



### Overview

- Attachment – definition, spectrum, symptoms
- Early, chronic trauma
- Attachment, trauma and loss
- Intermountain's Developmental/Relational Treatment Approach

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### Attachment

- Specific affectional bond between infant and caregiver that assures protection and safety (Bowlby, 1982)
- Separate from temperament, dependence (Sroufe, 1995)
- Recognized by child's behavior in a stressful situation (Ainsworth et al., 1978) – primarily, how the child *re-engages* after stress
- Stable across time (Sroufe & Waters, 1977)
- Forms cognitive framework for future relationships (Bowlby, 1988)

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### Attachment

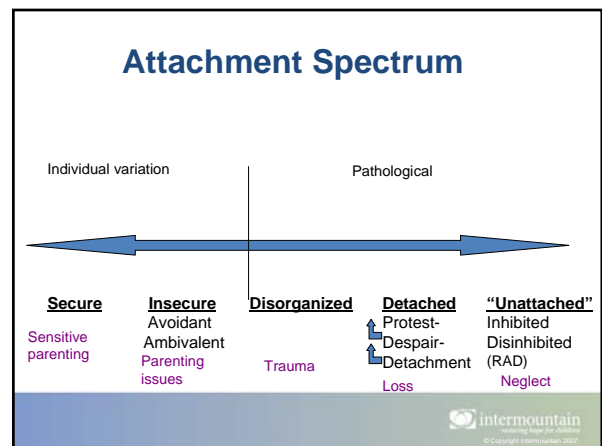
- Relationship that provides affect integration within the infant (Schorre, 1994; Winnicot, 1988)
- Associated with development of particular cortical structures (right orbitofrontal cortex) that connect with viscera and limbic systems (Schorre 1994)
- Predicts later success or psychopathology (Sroufe, 1995)

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### Attachment

- Dependent upon quality of care giving (Ainsworth et al., 1978)
  - Sensitivity
  - Acceptance
  - Cooperation
  - Psychological accessibility
- Child's original attachment pattern becomes engaged in new parental relationships (foster care)


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### “Unattached”

←—————|—————→  
Unattached

- Strictest diagnosis of Reactive Attachment Disorder (Boris et al., 2004)
- Typically the result of institutionalized care
  - Disinhibited – superficial, “indiscriminate” sociability, no strong attachment to one person
  - Inhibited - associated with failure to thrive, no reaching for anyone


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### Detached – attachment crisis

←—————|—————→  
Detached

- End result of loss (Bowlby, 1980)
- Protest, despair, detachment
- Can be re-engaged, but in reverse order


Loss →      ← Time since loss →  
 Protest      Despair      Detachment

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### Disorganized

←—————|—————→  
Disorganized


- “Suffering without solution” (Main & Solomon, 1990)
- Attachment figure causes terror
- Competing responses
- Child’s behavior becomes disorganized in crisis – dissociating, numb, controlling, aggressive, anxious
- Strong indicator of future pathology (Schoe, 2003)

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### Insecure

←—————|—————→  
Insecure


- Mother is inattentive, preoccupied or insensitive (“Slot machine mom”)
- Child’s response in stress is organized around sustaining mother’s attention
- Child ignores reunion or strikes out at mother after reunion
- Normal variant
- With more negative life circumstances can lead to psychopathology (depression, anxiety)

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### Secure Attachment


←—————|—————→  
Secure

- Mother responsive, accepting, calm, cooperative
- Child moves toward mother in stress, explores appropriately, touches base
- Optimal dependence leads to optimal independence
- Affect is modulated, parent is responsive to affective cues

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### Symptoms of Attachment Disturbance (Boris et al., 2004)

- Lack of differentiation among adults
- Seeking comfort from unfamiliar adults rather than direct caregivers
- Failure to seek or respond to comfort from caregivers
- Poorly regulated emotions – intense aggression from small disappointments, rage after limit setting

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### Symptoms of Attachment Disturbance (cont'd)

- Risk taking, aggression that is worse in the presence of attachment figure
- Adequate response to school; poor within primary relationship
- Failure to check back with caregiver after venturing away
- Absence of usual social reticence



### Trauma and Attachment

- Rarely does the child present just with attachment crisis
- Children with the worst history and most presenting problems also have experienced trauma, multiple losses, new relationships
- Early chronic trauma has it's own specific sequelae to be considered



### Trauma

- **Trauma** – life threatening experience that overwhelms the adaptive capacity of the individual
- **Life threatening** depends on age of trauma
- **Chronic** as different from acute trauma (Terr, 1991)
- Only 35% of children removed from parents due to maltreatment display typical PTSD (Famularo et al., 1996)
- Most children show complex dysregulation of all systems (attention, mood, cognition)



### Early, Chronic Trauma

- Early, chronic trauma gets “wired into” lower (sub cortical) centers of child’s brain as the way life is (Teicher et al., 2002; Chugani, 1998)
- This can create long-standing differences in responsivity in brain structures
  - increased irritability of amygdala (Joseph, 1999)
  - proclivity to dysregulated EEG activity (Teicher et al., 2002)



### Early, Chronic Trauma

- Early traumas are re-experienced through bodily reactions, not memories (Siegel, 1999; Perry & Pollard, 1998)
- If associated with attachment figure, they are re-triggered with the sight or sound or memory of attachment figure
- Or in a *new attachment*



### “Developmental Trauma Disorder” (VanderKolk, 2005)

- Multiple or chronic exposure to interpersonal trauma
- Dysregulation of several systems (affective, somatic, behavioral, cognitive, relational, self-attribution)
- Persistently altered attributions and expectancies
- Functional impairments (educational, familial, peer, legal, vocational)



### Brain Develops in Waves of Experience Dependent Growth

- Development Bottom – up
- Processing Bottom-up
- Higher systems build on lower ones

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### Diagnosis

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### Diagnosis – Developmental

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### Indications for Outpatient Therapy

- Child becomes dysregulated under mildly stressful conditions (“no” repeatedly leads to oppositionality and tantrums)
- Child is unable to co-regulate with adequate parent, i.e., unable to sustain support beyond the moment

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### Indications for Outpatient Therapy

- Child’s behavior is worse in the home than in less intimate settings (school)
- Parents are becoming increasingly punitive
- Child has threatened parents, siblings in a convincing way

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### Indications for Outpatient Therapy

- The more restrictive the discipline, the worse the child’s destruction
- The child sabotages almost all endeavors at closeness or connection
- The child’s behavior is increasingly odd (urinating in odd places, acting like an animal for extended periods)

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### Types of Outpatient Work

- Therapy must include the parent. Goal is to help the child regulate affect. Help the child "feel felt." (Siegel and Hartzell, 2003)
- Help the parent understand and hear the feelings beneath the behavior, speak for the child, calm the parent
- Increase parental attunement
- Dyadic Developmental Psychotherapy (Dan Hughes, Ph.D.; [dhughes1060@adelphia.net](mailto:dhughes1060@adelphia.net))




### Indications for Residential Care -Child

- Attachment relationship disorganizes child
- Child's affect not expressed in relationship, but in dangerous actions towards others (sexual acting out, violence to other children)
- Limited setting is responded to with violence (threats to murder, fire-setting, etc)



### Indications for Residential Care - Parents

- Parents have become punitive, discipline turns to revenge
- Parents trapped by fear of child – overconsequating, avoiding, appeasing
- Parents are exhausted, traumatized, cannot see the child with empathy, see the child as "evil"



### Intermountain

Developmental/Relational Treatment Approach



### Developmental


- The way of seeing the child's problems and resolution
- Child's behavior may express need at a developmental level younger than chronological age
- Child's developmental need for attached relationship to integrate affect
- Child's defensive structure "stuck" at early developmental stage



### Relational

Healing occurs within deep, connected relationships with responsive, safe adults:

- Not through medication, time-outs, self-control or rewards
- Affect is "metabolized" (Fosha, 2000) across all levels of staff within relationships



### Developmental/Relational Approach -Assumptions

- Children turn to the attachment figure in stressful times  
*but*
- Children with attachment disruption, attachment disorder or developmental trauma disorder become more disorganized as they get close to the attachment figure  
*which*
- Makes the pathology worse



### More Assumptions

- Children must be treated within relationship (Hughes, 1997)
- Life should be fun and rewarding
- Treatment can be a re-education in living, but that takes *time*
- Children can make sense of their lives.
- Children need to be *heard*
- Accurate help depends on how adults see children, not what children do



### Diagnostic Categories Treated

- Reactive Attachment Disorder
- Autistic Spectrum Disorder
- Mood disorders
- Anxiety Disorders (including Post Traumatic Stress Disorder)
- Oppositional-Defiant Disorder
- Psychotic Disorders (rule-out schizophrenia)
- Personality Disorders information



### Other Issues Treated

- Adoption issues
- Sexual reactivity
- Behavior from fetal alcohol effects
- Stealing, lying
- Peer difficulties
- Seizure disorder effects
- Running away, suicidal ideation
- Fire starting



### Factors Towards Success

- "Something in this child" – adults may feel this; child is reaching but no one has sustained a connection
- Dysfunction is not hardened part of the personality
- Aggression is not intentional, antisocial aggression, but reaction to fear
- Active, resilient parents
- Active social worker




### Diagnostic Categories Not Treated

- Bipolar (versus multi-system dysregulation)
- Schizophrenia (versus depressive or PTSD psychosis)
- Conduct Disorder (versus dysregulation)
- Developmental Delay
- Behaviors from severe brain damage
- Mental Retardation
- Sexual Predation
- Addictions (including to physical containment)



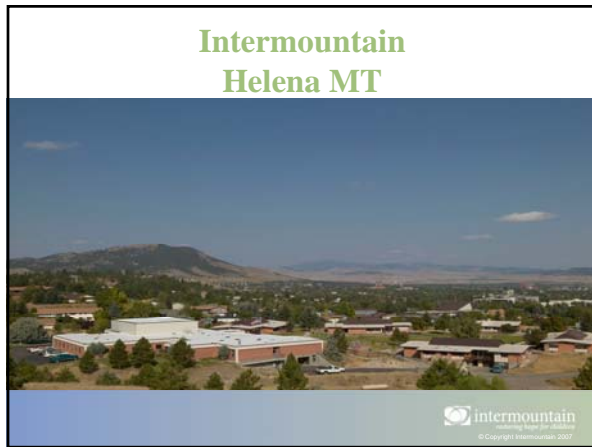

### Intermountain - Overview

- Children 4-12 at admission
- Residential setting surrounded by 40 acre campus in small town setting
- Average length of stay 18-24 months
- Children live 8 to a cottage (8 separate bedrooms), 4 cottages
- On grounds school with special education certified teachers



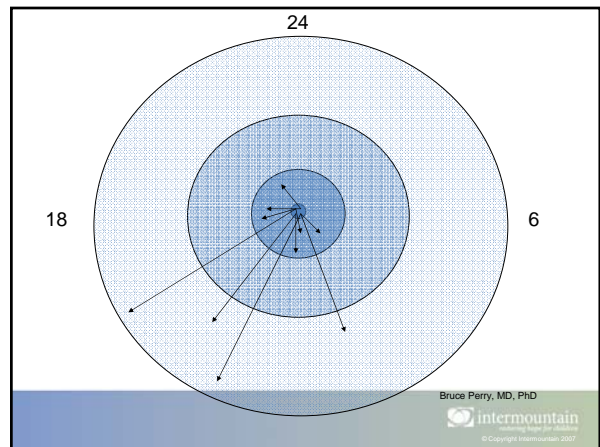
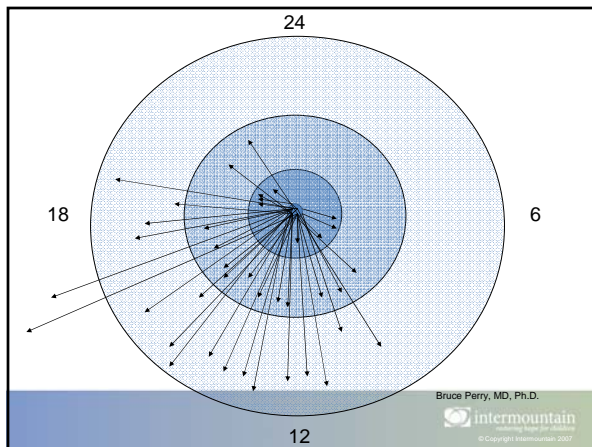
### Intermountain - Overview (cont'd)

- No locked doors, no time out rooms. Family-like environment
- Staff to child ratio is 1:4
- Average direct care staff tenure > 4 years
- Average leadership tenure > 15 years
- Agency is 100 years old; treatment approach is 25 years old



### Intermountain's Treatment Approach

- Provide structure
- Provide healing relationships
  - Each child forms a deep relationship with one staff
  - Child learns to tolerate anxiety and limits
- Create a campus community
  - School, milieu, therapy, peers, chapel
  - Reach in, don't wait
- Create a new narrative for the child
- Create broader response to joy and fun
- Transition the child back into the larger community



### Intermountain – Daily Life

- Deeply connected, intense parent-
  - Like relationship with BA level staff
  - Patterned, repetitive meeting of needs
- Frustration without shame-  
“No is something we do together.”
- Requires extensive staff training, longevity and supervision, professional expectations



### Intermountain - Psychotherapy

- Licensed, master's level clinicians
- Integrating loss and trauma
- Making sense of the child's emotional responses
- In the house – responsive to the child's daily experiences
- Directive, verbal work – lead the child into and through the pain – create a new narrative
- Help others attune to the child



### Intermountain – Psychotherapy

- Help parents, staff experience and sustain empathy for the child and create a picture of the child's inner world
- Parents must change too: Process group + curriculum
  - Supportive Structure
  - Natural and Logical Consequences
  - Language of Supportive Control
  - Attunement, Part I
  - Attunement, Part II
  - Re-Entry – Preparing to Come Home
  - Adoption is About Loss Too
  - Brain Development - Why Does He Do That?



### Intermountain - Education

- Tolerating frustration, containing “issues”, peer relationships, the fun of learning
- CST assessment and IEP formation
- Age and ability adjusted curriculum
- Reading enhancement
- Speech and occupational therapy assessment and interventions



### Intermountain - Activities

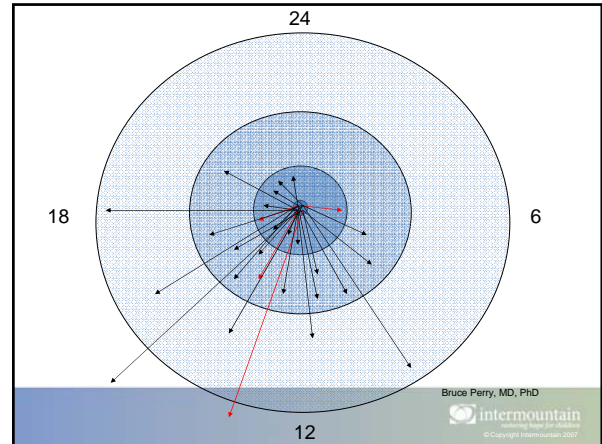
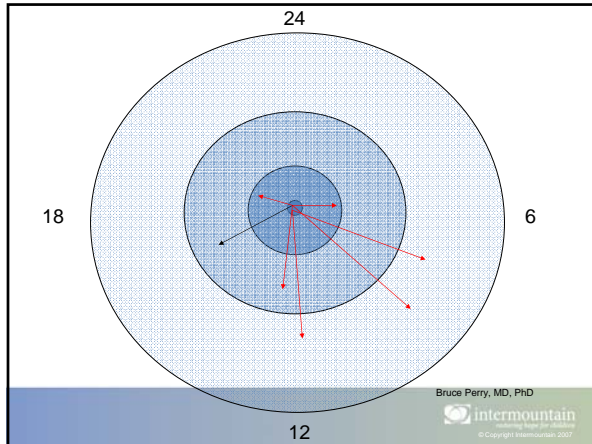
- Treating the whole child - child develops sense of self in larger context, balance work with fun
- Recreation – teamwork, dependence, frustration tolerance, community experience, fun
- Spirituality – supporting the child's faith journey, hope in the hopeless  
Is there more than me and my pain?



### Treatment - Medications

- Keep anxiety and arousal within tolerable window, adjunctive to relationship.
- Atypical antipsychotics (Seroquel, Abilify, Risperdal) may reduce anxiety, and thereby reduce aggression, oppositionality and enhance relationship
- Mood stabilizers (Lamictal, Topomax) may reduce limbic reactivity
- *SSRI's and SSNRI's (e.g., Zoloft, Prozac, Effexor) not used frequently as they tend to increase aggression, libido*





### Contacts

Website: [www.intermountain.org](http://www.intermountain.org)

- To refer a child:  
Tina Johnson – Director of Admissions  
(406) 457-4752; [tina@intermountain.org](mailto:tina@intermountain.org)
- To request a training:  
Sami Butler, RN – Professional Relations  
(406) -457-4744; [samib@intermountain.org](mailto:samib@intermountain.org)

### Contacts (cont'd)

- For education questions:  
Dustin Shipman – Education Program Manager  
(406) 457-4755;  
[dustins@intermountain.org](mailto:dustins@intermountain.org)
- For clinical questions:  
Elizabeth Kohlstaedt, Ph.D. – Clinical Director  
(406)457-4754; [liz@intermountain.org](mailto:liz@intermountain.org)

### Resources

• Refer EqualityCare (Medicaid) insured clients to APS Healthcare- **Healthy Together!** program-Behavior Health and Medical Case Management

- Call toll-free 1.888.545.1710
- Visit our web site at [www.wyoming.apshealthcare.com](http://www.wyoming.apshealthcare.com)

### ATTACHMENT DISTURBANCE AND TRAUMA: Questions?

Elizabeth Kohlstaedt, Ph.D.  
Clinical Director,  
Intermountain  
Helena, MT

"Mr. Osborne, may I be excused? My brain is full."

### State of Wyoming Resource Sharing Open Discussion

- What resources are available in your community?
- Do you want to learn more to become a resource?