ATTACHMENT ABC'S IN PEDIATRIC PRACTICE

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DISCLOSURES

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  - Baptist Community Ministries
  - Institute of Mental Hygiene
- No industry funding
- AAP Early Brain and Child Development Leadership Workgroup

LEARNING OBJECTIVES

- Be familiar with the crucial components of the early attachment relationship
- Be able to recognize patterns of suboptimal parent-child interactions
- Be familiar with primary care approaches to promoting healthy early relationships

OVERVIEW

- Stages of healthy parent-child relationship development
- Patterns of unhealthy attachment including reactive attachment disorder
- Promoting healthy relationships

THE CAREGIVING RELATIONSHIP

RELATIONSHIP COMPONENTS

- Parent perceptions
- Parent behaviors
- Child perceptions
- Child behaviors

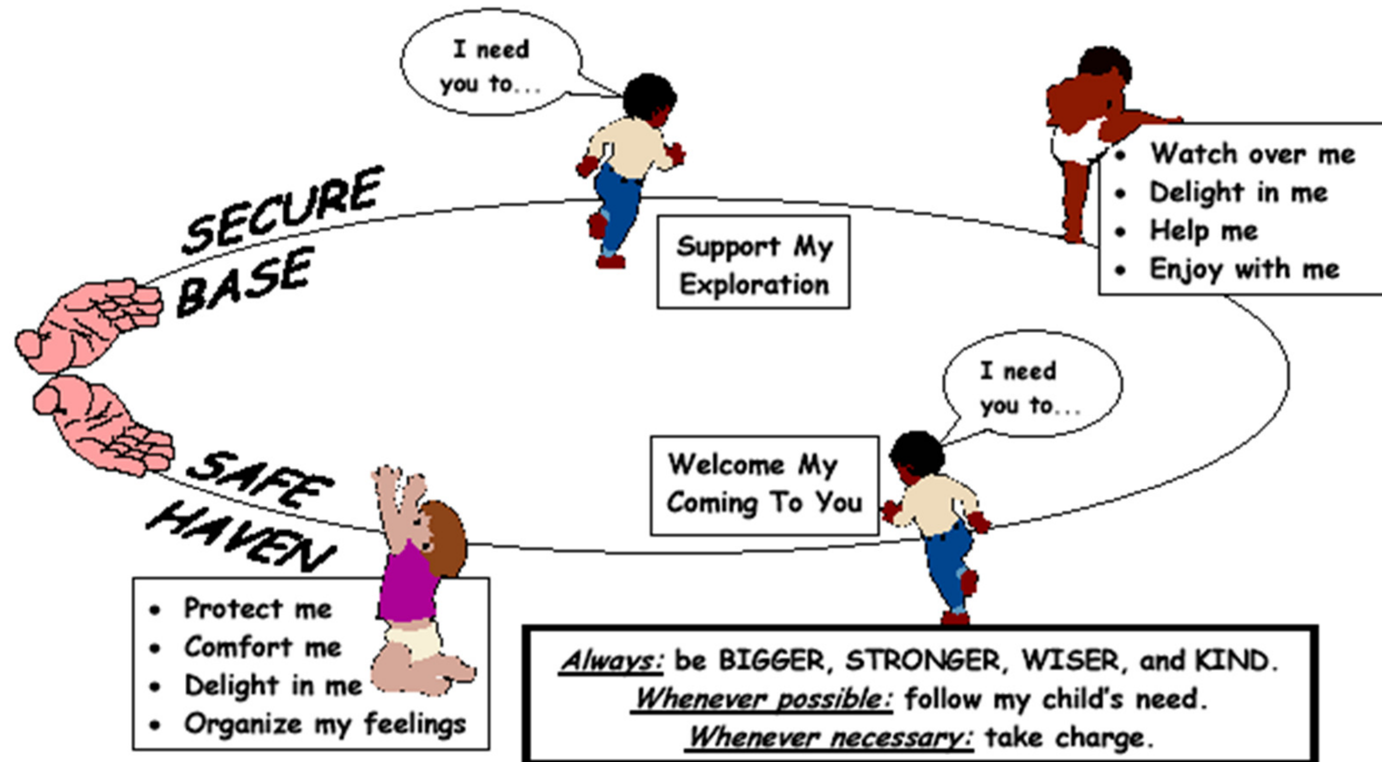
CHILD CONTRIBUTIONS TO ATTACHMENT RELATIONSHIP

- Temperament
- Genetic predisposition
- Cognitive status
- Medical and developmental problems
- Ability to successfully cue a parent contributes to relationship

STEPS TOWARDS BECOMING ATTACHED

- Prenatal: Parents develop stable perceptions about infant
- Perinatal: Infants are born with propensity to develop focused attachment relationship
- “Bonding”: parent’s early emotional connection to child
- Attachment: selective, focused proximity seeking in times of distress

Zeanah, Boris, Scheeringa, 1996

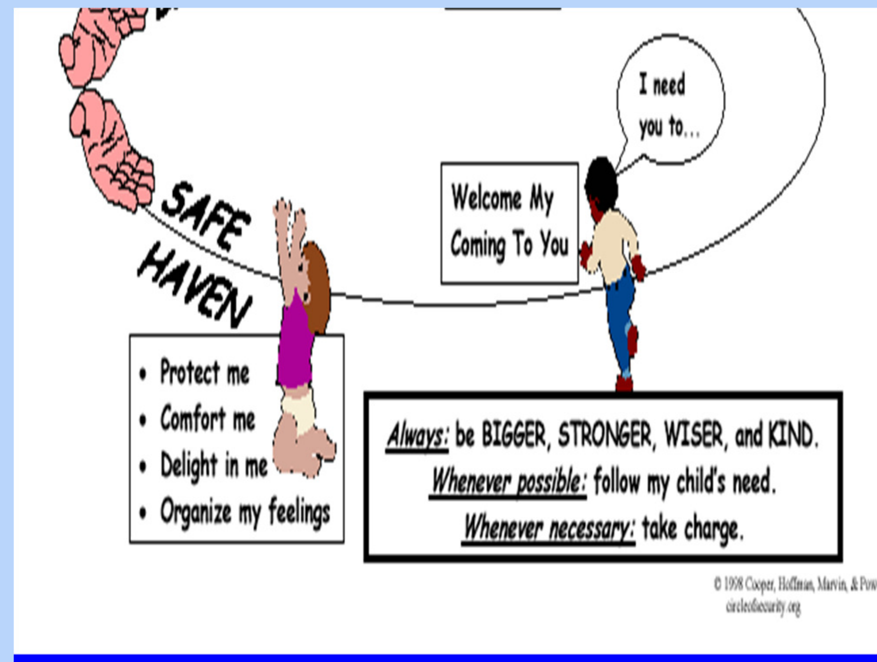


Cooper, Hoffman, Marvin, Powell, 1998 www.circleofsecurity.org

HIGH SAFETY/LOW STRESS SITUATION

Cooper, Hoffman, Marvin, Powell, 1998 www.circleofsecurity.org

HIGH STRESS/LOW SAFETY SITUATION



Cooper, Hoffman, Marvin, Powell, 1998 www.circleofsecurity.org

Organized, balanced, coherent narrative about infant (even prenatally)
Warmth

Infant tracks face briefly

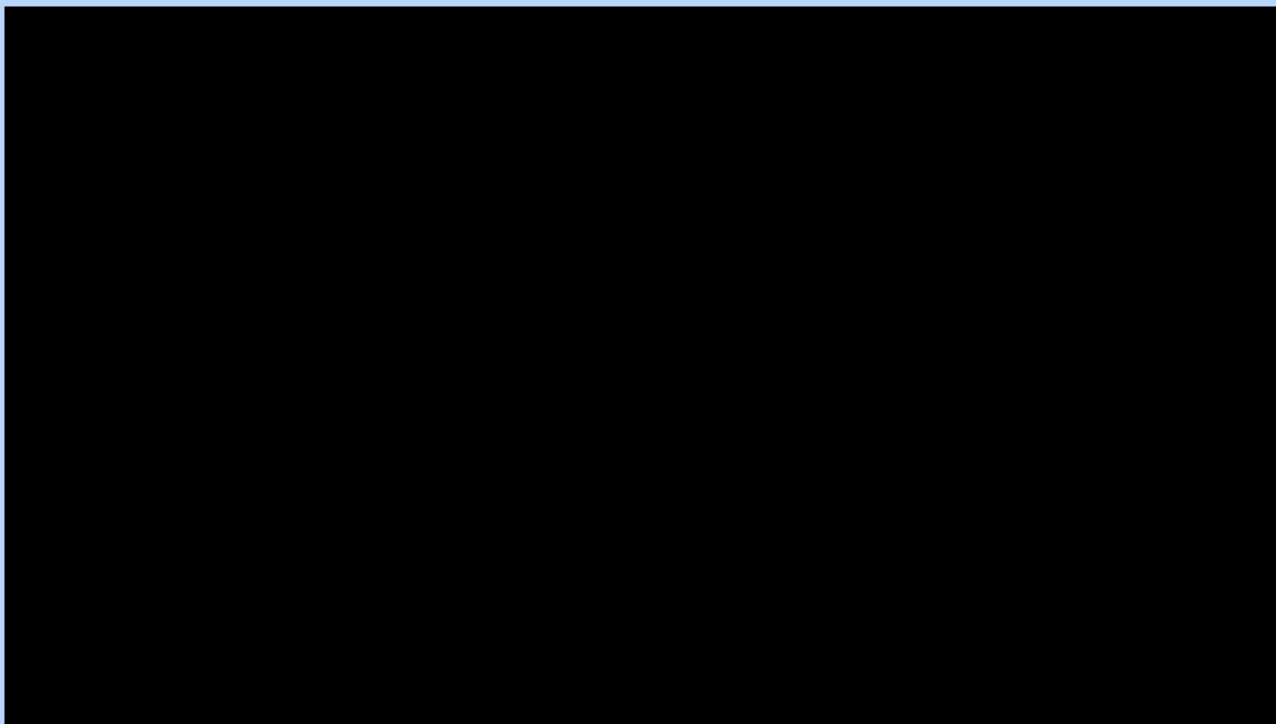
Responding to infant cues of distress or joy and anticipating needs

Looking at relationships in infancy

RED FLAGS

- Parent sounds detached, disinterested, disorganized, or overtly disdainful when talking about infant
- Parent does not respond to infant cries or coos
- Infant averts gaze

STILL FACE



FOCUSED ATTACHMENT DEVELOPMENT: 7-12 MONTHS

- Preferred attachment ("falling in love")
- Stranger wariness develops
- Separation protest becomes evident

WHAT DOES IT LOOK LIKE?

- Toddler
  - Child shows distress around new people and seeks proximity to mother for comfort
  - New distress when mother leaves the room
  - Proximity to parent resolves infant distress
- Parent
  - Parent acknowledges and tries to resolve infant's new anxiety

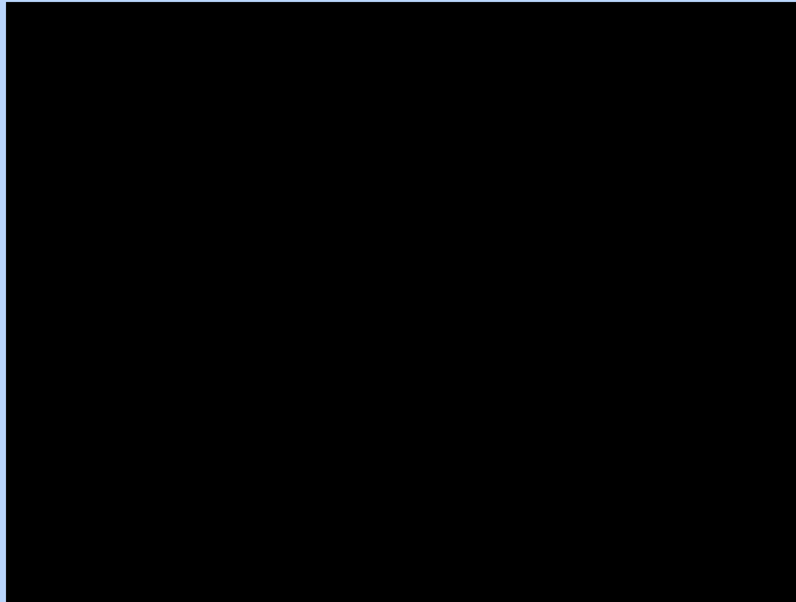
Organized, balanced, coherent narrative about child ; Warmth

Responding to child cues of distress or joy and anticipating needs

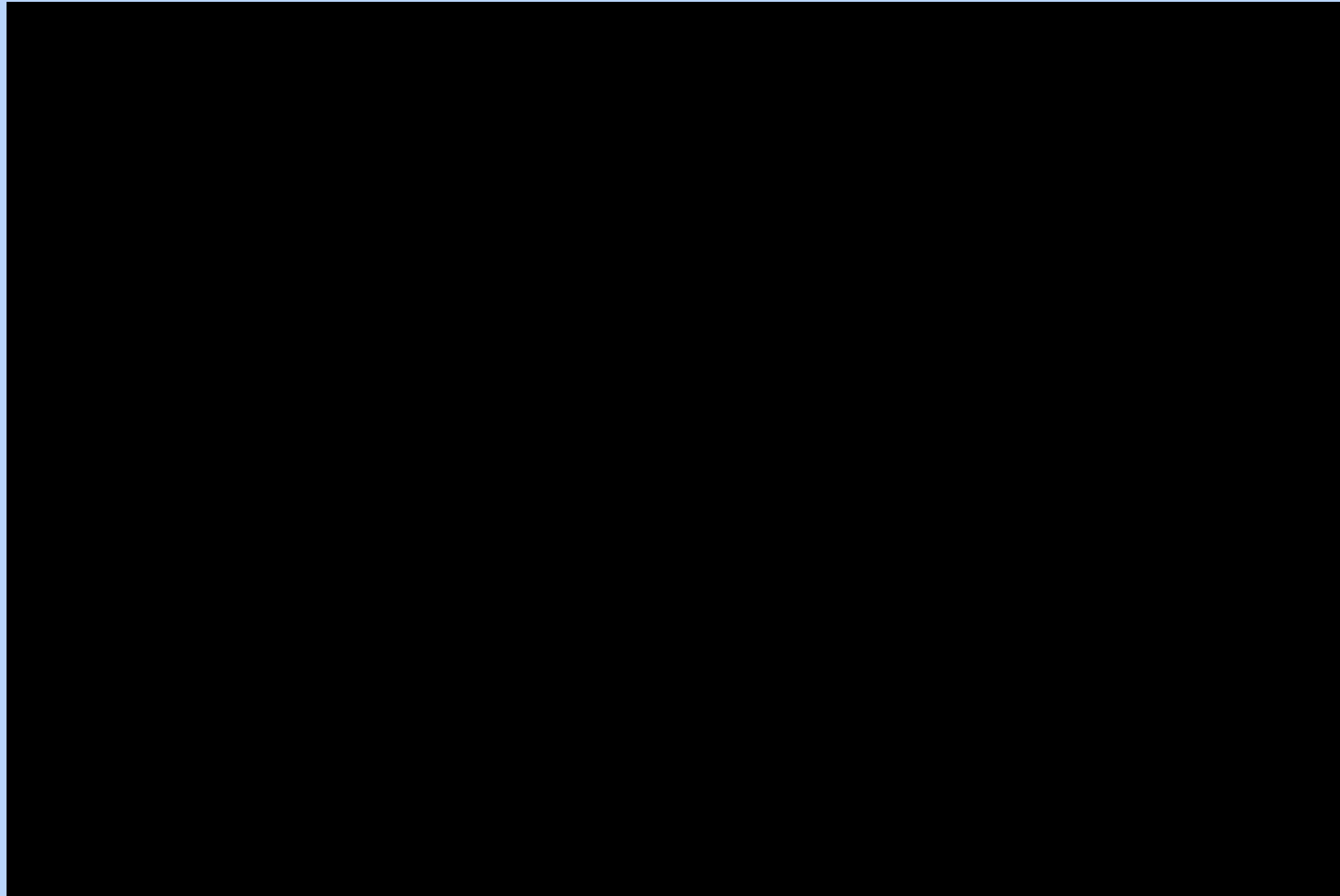
Stranger distress
Proximity seeking in times of distress
Proximity resolves distress

Looking at relationships in toddlerhood

FOCUSED ATTACHMENT



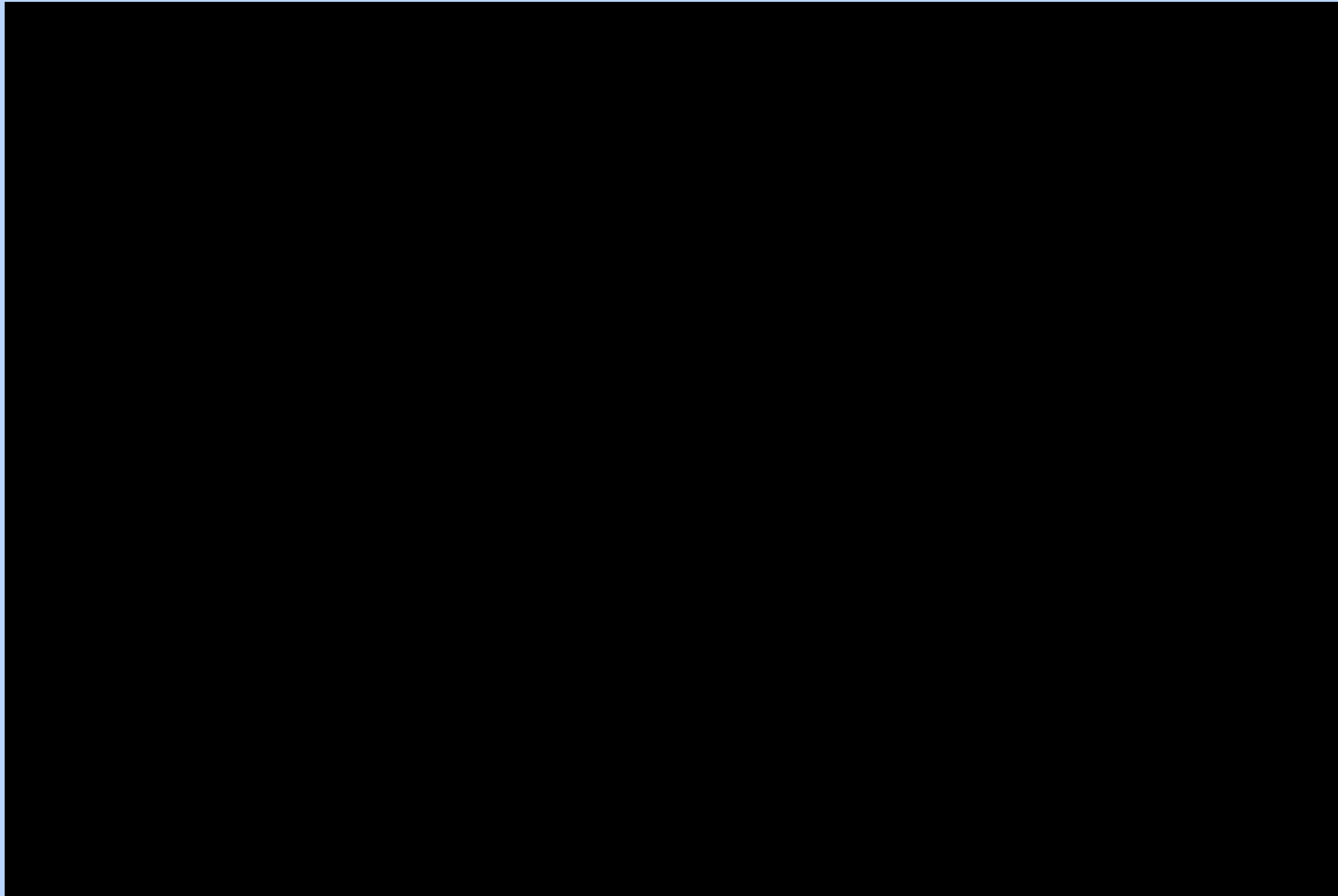
USING PARENT FOR COMFORT



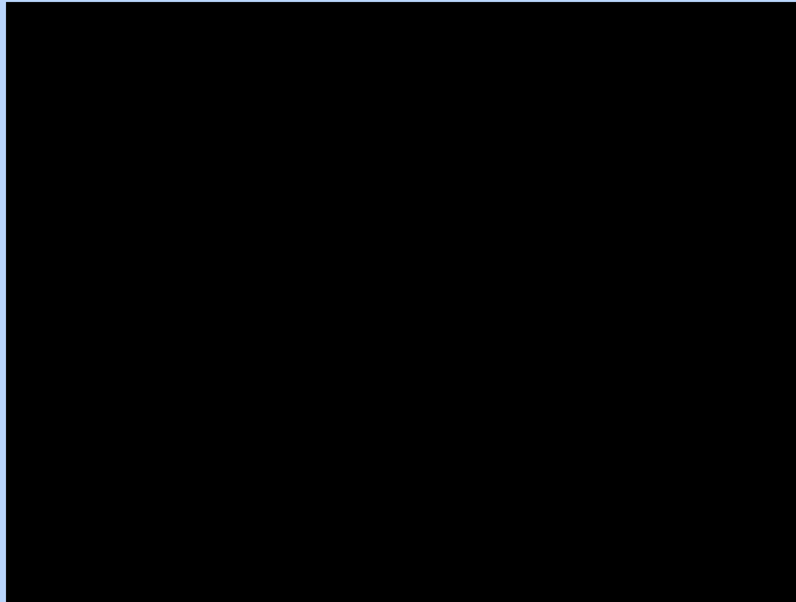
RED FLAGS: TODDLERS

- Indiscriminate behaviors
- Overly withdrawn and clingy
- Proximity to mother does not resolve infant's distress
- Mother resents or rejects comfort-seeking behaviors

PARENT PERCEPTION



WHEN PROXIMITY ≠ COMFORT



FORMAL CATEGORIES OF ATTACHMENT BEHAVIORS

- A- avoidant
- B- secure
- C- withdrawn/resistant
- D- disorganized
- Insecurity is NOT a sign of psychopathology
- Organized patterns most strongly predict future mental health

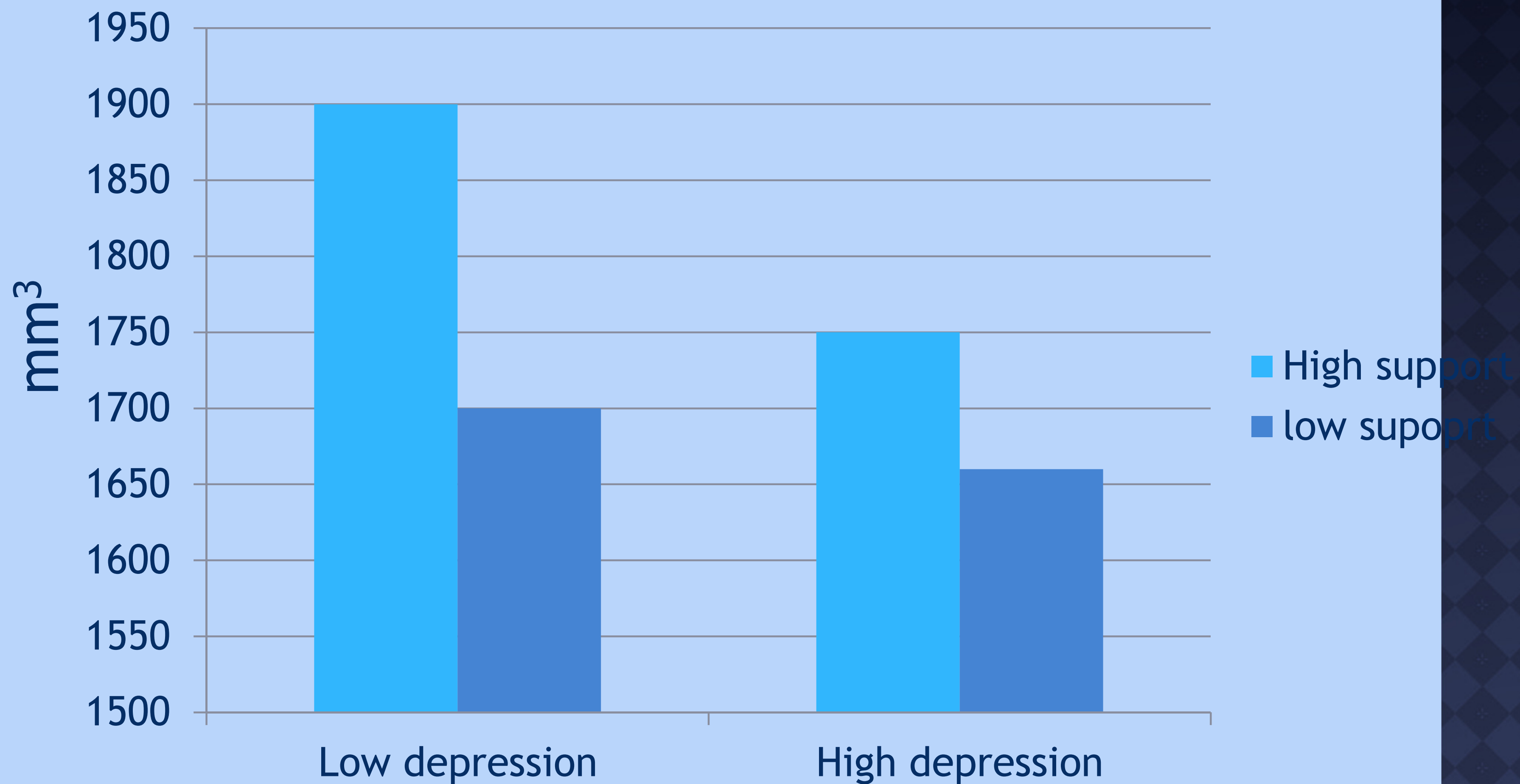
WHY DOES ATTACHMENT MATTER? ANIMAL MODELS

- Stress response system (including HPA axis) developed in response to caregiving environment
  - Impaired early caregiving in monkeys -> high CRF and fearful behaviors
  - Rat mother nurturing increases synapse formation in hippocampus, development of HPA axis
  - Rats born to non-nurturing mothers raised by nurturing mothers showed brain development similar to the biologically related offspring

WHY DOES ATTACHMENT MATTER?

- Securely attached infants vs insecure infants
  - More pro-social as school aged children
  - Less aggressive as school aged children
  - More concerned attentiveness
  - More positive self-image as school aged children
- Securely attached adults vs insecure
  - Have more satisfying adult intimate relationships
  - Are better able to seek care
  - Are better able and more likely to provide care to others

HIPPOCAMPAL VOLUMES *(LUBY 2013 PNAS)*



WHY DOES ATTACHMENT MATTER?

- Attachment relationships are intergenerationally transmitted

INTERGENERATIONAL TRANSMISSION

Grandmother's Perception of own attachment relationship

Adult Mother's perception of own attachment relationship

Prenatal perception of self in intimate relationships **and** perception of child

Infant attachment classification at 1 year old

Child's perception of own attachment relationship

Arrows indicate prediction, although not necessarily causation

WHEN RELATIONSHIPS ARE DISTURBED

- Child may not use parent for comfort effectively
  - Self-soothe/not soothe
  - Seek comfort from strangers
- Child and parent may not share joy together
- Child may not learn to organize feelings
- Parent may not protect child effectively
- Child and parent may have trouble understanding each other's cues

CAREGIVING DEPRIVATION AND CNS DEVELOPMENT

- Lower EEG power
- Lower brain volume (grey and white)
- Decreased uncinate fasciculus connectivity Lower grey-white differentiation in areas related to cortical/amygdala connectivity
- HPA axis dysfunction (cortisol, CRF)

CAREGIVING QUALITY AND METHYLATION

- 14 children in institution since birth (Russia)
- 14 children raised at home
- Mean age 8 (7-10 yo)
- Measured whole genome methylation
- Higher methylation in institutional group
  - Especially immune responses
  - Cellular signaling (neural communication and brain development)

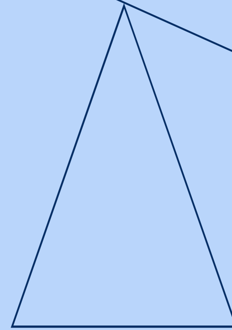
REACTIVE ATTACHMENT DISORDER

REACTIVE ATTACHMENT DISORDER

- Occurs in children with history of pathogenic caregiving
- Inhibited- do not effectively use caregivers in times of distress, limited reciprocity
- Indiscriminate- show minimal selectivity in use of adults

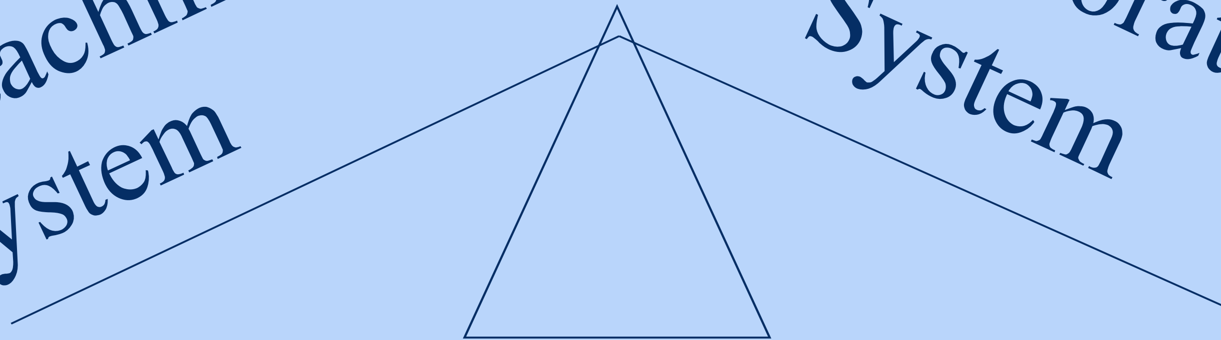
HIGH STRESS/LOW SAFETY SITUATION

Attachment System

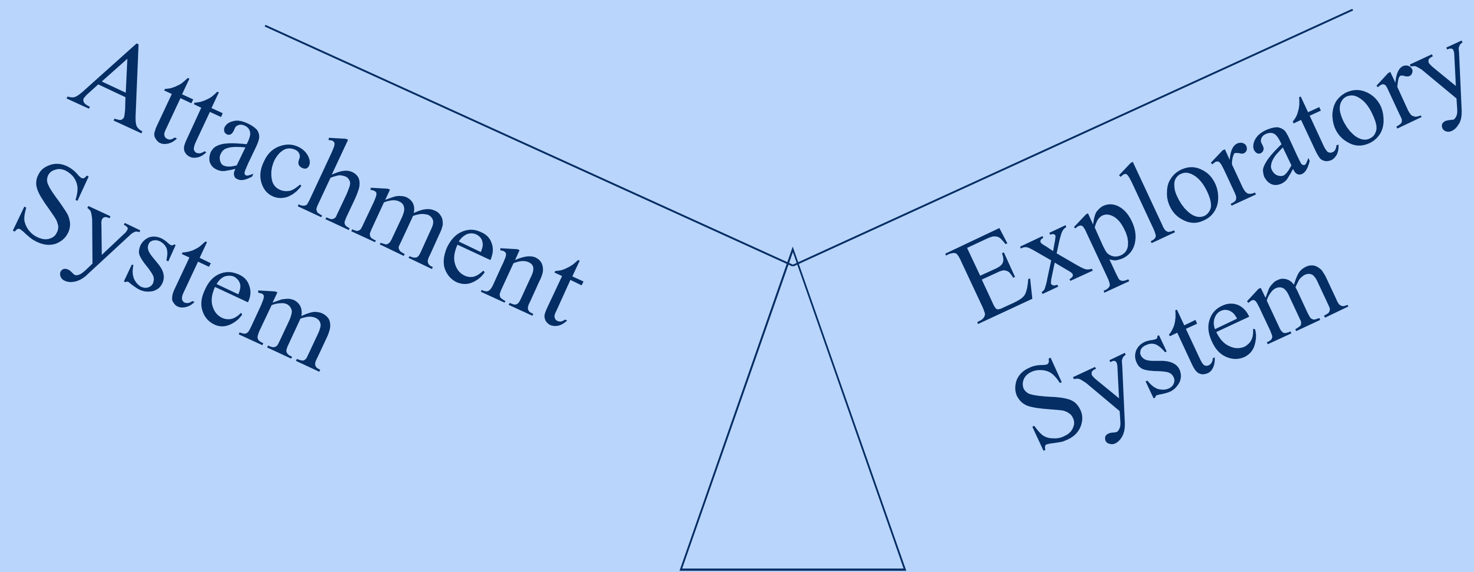


Exploratory System

HIGH STRESS/LOW SAFETY SITUATION: INHIBITED RAD



HIGH STRESS/LOW SAFETY SITUATION: DISINHIBITED RAD



EPIDEMIOLOGY

- Rates of RAD in institutionalized toddlers
  - indiscriminate RAD ~30%
  - Inhibited RAD ~4%
- Intensity of RAD symptoms correlates with risk of pathologic care
- Institution > high ratio pilot unit in institution > never institutionalized group

- Gleason et al, 2011; Zeanah, Smyke, and Dumitrescu, 2002

CLINICAL PRESENTATION OF RAD

- Two disorders
  - Different correlates
  - Different treatment responsivity
- Both associated with caregiving adversity
- Both associated with functional impairment (concurrent and predictively)
- Clinical presentation in older children is less clear

  - *Gleason et al. 2011*

INDISCRIMINATELY SOCIAL TYPE RAD

- Symptoms continue in a setting of deprivation and slowly decline after placement
- Some ADHD symptoms, but low rates of true co-morbidity
- Can have organized attachment patterns
- Associated with significant concurrent and future impairment

(Gleason et al 2011)

INHIBITED TYPE RAD

- Responds rapidly to treatment
- Lower prevalence
- Appear depressed, withdrawn, do not use parent selectively for comfort even when distressed

RAD IN SCHOOL AGE CHILDREN

- No longitudinal studies
- Descriptions of behaviors are quite divergent from data in younger children
- Descriptions on internet etc use extraordinarily inclusive criteria
- Preliminary findings suggest that signs of RAD are stable up to 8 years using strict criteria

TREATMENT FOR RAD

- Removal from institution and placement in foster homes is related to decreased reactive attachment disorder symptoms (inhibited >> disinhibited)
- No other treatments have been studied as interventions for reactive attachment disorder

- *Zeanah et al 2010; Smyke et al. under development*

CLINICAL ASSESSMENT OF PARENT CHILD RELATIONSHIPS

FORMAL ASSESSMENT OF ATTACHMENT

- Child perception: Must be inferred
- Child Behaviors
- Parent Perception
- Parent Behaviors

Infer: child perception

Listen: parent's perception

Observe: parent behaviors

Observe: child behaviors

Assessing the relationship

ASSESSMENT: OBSERVATIONS

- Serial observations important
- Attend to child's interactions with stranger (clinician) and parent
- Observe child's ability to comfort, and parent's ability to anticipate needs for comfort and to provide comfort
- Can provide opportunity for planned separation and watch reunion strategies
- Be aware of child's excessive friendliness with strangers

ASSESSMENT OF ATTACHMENT: CHILD BEHAVIORS

- Is child overly friendly with office staff or MD?
- Does child reference parent during appt
- Does child seek proximity to parent under stress
- Does proximity to parent help calm child during exam or immunizations

PRIMARY CARE ASSESSMENT OF ATTACHMENT: PARENT PERCEPTION

- Tone when parent talks about child
- Attributions about child appropriate?
- Is description of child coherent or fragmented/difficult to follow?

PRIMARY CARE ASSESSMENT OF ATTACHMENT: PARENT BEHAVIORS

- Does parent allow child to explore appropriately and safely?
- How does parent overly limit exploration?
- Does parent recognize child distress
- Does parent try to soothe distressed child?
- Does parent allow child to approach for calming

PROTECTIVE COMMUNITY FACTORS IN EARLY CHILDHOOD

- Having at least one supportive adult (even in setting of family violence)
- Community identity and pride (even in low-income neighborhoods)
- Affluence (only by reducing number of risk factors, not in a direct manner)

PEDIATRIC ROLE

- Promote well-being through anticipatory guidance
- EBCD Grid
  - **E**xplore the child's environment
  - **B**uild relationships and reciprocity
  - **C**ultivate development
  - **D**evelop parenting confidence

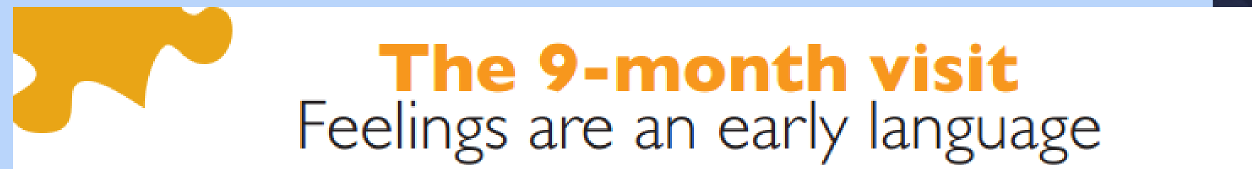
http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/EBCD_Well_Child_Grid.pdf

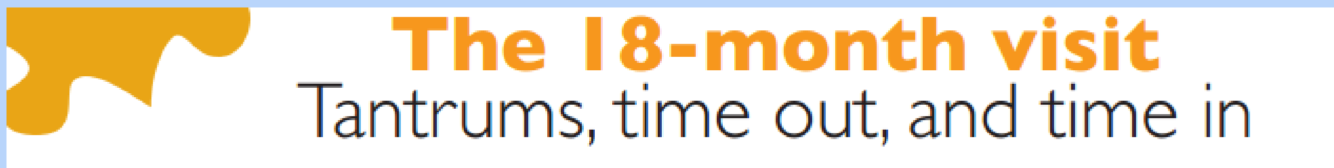
Early Brain and Child Development
BUILDING BRAINS, FORGING FUTURES
A Program of the American Academy of Pediatrics

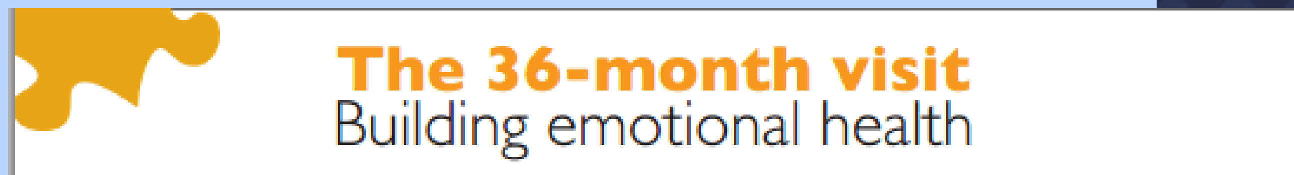
The First 1,000 Days: Bright Futures Examples for Promoting EBCD

PEDIATRICIANS are Encouraged to →	Explore the child's	Build relationships / reciprocity
General Principles →	Cultivate development	Develop parenting confidence
	What pediatricians might teach parents about development	**How pediatricians might support parents as they nurture their child's development**
4 months	Encourage reaching for objects that are safe and easy to hold	Recommend regular bedtime routine
6 months	Anticipate the development of social-emotional distress (eg, separation anxiety, stranger anxiety)	Support the enjoyment of books

EBCD PURPOSEFUL PARENTING







PEDIATRIC ROLE

- Identify children in unsafe caregiving situations including institutional care or maltreatment
- Acknowledge caregiving challenges for children with such histories
- Identify co-morbid conditions

Pediatric Role: Recommendations for Parents

- "Time in"
- Encourage
  - Perspective taking
  - Consistency and dependability
- Re-frame maladaptive behaviors
- "Walk through" the Circle of Security

DIAGNOSTIC UNCERTAINTY

HELP build a therapeutic alliance:

- H = Hope
- E = Empathy
- L^2 = Language, Loyalty
- P^3 = Permission, Partnership, Plan

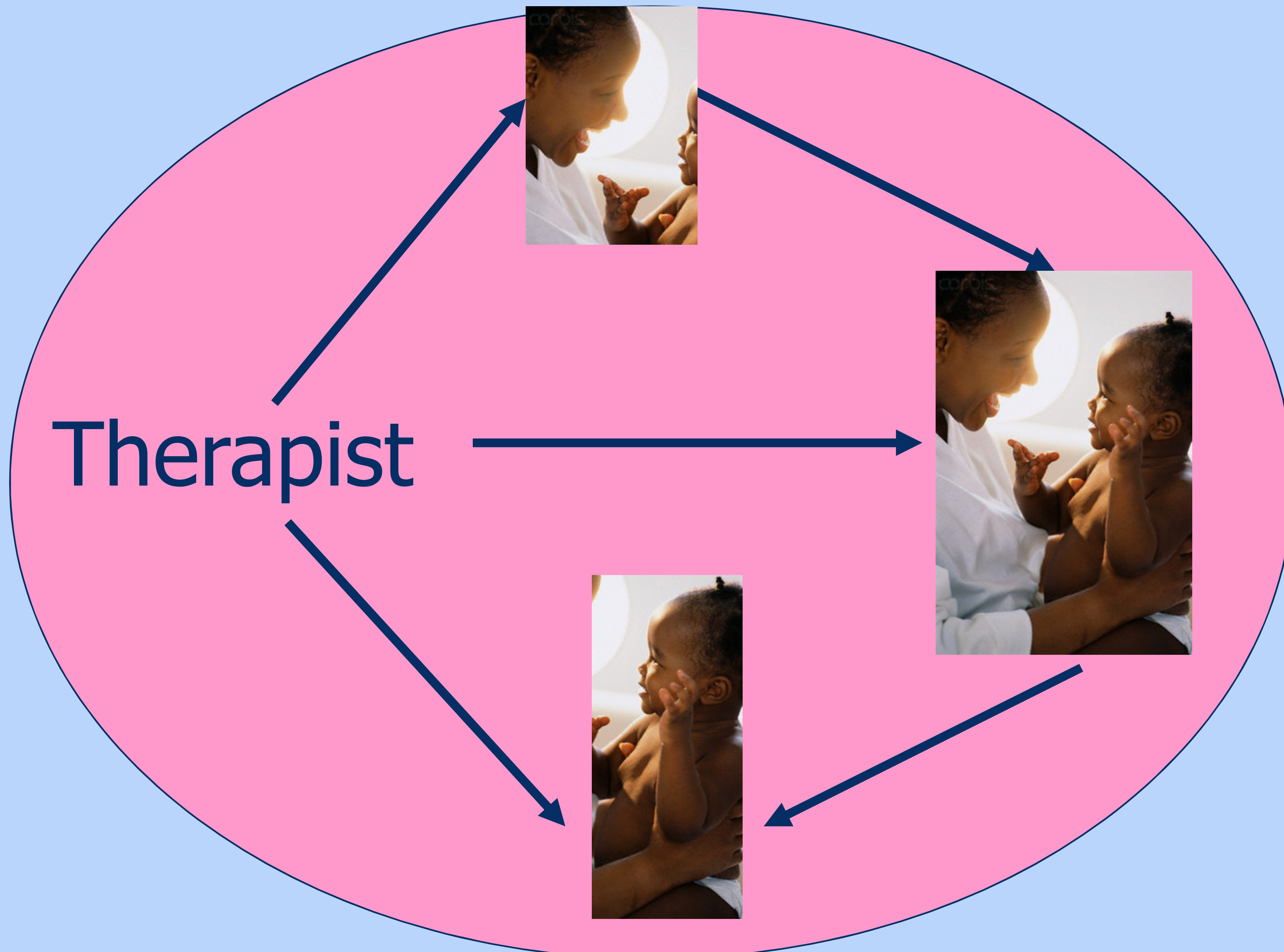
PEDIATRIC ROLE: REFERRALS

- When family ready
- Consider for
  - Overwhelmed parents
  - Not sure of diagnosis/clinical problem
  - Severe relationship disturbances
  - Children whose inhibition is precluding developmentally appropriate interactions
  - Indiscriminate behaviors putting child at risk
  - Co-morbid conditions interfering with functioning

PEDIATRIC ROLE (3)

- Do not prescribe medications for attachment or coercive therapies
- Collaborate with therapist to treat re: co-morbid conditions

EARLY CHILDHOOD ATTACHMENT-FOCUSED TREATMENT



EVIDENCE BASED THERAPEUTIC INTERVENTIONS: CONSISTENT THEMES

- Dyadic work most promising
- Must include a strong emphasis on developing a strong, respectful and nurturing therapeutic alliance with mother
- Strength-based approaches
- Increase insightfulness (perspective taking)
- Increase sensitivity to cues
- In vivo positive interactions

COERCIVE THERAPY

- = for… …purpose other…
- has b… …ssional orga…

SUMMARY

- Parents and infants contribute to the developing relationship

Your Questions?

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