance from child welfare professionals to secure firsthand information about children in protective custody that may be vital to accurate assessment.

As previously indicated, recent literature notes concerns about over-diagnosis of Reactive Attachment Disorder, and the failure to rule out other more commonly encountered conditions, such as anxiety disorders, antisocial behavior and dissociative symptoms.⁴ An additional evaluation by a mental health clinician with specific and substantial training in early childhood development and differential diagnosis should be considered for a second opinion when diagnosis is unclear or treatment has been ineffective.

Clinical Interventions

Interventions used should be founded on principles of sound theory, broad clinical acceptance and, whenever possible, on research-based practice. While ADHS does not endorse protocols that rest solely on anecdotal accounts, it recognizes the potential of innovative therapeutic approaches. In all treatment approaches, however, the safety of the child and the child's sense of security must be assured. Therapies which cause pain or discomfort, that have the potential to result in injury or perceived abuse by the child or others, or that unnecessarily remove a child from proximity to home or natural supports are not permitted.⁵ Treatment protocols that unduly restrict a child's physical movement may endorse techniques that come uncomfortably close to physical restraint. These are specifically disallowed in settings other than Level I facilities by the Office of Behavioral Health Licensure Rules (A.A.C. R9-20-602) and are likewise not permitted.

³ *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Reactive Attachment Disorder of Infancy and Early Childhood*; American Academy of Child and Adolescent Psychiatry; 2005

⁴ <http://www.zerotothree.org/vol20-2.html>

⁵ Certain techniques, which have been utilized to treat attachment disorders, have included the use of coercion, enforced holding and other methods of control. ADHS/DBHS does not endorse the use of these techniques. Nurturing touch, therapeutic massage, cradling/lap time, warm words/soft music, positive/accepting eye contact and positive praise are other techniques which have been used effectively.

Given the various severities and conditions presented, treatment interventions must be based on sound clinical best practice, delivered in a timely manner and in accordance with the Arizona Vision and Principles. Although a thorough and comprehensive assessment is required before a treatment plan can be fully developed, needed services should not necessarily be delayed while the initial assessment process is being completed.

ADHS endorses the “Circle of Security” approach⁶, designed to promote secure attachment in children at high risk for disorders of attachment. Interested clinicians are encouraged to examine “From Neurons to Neighborhoods,” a major review of research by the American National Research Council of the National Academy of Sciences, for a summary of core replicated findings over 30 years of evaluating early intervention programs.⁷

Other treatment approaches for enhancing early relationships which are theoretically consistent with the “Circle of Security” approach include “Parent-Child Psychotherapy,”⁸ “Watch, Wait and Wonder,”⁹ “Interaction Guidance”¹⁰ and “Attachment and Biobehavioral Catch-Up” (ABC).¹¹ Various child-caregiver dyads at particular times in their relationship building may be helped through the use of more than one treatment approach.

ADHS/DBHS does not require T/RBHAs to provide specific treatment modalities or to embrace any particular treatment philosophy or orientation related to the treatment of attachment disturbances or disorders. ADHS/DBHS does, however, require T/RBHAs to maintain adequate network capacity to competently treat children presenting with any degree of symptomatology. All presentations of attachment disturbances require interventions that are individualized to the specific needs of the child and family, designed and planned with full family collaboration, and implemented with sensitivity to the family’s values, culture, and treatment desires, preferably within the context of a Child and Family Team. For children in protective foster care, “family” may be understood to include both the child’s birth family, and the child’s current protective caregivers (e.g. relatives, foster parents). Requests for a specific treatment modality from Child and Family Team members must be given due consideration and regarded within the context of clinical applicability, consistency with the 12 Arizona Principles, evidence of efficacy, likelihood of success and cost-effectiveness.

⁶ Glen Cooper, Kent Hoffman, Bert Powell (Marycliff Institute) and Robert Marvin (Child-Parent Attachment Clinic) at www.CircleofSecurity.org.

⁷ Shonkoff, J.P. & Phillips, D. A. (Eds) (2000). From Neurons to Neighborhoods: The Science of Early Childhood Development. Washington D.C.: National Academy Press. Also instructive is the work of Bruce D. Perry, MD PhD at www.childtrauma.org.

⁸ Lieberman, AF (2004). *Child-parent Psychotherapy: A Relationship-based Approach to the Treatment of Mental Health Disorders in Infancy and Childhood*. Sameroff, AJ, McDonough, SC & Rosenblum, KL (Eds.) Treating Parent-infant Relationship Problems: Strategies for Intervention. New York: Guilford Press.

⁹ <http://www.hincksdellcrest.org/institute/documents/WWWManualPreface3.pdf> and http://www.earlylearning.ubc.ca/documents/2006/2006workshop/cohenWWW_UBC_May_2006.ppt

¹⁰ McDonough, SC (2000). *Interaction Guidance: An Approach for Difficult to Engage Families*. Zeanah, CH (Ed.) Handbook of Infant Mental Health, 2nd Edition. New York: Guilford Press.

¹¹ Dozier, M., Lindhiem, O., & Ackerman, J. (2005). *Attachment and biobehavioral catch-up*. L. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. Greenberg (Eds.), Enhancing Early Attachments. New York: Guilford.

Treatment Planning

As with all behavioral health conditions, treatment plans must be based on the distinct needs of the child and family and not determined solely by diagnosis. Treatment plans must be strength-based in addressing needs and whenever possible should draw upon natural and community-based supports. The safety of the child, the child's sense of security, and the child's stability (e.g. support for caregivers, development of long-term placement options and anticipated permanency) must be considered top priorities. Sensitivity to a child's placement history, sense of loss, and fears of permanency must be promoted through conscientious treatment planning. When child welfare is involved, treatment planning should be consistent with expectations outlined in the Practice Protocol "The Unique Behavioral Health Service Needs for Children, Youth, and Families Involved with CPS."¹²

Coaching primary caregivers through family-centered and supportive educational approaches in the following skill building areas is recommended:

- how to nurture,
- how to understand the reasons for their child's behaviors before disciplinary consequences are considered,
- how to interact with their child based on his/her emotional, as well as chronological age,
- how to be consistent and predictable when interacting with their child,
- how to effectively listen and talk with their child,
- how to develop and maintain realistic expectations, and
- how to teach and model healthy interactive social behavior.

These areas, among others, can be approached through supportive interventions and education that address caregiver self-care and self-preservation, communication training, family or marital therapy, family support, parent-child groups, respite and home-based outreach services.

Individual treatment of the child must be provided in the least restrictive, effective setting that sustains the child's proximity to home and natural supports. All service settings, the full array of covered services, and specially skilled and experienced providers must be considered as indicated. For infants and toddlers, home-based services, which virtually always include the child's principal caregiver, may be especially well-suited to enhancing parents' well-being and the child-parent relationship.¹³

The treatment continuum should include community-based in-home services, respite, outpatient services and psychotropic medication prescribing and monitoring when appropriate. Counseling interventions may include individual, group and play therapies that promote social skills, anger control, and behavioral modification and management.

The Child and Family Team should primarily focus on the establishment, strengthening and/or support of beneficial, trusting relationships between the child and identified primary caregivers. While out-of-home placements must be available as part of the treatment continuum, the Child and Family Team should give careful consideration to the nature of caregiving relationships the child's needs, and the "fit" between such needs and placement staffing patterns (e.g. staff

¹² http://www.azdhs.gov/bhs/guidance/unique_cps.pdf

¹³ Berlin, L.J., O'Neil, C.R., & Brooks-Gunn, J. (1998), *What makes early intervention programs work? The program, its participants, and their interaction*. *Zero to Three Journal*. 18 (4) 4-15.

members who work in “shifts” which may not closely reflect those the child will experience in a stable family home). Most importantly, out-of-home care services must be utilized, when necessary, in full adherence with the ADHS Practice Protocol: Out of Home Care Services.¹⁴ When symptoms preclude a return to home and family, treatment must be supportive of and coordinated with child welfare agencies and the juvenile court. Collaborative efforts should be used in assessing and determining long-term, permanent placement needs. ADHS emphasizes that the more a child experiences transitions and multiple placements, the greater likelihood for the development of longstanding attachment disturbances.

Training and Supervision Recommendations

This Practice Protocol applies to T/RBHAs and their subcontracted provider agencies that provide direct service delivery to children. Formal training on this Practice Protocol is not provided by ADHS/DBHS.

All T/RBHA and provider agency clinical staff working with children and adolescents are encouraged to read this Practice Protocol. It is also recommended that staff sign a statement acknowledging that they have read the Practice Protocol and understand its content.

Whenever this Practice Protocol is updated or revised, it is recommended that T/RBHA and provider agency clinical staff working with children and adolescents carefully read the updated/revised document and sign an updated acknowledgement statement.

It is recommended that copies of signed and dated acknowledgement statements be maintained on file at the provider agency in a central location for reference.

Supervision regarding implementation of this Practice Protocol should be incorporated into other supervision processes the T/RBHA and their subcontracted provider agencies have in place for direct care clinical staff.

Anticipated outcomes

Anticipated outcomes include:

- Increased ability to accurately recognize when disturbances or disorders of attachment may exist;
- Completion of thorough and comprehensive assessments that evaluate for co-occurring disorders and discern conditions associated with deficiencies in attachment;
- Appropriate treatment interventions that address attachment disturbances/disorders which are individualized to the specific needs of the child and family and consistent with the 12 Arizona Principles;
- Treatment plans that include the use of natural and community-based supports;
- Increased delivery of home-based services that include the child’s principal caregiver.

¹⁴ <http://www.azdhs.gov/bhs/guidance/oohcs.pdf>

Disturbances and Disorders of Attachment Desktop Guide

❖ Key elements to remember about this best practice:

- Young children who experience multiple transitions and placements or live in institutional settings have a greater likelihood for attachment disturbances.
- The period of child development when focused attachments are expected to occur is between 7-9 months of age when cognitive level is congruent with chronological age.
- Repetitive changes of primary caregivers hinder the formation of stable attachments.
- Children need to be evaluated for co-occurring disorders.
- An accurate history of the child's relationships with primary caregivers is a vital component of the assessment process.
- A second opinion evaluation by a mental health clinician with specific and substantial training in early childhood development and differential diagnosis should be considered when diagnosis is unclear or when treatment has been ineffective.
- Treatment approaches must ensure the safety of the child and the child's sense of security.
- Treatment approaches must also be individualized to the specific needs of the child and family and consistent with the Arizona 12 Principles.
- All T/RBHAs are expected to have adequate network capacity to competently treat children presenting with symptomatology related to disturbances and disorders of attachment.
- T/RBHA and provider agency staff are expected to coordinate treatment and service delivery with other involved agencies such as child welfare and the juvenile court.

❖ Benefits of using this best practice:

- Appropriate treatment interventions that address attachment disturbances/disorders which are individualized to the specific needs of the child and family and consistent with the 12 Arizona Principles;
- Increased ability to accurately recognize when disturbances or disorders of attachment may exist;
- Prompt evaluation and recognition of potential co-occurring disorders/conditions associated with deficiencies in attachment;
- Improved child-caregiver relationships;
- Treatment plans that include the use of available natural and community-based supports;
- Increased delivery of home-based services that include the child's principal caregiver and decreased numbers of children placed in out of home care