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ATTACHMENT DISORDER (AD) **INTRODUCTION**

ATTACHMENT BONDS: An attachment bond contains all of the following elements:

- ♥ Comfort and safety is sought within the relationship
- ♥ Desire for physical proximity to the attachment figure.
- ♥ Emotional distress in response to enforced separation.
- ♥ The attachment figure is a specific other person and is NOT interchangeable.
- ♥ Emotional significance as safety is established.
- ♥ Persistence across time and situations.
- ♥ Reciprocity and mutuality
- ♥ Develop gradually over time and underlie self and object constancy. Until constancy is achieved, the length of separations should be monitored so as not to overstretch the developing bond and tear it.

ATTACHMENT & DEVELOPMENT: The quality of the initial attachment is enormously important, for it contours all subsequent development. A functional attachment relationship has been identified as playing a vital role in all of the following:

- ★ The context for the neurological structuring of the right hemisphere of the brain and integration of right and left hemispheres
- ★ Functioning of the neuroendocrine system: production of hormones and neurotransmitters
- ★ Development of an integrated Internal Working Model
- ★ Regulation of: arousal level, reactivity to sensory input, motor activity, feelings, attention, and thinking
- ★ Developing relationships with others / capacity for empathy
- ★ Encouragement of exploration and learning vs. the management of anxiety
- ★ Speech & language organization
- ★ Practical reasoning and problem solving
- ★ Memory functioning
- ★ Acquisition of a conscience
- ★ Developing a sense of time as continuous and sequential
- ★ Resilience in the face of stress or novelty

ATTACHMENT AT THE CELLULAR LEVEL: Recent research from the Tulane School of Medicine demonstrated the impact of institutional life at the cellular level. The focus was telomeres, which are strands of DNA attached to the chromosomes. Telomeres shortened with age and their length appears related to life span. The subjects were 100 Romanian children and what emerged was that the more time the children spent in an institutional setting during their first 4 years, the shorter were their telomeres. Molecular Psychiatry. May 2011.

MULTIPLE ATTACHMENTS: Contrary to popular mythology, infants are capable of more than one attachment. Multiple attachments are not equivalent, but are arranged in an internal hierarchy. The highest functioning infants have two working attachment bonds they can rely on. The quality of paternal, or other secondary attachments, primarily reflects the attachment skills of the relevant adult rather than a limitation in the infant's capacity to form multiple attachments. Children in institutions will attempt to form multiple attachments with their caretakers and typically select one caretaker to be the primary attachment figure. To date, we have no research data to inform us as to how the Internal Working Model of infants and young children, exposed to conflicting experiences with multiple potential attachment figures, is affected.

QUALITIES OF ATTACHMENT FIGURES: An attachment bond is secure if an infant can reliably experience security / comfort / safety within it. This is critically dependent upon the infant perceiving the attachment figure as predictable, available, and competent. The overarching task of caretakers is to facilitate the child's integrating of component parts into a cohesive whole. Research has identified the key ingredients to being a viable attachment figures are:

- Communicate that they can manage situations (safety)
- Assist child to regulate arousal to prevent states of overarousal / fragmentation
- Responsiveness to crying / distress
- Carry out interactive repair as needed
- Ability to set effective limits in a practical manner
- Claim child as belonging with attachment figure
- Ongoing sense of curiosity
- Sense of humor
- Well developed empathy or attunement skills. Without such external validation, a child's ability to construct an internal model of the outside world (IWM), as well as a sense of the self as real, becomes impaired.

EMPATHY / ATTUNEMENT: Empathy or attunement can be defined as the ability to accurately perceive and reflect back the internal state of another. One way to describe empathy is as a welcoming of feelings just exactly as they arrive without trying to change them, take anything away from them, add anything to them, fix them, or explain them. Being present to the child requires the adults to be aware of where they are placing their attention. It is easy to believe that one is reflecting the internal state of the child, when, in fact, the adult's attention is focused on something internal to the adult. (Example: the child is feeling poorly about herself and says that she doesn't believe her parents love her. A common and understandable adult response would be to offer reassurance to the child of the parents' love.) This response comes from the adults' distress that the child feels unloved and a desire to change that. Here the adult attention is focused on the adult's desire to change how the child is feeling. As such, this may be a reassuring, sensitive response, but it is not an attuned one. A precisely attuned response would communicate that it is hard for the child to believe that her parents love her, and so she has a lot of hurt here- this is what the child herself has expressed. This response makes no attempt to shift how the child is feeling- it only describes, precisely, the feeling. One cannot accurately reflect something if one is trying to change it, as reassurance aims to do. Reassurance can even backfire as research has amply demonstrated. The reassurance can seem so far beyond believable to the recipient, that the reassurance only serves to reinforce how badly the recipient really does feel and can undermine the credibility of the one offering reassurance. Sensitive / reassuring, but misattuned responses, have more to do with the adults' own reaction to what the child has expressed rather than to the content of the child's expression itself. This is a very important distinction, for the more accurate the empathic comment, the more powerful its emotional impact; and the more deeply wounded a child is, the more accurate must the empathy be to be soothing. In addition to empathic verbal content, adults should also

be skilled at nonverbal empathy. This involves using voice qualities (e.g. loudness, inflection, rate of speech), bodily gestures, facial expressions, and physical proximity to communicate empathy with the AD child's internal state.

BRAIN FUNCTIONING:

- An infant's brain makes 1000 new neuronal connections per minute. This pace of brain growth will never be seen again throughout the life span.
- The more a brain circuit is used, the more efficient and faster it becomes (uses less energy), the more information it can process, and the more flexible it is.
- The power of attention can alter brain structure by enhancing the brain circuits in use.

ETIOLOGY OF AD: When the attachment process does not go well, it is almost never because of any single cause; but because of multiple influences interacting. A number of risk factors have been identified as increasing the probability of attachment difficulties:

- Intrauterine exposure to alcohol, drugs, and/or toxins.
- An early history of loss / abandonment.
- A history of multiple caretakers, and/or multiple changes in living location early in the child's life
- Emotional unavailability of primary caretaker.
- Physical and/or sexual abuse.
- Neglect.
- Chronically elevated cortisol levels.
- Failure to thrive.
- Chronic illness or pain.
- Sensory under- or over-reactivity that obstructs interaction with the environment.
- Significant parental mental health problems, particularly maternal depression in the first 2 years.
- Parental substance abuse.
- A history of harsh, overindulgent, extremely inconsistent, or chronically misattuned parenting.
- Chronic severe marital conflict / domestic violence.

ETIOLOGY: CORTISOL

DESCRIPTION: Cortisol is a steroidal hormone produced by the adrenal glands. Its primary functions are to increase blood sugar, aid metabolism, and suppress immune system functioning. It also decreases bone growth. Cortisol is released in response to stress or to insufficient blood levels. Cortisol levels vary on a predictable diurnal rhythm. Chronic stress or trauma can generate prolonged excessive cortisol.

ELEVATED CORTISOL: Elevated levels of cortisol can have a range of damaging physiologic effects.

Excessive cortisol erodes the myelin sheath that covers neurons, and this impairs the transmission of nerve impulses. It can damage in the hippocampus, thereby impairing both long term memory and spatial navigation. On the other hand, elevated cortisol can facilitate neural workings in the amygdala which can lead to increased levels of fear and anxiety (Sapolsky, 2003).

ATTACHMENT & CORTISOL: There is a direct relationship between the security of attachment and the level of cortisol in the system. Securely attached infants do not show elevated cortisol in response to parental separation. This is not the case with infants who are insecurely attached or demonstrate disorganized attachment behaviors. Maternal depression in the first two years is the single best predictor of elevated cortisol levels at elementary school age. Orphanage reared children as well as neglected infants in families of origin both show a lack of the daily cortisol rhythms.

EMOTIONAL REGULATION: Crying infants left to cry without response leads to elevated cortisol levels that can reach a point capable of producing brain damage that can impair future learning capacity. It is

not the crying per se that is the problem, but the lack of a regulating caretaker response (Leach, 2010). Tactile deprivation produces increases in the circulating blood level of cortisol.

CORTISOL & ANIMALS: A few minutes of petting a dog lowers cortisol in both the human and the animal.

PROGRESSION OF AD: AD develops over a span of time. In the face of early experiences of interactive dysregulation and a lack of emotional safety, infants and toddlers attempt to cope by presenting an array of attachment signals and behaviors to procure needed nurturance. Trial and error tends to guide this, and the overall result is a disorganized attachment style that is rather fluid. This disorganized style can appear as: 1) sequential or simultaneous approach/avoidance, 2) interrupted speech or movements, 3) poor coordination and stumbling primarily when the parent is present, or 4) rapid changes of affect. Without appropriate prior intervention, by age 6 this more fluid disorganized attachment style crystallizes into a more organized, rigidified attachment disorder, designed to control both the inner and outer worlds. Now the child will fall somewhere along the AD Spectrum. This underscores the value of early intervention with AD as with so many other things.
Lyons-Ruth. Psychiatric Clinics of North America. 2006.

PREVALENCE OF AD: The media tends to describe Attachment Disorder in children as “rare to extremely rare”, probably because the media’s focus is on the severest of cases. However, infant research and adult research using the Adult Attachment Interview (AAI), have identified the distribution of categories of attachment problems in the population as far more common: .

- 60% of adults are securely attached.
- 25% of adults have an avoidant attachment style.
- 10% of adults have an ambivalent attachment style.
- 5% of adults have a disorganized attachment style.
Cassidy & Shaver. Handbook of Attachment. 2008
- 50% of adults are securely attached.
- 25% have an avoidant attachment style.
- 20% have an anxious attachment style.
Levine & Heller. The New Science of Adult Attachment. 2010.
- 15% of infants from advantaged, low risk populations display disorganized attachment strategies.
Lyons-Ruth. Psychiatric Clinics of North America. 2006.

ATTACHMENT DISORDER: MANY CONCEPTUAL NAMES

NARCISSISM: Much of what comes under the rubric of attachment disorder has been around for a long time, packaged in different terminology. Within the psychoanalytic tradition and its more recent iterations, object relations and self psychology, the concept of narcissism overlaps substantively with the attachment realm. Narcissism came to be defined as comprising those operations that function to regulate self-representation and protect its stability. Narcissistic patterns such as fantasies of magical omnipotence, unlimited entitlement, bodily preoccupation, and an insatiable appetite for attention (all commonly seen in AD children) function as efforts to repair damage to the self-representation from early traumatic experiences (prevalent in the histories of AD children) and avoid its dissolution (annihilation anxiety). Narcissistic object choices are essentially substitutes for missing or malfunctioning skills for regulating the self-representation. This plays out either as seeking mirroring of the fantasied grandiose self-image or seeking fusion with what is perceived to be an omnipotent object (patterns AD children frequently display). With the Grandiose Self, all unacceptable elements are dissociated and assigned to external objects which are then devalued. With the Idealized Object, all unacceptable elements are dissociated and buried within. In both cases, dissociation becomes a central feature of ongoing functioning with the goal being averting fragmentation and disintegration of the self (the central goal of

AD children). Narcissistic disturbance refers not to a diagnostic category, but to a dimension of psychopathology (The AD Spectrum) that cuts across diagnostic entities, with the degree of narcissistic disturbance referring to the fragility of the self and its vulnerability to disintegration. And so in the end, narcissism comes down to a concept embracing regulatory and protective functions, and its disorder is dimensional rather than categorical. The exact same statement can be made about attachment and attachment disorder.

ROBERT STOLOROW. INTERNATIONAL JOURNAL OF PSYCHOANALYSIS. 1975.

TRUE & FALSE SELF: The True Self (TS) emerges from sufficient synchronized experiences with the primary attachment figure. This facilitates faith in the external environment which lowers the need for self-protection. The TS houses real feeling, spontaneity, creativity and the sense of bodily aliveness. The False Self (FS), by contrast, begins with the initial attachment figure not coordinating with the infant's signals, but instead ignoring them, misinterpreting them, overindulging them, or imposing the adult's needs over them. The purpose of the FS is to protect the True Self (TS) from annihilation, primarily through exploitation by others. In this sense, the FS is a replacement attachment figure pursuing the primary goal of an attachment bond: safety. There is a spectrum of the TS being intermittently hidden to being completely hidden all the time (Spectrum diagrams). The FS is rigid in its workings and inhibits growth (IWM of AD). It houses intellectual activity while seeking to escape emotional and bodily experience. Living within the FS brings a sense of futility, deadness, and a feeling of not really existing. The emotional reactivity of the FS to perceived external threat should not be mistaken for the genuine feelings that belong to the TS. Real experience does not "stick" to the FS but flows through it like water through a sieve. This underlies the child's lacking any sense of existence through time nor any internal sense of time as a continuum. The deeper the split between the FS and the TS, the more the child demonstrates poor use of symbolism, significant restlessness, inability to concentrate, and a need to "collect" stimuli from external reality. The child's "living-time" can then be filled with reacting to these stimuli.

The FS is adept at taking in aspects of others (not true internalization) and weaving them into its pretense of being real- imitation is one of its skills. An organized FS can be very deceptive. The world sees the appearance of functioning and does not imagine the real internal distress that exists within the child. The world falls for the pretense, and the FS is seen as the whole child. This is extremely damaging to the child for it only enhances the sense of not really existing. Relative to the TS, the world being deceived by the FS is an ultimate act of misattunement. All this being said, the ultimate goal of the FS, is to find a way to give birth to the TS.

Transitioning from the FS to the TS comes with a phase of extreme dependence, which the FS is likely to desperately fight (the worsening behavior that accompanies progress initially). Healing involves recognizing and communicating the child's sense of not really existing- an act of attunement. On the other hand, the FS can collaborate for a long time with a clinician who mistakes the FS for the real client. D.W. Winnicott. Maturational Processes and the Facilitating Environment. 1960.

ASSESSMENT & DIAGNOSIS

LANGUAGE AND THE PERCEPTION OF DIAGNOSTIC REALITY: There are several decades of research demonstrating the significant influence of language on perception. At the most basic level, all words are symbols, not real entities. However, it is easy to get too wedded to one's language and conceptual terminology and start treating words as real objects. When this happens, the concepts can function as filters that obscure, or worse still, replace the reality of what is actually occurring in the moment. The client ends up getting dressed in a concept, and very valuable information, gets lost behind the label. Naming something is not the same as understanding it. Regardless of the concept attached, the clients remain the same. How they are functioning is still how they are functioning. So, the important question becomes, what difference does it make to the clinician to decide, "Is it this diagnosis or is it that

diagnosis?” How does that decision impact treatment- for better, for worse, or not at all? And once we have decided, are we still curious about what’s happening in front of us or have we decided “we know”? But do we really know, or do we just think we know based on a “conceptual certainty”. Has the concept come to replace the reality of the client’s functioning?

ASSESSMENT: Attachment Disorder is a very complex entity. As such, trying to assess it in any single diagnostic appointment, as the current insurance-driven climate demands, is very prone to go astray. It is a disorder which manifests in the nuances of day to day life, and data on day to day functioning is therefore the most relevant. By definition, “day to day functioning” can’t be observed in a meeting or two, nor can it be captured by comprehensive testing procedures, all of which are still snapshots in time and place. There are several behavioral checklists for AD. However, as with other disorders, none of these checklists are diagnostically conclusive. In a comprehensive review of rating scales for Depression, Generalized Anxiety Disorder, Obsessive Compulsive Disorder, AD/HD, Bipolar Disorder, Schizophrenia, and Autism, the authors concluded:

Symptom specific rating scales should be employed with care. While they assess symptoms, they are not diagnostic measures. Use of these scales still requires clinical expertise and careful assessment to insure optimal outcomes.

Hirschtritt & Bedoya. 2011.

The richest database for assessing AD is the information provided by parents, as they clearly have the most extensive data on daily functioning over time. This is supplemented by observations of parent-child interactions in therapy (just one reason parents need to be present in attachment work). Data provided by teachers is the next best source, though of considerably less value than parental input, given the differences in the relationships with the child.

PARTIAL DIAGNOSIS: Because attachment impacts development in so many different ways, the symptomatic presentations of AD children can be found in all of the following current diagnostic categories:

- Attention Deficit Hyperactivity Disorder: Since attachment problems can disrupt neuroendocrine functioning, dopamine deficiencies can appear in both AD and AD/HD.
- Oppositional Defiant Disorder
- Conduct Disorder
- Generalized Anxiety Disorder
- Phobias
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Dysthymic Disorder / Major Depression
- Bipolar Disorder

Because AD children present clinicians with such a diagnostic array of possibilities, these children are not so much misdiagnosed, as they are partially diagnosed. This is almost a guaranteed outcome of evaluations based on one or two sessions. One aspect of their functioning, typical of one of the above disorders, may catch a clinician's eye. The child is then given that diagnosis, and the larger Attachment Disorder picture gets lost as "the part is mistaken for the whole". Treatment is then based on the partial diagnosis, and this all but guarantees treatment failure.

THE FUTURE: DSM-5

REACTIVE ATTACHMENT DISORDER (RAD)- DSM 4: RAD first appeared in DSM-3 in 1980, so it has a 30 year history. A primary objective of DSM-3 was to divide psychiatric disorders into separate categories that did not overlap. This works against integrative thinking and tends to generate multiple unrelated diagnoses for individual clients. Given its complexity, RAD has never cooperated with this objective, and this likely contributes to its controversial reputation. Within the current DSM-4, RAD is listed as: 313.89: Reactive Attachment Disorder of Infancy or Early Childhood. There are two types: Inhibited and Disinhibited. The DSM-4 criteria are accurate as far as they go, but are too limited in scope in their description of inappropriate social relatedness and of the etiology of AD. The functioning of children with AD is far more complex than the criteria outlined in 313.89, and as a result, in terms of DSM-4, AD children are scattered across the diagnostic map.

RAD and DSM 5: In the draft DSM-5, greater prominence has been given to the absence of seeking or experiencing comfort / protection in human relationships that lies at the center of AD. In addition, the onset has been lowered from age 5 to nine months, which is more in line with the origins of AD. These are plusses. On the minus side, the two types of RAD in DSM-4 have been split into two entirely different disorders: Reactive Attachment Disorder of Infancy or Early Childhood and Disinhibited Social Engagement Disorder (DSED).

SYMPTOMATIC DIAGNOSES: These diagnoses are based on a predominant symptom that typically cuts across multiple disorders, but has been extracted as a stand-alone disorder. They are not really disorders in and of themselves. Current examples of such diagnoses are: Oppositional Defiant Disorder, Conduct Disorder, Intermittent Explosive Disorder, and Generalized Anxiety Disorder. Such diagnoses erase the need for differential diagnosis and encourage progressively shallower clinical thinking. In the case of AD, wherein problems are often layered, symptomatic diagnoses skim off the surface problem while missing the deeper problems that are the real source of the surface problems. DSM-4 carries a number of symptomatic diagnoses, and DSM-5 appears to be expanding them. Because they carry no reference

to underlying etiology, symptomatic diagnoses, are of minimal clinical utility, except as possible targets for psychopharmacological intervention.

- **DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD)**: This disorder has been proposed for DSM-5. It is a combination of two earlier proposed disorders: Severe Mood Dysregulations Disorder and Temper Dysregulation Disorder with Dysphoria. These proposed disorders, in turn, grew out of two areas of disagreement: 1) where aggression and labile affect both exist in a child, is this a “mood disorder” or a “disruptive disorder”, and 2) is Bipolar Disorder in children episodic as it is in adults, or chronic. The second question has taken on much importance as a result of the 40-fold increase in children being diagnosed with Bipolar Disorder during the last decade. This statistic is raising questions about the credibility of the psychiatric diagnostic process. Despite the possible change in diagnostic terminology, a frontline treatment for DMDD will remain the same as with Bipolar Disorder: second generation antipsychotics and mood stabilizers. The unacknowledged goal here is to capture some of the children currently in the bipolar category and remove them to another diagnostic class, thereby reducing the credibility-taxing explosion in the diagnosis of Bipolar Disorder. Curiously, nowhere in the formulation of DMDD is there any reference to attachment or trauma.

November 6, 2011 Version 4.4