Attachment theory and attachment difficulties: supporting autistic children and young people in residential school settings

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Editorial comment

In this paper, the authors, Dr Felicity Hepper (a child and adolescent psychiatrist), Kathleen Bartlett (an assistant psychologist) and Mary-Clare Fearn (a music therapist) argue that some autistic children and young people who attend residential schools also have an attachment disorder and that their needs arising from attachment difficulties also need to be addressed. The paper is in three parts and starts by describing different attachment styles and then goes on to suggest how these might manifest in a child's behaviour and how staff might be supported to understand this. The final part makes suggestions on actions likely to help autistic children to feel secure in a residential school setting, especially when coping with daily transitions between staff and between home and school. The authors state their aim is to be a 'good-enough' in-loco parent with a positive regard for the child, providing warmth and encouragement. By liaising effectively with parents and other family members to understand the underlying reasons for some of the child's responses and actions, staff can then deal sensitively and appropriately to the challenges they face and the child will slowly develop their trust in others and feel secure in their attachments.

Introduction

As practitioners in a clinical team working in a group of residential schools for young people with autism and intellectual disability, we have noticed a trend in referrals for a school placement, which is an increasing number of children who have experienced early childhood adversity, bereavement, loss or inconsistent parenting and are deemed to have 'attachment difficulties'. We have had to consider how to adapt practice to take these children's histories and difficulties into account. While the literature on good autism practice informs the therapeutic approach and behavioural support at our schools, staff providing education and care in autism specialist schools do not necessarily receive training in Attachment Theory and attachment difficulties.

Faced with the increase in referrals of autistic children with a history of attachment difficulties we have considered the staff training and skill set needed to meet this cohort's needs. This paper draws from our reading of relevant literature, our discussions within our team and with colleagues working in this field and our experiences of setting up additional staff training and support for children who recently joined the school.

Aims of the paper

The aim of this paper is to consider how to adapt school practices and develop staff training and supervision structures to take into account the needs of children who have attachment difficulties, arising from early childhood adversity, as well as having autism and intellectual disability. The paper is divided into three parts. Part One is a theoretical overview of attachment theory and how it sits alongside a diagnosis of autism. Part Two considers the systems for staff training and supervision needed to expand the skill set of staff in a school primarily for autistic young people, when working with attachment disorder. Part Three contains some principles for improving 'attachment- informed care'.

Part one: overview of attachment theory

One of the things we have learned in our residential schools from the Covid-19 pandemic 'lockdown' is the importance of young people's relationships with parents, and the importance of regular communication with them for their emotional wellbeing and security. *Bowlby's Attachment Theory* describes the development of the special bond that children form with their primary caregiver (Bowlby, 1982). Babies are dependent on the physical and emotional availability of the adults who take care of them. When a baby needs something, the caregiver responds to their cry and attends to the need. The adult who responds most frequently to these needs becomes extremely important and the child forms a preferential 'attachment' to them.

Different types of attachment style

Ainsworth et al (1978) described different types of attachment style observed in behavioural experiments where 12 to 18 month old babies were briefly separated from their primary caregiver and then reunited. Two main categories were observed: Secure Attachment and Insecure Attachment patterns, the latter having two variants (Insecure Avoidant and Insecure Resistant).

Secure Attachment

Young children who were classified as showing Secure Attachment played happily when their caregiver was present, protested when they left and went to them for comfort on their return. A Secure Attachment is possible when the primary caregiver is available in a consistent and reliable enough way. The primary caregiver has the emotional capacity to be attuned to their baby enough to understand their baby's needs, to know how to soothe their baby, and how to provide comfort and care. When the primary caregiver understands the baby and meets their needs, the baby feels safe and learns to trust.

Insecure-Avoidant Attachment

Children with an Insecure-Avoidant pattern of attachment showed little distress at separation, tended to avoid contact with the caregiver on return, and appeared not to discriminate markedly in their behaviour between a stranger and the caregiver.

Insecure-Resistant Attachment

Children with an Insecure-Resistant pattern of attachment showed extreme distress when separated from their caregiver, but rejected efforts to comfort them on reunion.

Subsequently, Main and Solomon (1986) identified a more disrupted attachment pattern called Disorganised Attachment. When separated from their caregiver, children with this attachment style switched between ambivalence, resistance and avoidance as they appeared confused and angry.

An Insecure Attachment forms when the primary carer is not consistently available (eg if they are preoccupied with their own emotional problems or stress). In these circumstances, the baby's strategies to get their caregiver's attention may include becoming more 'clingy', or the opposite, detaching from their caregiver into their own world and self-soothing. These children may have less understanding of their own emotions and as a consequence, show more extreme emotional reactions which are difficult to console.

Having an Insecure Attachment style is not necessarily maladaptive. It may be the most successful way of optimising care from a parent who finds it hard to tolerate the child's distress. However, children with an Insecure Attachment do not have a 'secure base' from which they can explore the world and generally have higher rates of emotional problems in later life than those with secure attachments.

Factors which affect the quality of attachment

The attachment pattern of behaviour between child and caregiver at 12 months is not fixed for life. While children who have Secure Attachments are more likely to maintain this model of relating into adult life, children with Insecure Attachments can develop more 'secure' patterns of attachment behaviour when they have input from other key people in their life who provide emotional attunement and consistent care.

The quality of the attachment is affected by child factors and caregiver factors. Having autism does not prevent children forming attachments with their primary caregivers, however, attachment formation may be affected in autistic children who have also experienced early adversity of maltreatment and/or neglect. Maltreatment and neglect affect the 'hard-wiring' of the limbic and cortical structures, which are linked to facial recognition and emotional regulation (Sivaratnam et al, 2015), processes that are some of the 'building blocks' for attachment formation.

In the typically developing population, approximately two thirds of babies show a Secure Attachment pattern of behaviour and a third an Insecure Attachment pattern. However, in children with autism there is a higher proportion of Insecure versus Secure attachment (Sivaratnam et al 2015).

Implications of attachment difficulties for autistic children and young people in residential schools

What does this mean for children in our care who have autism in addition to early adverse experiences or developmental trauma? Behavioural presentations associated with autism and from the experience of maltreatment and neglect may appear similar, but there are differences in the function and meaning of the behaviours.

In an autism specialist residential school, this can lead to staff feeling confused when trying to make sense of a child's behaviour and emotions. For example, autistic children and children who have developmental trauma may both find staff absence triggers anxiety, but for different reasons, with different solutions needed. For autistic children, a staff member not being on shift might be difficult because it is a change from the expected routine, and may be ameliorated by visual aids to depict who is working with the child that day and when the preferred member of staff is back on shift. A child who has experienced inconsistent or neglectful parenting may find the absence of a preferred staff member difficult because they fear being abandoned.

Children project their expectations of how their needs will be understood and met onto the staff caring for them, based on their primary carer relationship. The child who expects abandonment, punishment or abuse may test the staff to see if they too will repeat the abandonment, punishment or abuse. This inability to trust and the testing behaviours that accompany it can be emotionally wearing to staff and work against the best interests of the child. Ultimately placements can breakdown if staff do not have the skills and emotional resilience to understand and address the child's behaviour. The next section discusses staff training and supervision requirements when supporting children who have attachment difficulties.

Part two: staff training and supervision

Autistic children who also have developmental trauma can benefit from 'therapeutic parenting' which uses techniques to nurture secure attachments and to develop trust in others (Steele and Malchiodi, 2012). We suggest that staff need training in Attachment theory and in understanding therapeutic parenting principles and techniques, such as Dyadic Developmental Psychotherapy (Golding and Hughes, 2019).

Weekly group supervision sessions for staff

Furthermore, we propose that there is ongoing weekly group supervision, delivered by a qualified psychologist or psychotherapist with experience in working with children and young people with attachment difficulties. There are three key reasons for these group sessions.

Making sense of what happens

First, this is to get 'the basics' right: developing self awareness or 'mind mindedness', self regulation and care, so that staff are emotionally available to tune into the child in their care. Staff supervision can help to make sense of what is going on and is informative and reassuring for staff. It can address emotions that arise from the child's distress. Small groups may support staff to feel they can be open and honest about their own feelings in relation to caring for someone with developmental trauma.

Testing behaviour and splitting behaviour by the child

Secondly, because children who have experienced trauma and have attachment difficulties are likely to have difficulties in trusting people, they are more likely to engage in 'testing behaviour' and 'splitting behaviour', where the strength and resilience of staff is challenged and safe boundaries are compromised (Hughes et al, 2019). 'Splitting' is an ego defence of keeping apart the 'good' and 'bad' aspects of people because it is too distressing to tolerate the idea that a 'good' person may have 'bad' aspects, or may let you down. This leads to idealising some people and denigrating others. 'Splitting' can have a significant impact on the team around the child and how the team works together. Psychotherapeutic supervision is a place to process these feelings and make sense of why they are happening. At the extreme end of 'testing' are allegations made against staff.

Any allegation needs to be taken seriously and investigated with the safeguarding of the young person paramount. However, allegations are disturbing and anxiety provoking for staff. Moreover, they may lead to staff being moved away from working with the young person, repeating the loss of a significant caring relationship. An example of this occurred in the case of a young person we were working with. When in a highly anxious state, they sometimes falsely accused staff of having hurt them. This led to the immediate removal of the adult carer while the matter was investigated. Such abrupt disappearances of favoured and trusted adults, has the potential to revive previous experiences of abandonment that had occurred in the child's life when significant adults suddenly died or left the family home.

Supporting the child's individual therapy

The third reason for weekly supervision is to support the child's individual therapy. Once the child is settled in school and has formed relationships with staff, children with a history of maltreatment or neglect will benefit from therapeutic work to help make sense of their life experiences and to process trauma. This is when the staff team need supervision as they will provide the secure base for the child who may become more emotionally distressed as they explore their past.

Traumatising experiences are difficult for children to process as they often do not have a full understanding of what is happening to them, or why it is wrong. This can be confusing for the child as they grow up and try to process what has happened. Life story work (Fahlberg, 1991) can help the child to process their own story and understand why some things might trigger certain emotions. Psychotherapy or arts therapies such as music therapy can help the child build trust and feel secure enough to be in contact with their feelings and learn how to communicate these, make sense of them and regulate them. However, it is important that any psychotherapy only starts when the young person has a secure, resilient, contained 'parental team' established around them, able to 'hold a safe psychological space' for the young person between psychotherapy sessions.

Part three: suggested tools for incorporating attachment informed care when working with young autistic people in residential settings

This section gives details of some of the ways we have been adapting usual practice, to incorporate awareness of attachment theory and the impact of developmental trauma into the well established good autism practice in a residential school for autistic children. We suggest these principles are useful for all young people, whether or not there is a known history of trauma. The very act of coming into residential care is a major separation from family and home, involving significant losses. However, for children who have experienced early adversity, mistreatment and loss, these principles offer ways to improve 'therapeutic parenting' and to foster a child's ability to develop more secure attachments while at school.

Pre-admission and assessment process

The pre-admission and assessment process is an opportunity to obtain background information about the young person relevant to attachment. Clear information about early adverse experiences is crucial for creating a formulation of the child's presenting difficulties to share with the team around the young person. Information needs to include:

- details of alternative care arrangements and relationships with carers if the child has been 'looked after', a history of neglect or abuse and what support and interventions have been provided
- a history of parental mental illness or substance misuse
- school history including any adverse experiences (eg bullying, abuse, episodes of intentionally or unintentionally harsh or frightening care from teaching staff, exclusions, breakdowns of placement)
- bereavements, separations, loss of key people in their lives (eg carers, teachers, friends and family)

In addition to a chronology of adverse events, questions to elicit an understanding of the child's way of relating to primary caregivers could include how the young person seeks comfort and reassurance, and what soothes them. Knowing what they enjoy and what their favourite objects and activities are, is also crucial.

First day at the school

When a child arrives, it is important to imagine what they need to know in order to feel safe and cared for: who is their carer; who they go to for help, comfort, and safety; when will they see their parents/carers; when will they go home; and who are they, now they are separated from their family and home?

We suggest:

- Having an identified person who is the 'special relationship' (explained in more detail below)
- Having a clear, visual, plan for contact with parents/carers – telephone, video calls and visits, and if there is a plan to go home
- Their room needs to reflect their autobiography – it may be that they like things minimal but in that case a book, or DVD or a box of favourite objects can be kept
- That parents/ carers prepare an autobiographical account of the child's life so far, using the medium of their choice that incorporates photos. It could include a DVD or a 'Memory Box' (it is a visual, preferably also tactile aid to supporting a child to maintain their sense of self and identity)
- That the autobiography also includes a 'sound autobiography', containing a list of songs/pieces of music that the child enjoys and benefits the child. Certain pieces may help with transitions, certain pieces may be relaxing, and other pieces may be purely enjoyable. These pieces can be included in their transition to allow for familiarity and continuity. Sounds from home can also support cultural identity (songs in the language spoken in the home, radio of the child's home language can support the child in the sense of 'who they are').
- That whatever form their autobiography takes, this will continue throughout their school journey during which there may be many transitions to navigate, including the ultimate transition of leaving. (The person with the special relationship could be responsible for continuing and building up the autobiography in liaison with parents and other key people involved with the young person)

Special designated person

It is important in trauma recovery to value the healing potential of special relationships rather than trying to treat every caregiver the same. The child should have an identified person with whom they have a 'special relationship', who knows their likes/dislikes, favourite things, how they express emotions, seek comfort and what makes them feel secure (Furnivall, 2011). This relationship will help to establish positive attachment and improve the child's interpersonal skills.

This person could be a member of care staff, for example, a key worker, house manager or deputy house manager. It is their responsibility to be attuned to the child's needs. They can have intentional, meaningful interactions, to work on attunement such as making time for play, building trust and rapport through fun and enjoyable activities.

This relationship needs to be as consistent and constant as possible, therefore, maintaining the relationship when the staff member is not on duty is imperative. There are a number of tools that can be helpful with this (eg a calendar countdown as to when the staff will be back; a photo of the staff member that the child can hold on to; and having a 'post box' where the child can post their caregiver notes or letters when they are absent).

Regular talking time

Schedule regular 'talking time' between the child and their special person. This should be done in a structured way that focuses on emotional labelling and coping, setting goals and problem solving. This can also be a good time to debrief the week's events. This talking time will help to build a trusting relationship between the child and their special person.

Consistency

Consistency is paramount to developing emotional security. It can be difficult to foster secure relationships in residential care as care staff necessarily come on and off shift, creating unpredictability for the child. A 'who is here today' board, displaying the pictures and names of staff can help with this, with 'now' and 'next' sections to provide predictability. It should be made clear to the child each day who they are working with. Staff going off shift must ensure that they take proper time to say goodbye to the child and inform them of when they expect to see them again. Staff going on annual leave should prepare the child in advance with appropriate visual aids such as a holiday chart or calendar, and explain why they are going away, and that they will be back. It should not be underestimated that even short breaks, where the staff supporting a child, swaps with another member of staff for a break, can cause anxiety. Communicating what is happening and when the preferred or planned staff member will return acknowledges the need for security the young person may have. Of course, there will always be the chance of disruption to staff's schedules. In these cases, another staff member should explain these changes to the child.

Use of language

Care needs to be taken with the use of 'abandonment type' language. Avoid words such as 'leave' or 'go away'. For example, if X is hitting out at Y, instead of saying, If X doesn't stop hitting, then Y will leave", say, "Y would like X to stop hitting her so that she can stay". Paying attention to the language that is used and knowing the words that seem to trigger strong and adverse reactions in the child is very important. Some children do not like adults to use certain words as they have a specific meaning for the child and/or they are associated with a bad experience and it is important to know which words these are and to avoid using them.

Touch

If a child has experienced abuse, what may seem like a comforting or caring gesture can be scary for the child. On the other hand, physical touch can be soothing and grounding when used correctly. The child's responses to different types of touch need to be established to inform staff actions. All physical touch needs to be carefully thought about, including in sensory programmes, intimate care and physical support when a child is threatening to harm themselves or others. Social workers, parents and the therapy team should have a discussion involving the child, where possible, about what type of touch the child prefers and dislikes. Agreed forms of touch need to have a purpose and be explained to the child. It is imperative that the concept of consent be discussed with the child

at a developmentally appropriate level. Explaining to a child and teaching them to say No, or Stop, at any point, gives them agency over their own body. It encourages trust and respect.

Debriefing after witnessing distressing incidents

Children who have witnessed aggression may be hyper vigilant and distrusting, leading them to misread social and emotional cues. They may mistake another child's positive vocalisation, as aggression. Equally, if they witness another child having a meltdown, this can be triggering and upsetting. It is extremely important to debrief any child who witnesses a distressing incident. The child needs help to communicate their emotions, and staff need to explain the situation and reassure them that they are now safe.

Contact with parents/carers

All staff should be very clear as to when visits from parents and visits home are happening, and what this entails for the child. It is important to give certainty and not to say that they 'might' see their parents soon. Visits require extra thought for children who have experienced separation and loss. They may be worried that that the people who are leaving them at the school will not come back. Having a visual calendar to mark up the next visit is helpful for those children who can understand this. Visits home also need careful preparation, so the child knows where they are going, when they will return, and when they will see the staff and other young people again.

Major transitions

Children who have experienced significant loss are more sensitive than others to further loss (Furnivall, 2011). Children who struggle to trust feel more anxious when they lose their 'trusted person'. Major transitions such as coming to school for the first time, returning after holidays, changing classes, changing houses, staff or pupils leaving, or the conclusion of a school placement, are all significant transitions that need careful management to avoid repeating traumatic loss. How to manage such transitions will depend on the child, but key points to consider include:

How is the transition communicated to the child? (ie consider the timing, the rationale and a plan for staying in touch with those they are leaving)

- How can the child take positive memories with them? (eg gifts, pictures, photobooks, and Social Stories can all work)
- How is the child supported to say goodbye?
- How is the child 'debriefed' and supported with feelings of loss, sadness, anger, and anxiety?
- How is key information passed on to the next setting?

Concluding comments

The referrals of young people for residential specialist schooling are increasingly including autistic children and young people who have also experienced adverse childhood experiences, trauma, neglect or abuse. These factors complicate their mental health and emotional regulation and can result in behaviours that lead to the breakdown of school and home placements.

Having an understanding of attachment theory and how attachment can be affected by a child's early experiences is vital to support traumatised children. We want them to feel secure so that they can begin to recover developmentally and emotionally. Unless positive relationships are developed, their trauma of disrupted relationships may be repeated. The aim is to be a 'good-enough' in-loco parent with a positive regard for the child, providing warmth and encouragement, understanding their communications and being able to implement firm, fair boundaries.

In this paper, we have suggested ways of supporting both the children and the staff. These principles can be extended for all children at residential schools to foster security and mitigate against the separation and loss inherent in the residential education system.

References

Ainsworth, M D S, Blehar, M C, Waters, E and Wall, S (1978) Patterns of attachment: a psychological study of the strange situation Hillsdale, N J, New York: Lawrence Erlbaum Associates.

Bowlby, J (1982) Attachment and loss: retrospect and prospect American Journal of Orthopsychiatry, 52 (4) 664–678.

Fahlberg, V (1991) A Child's Journey through Placement British Agencies for Adoption and Fostering (BAAF): London.

Furnivall, J (2011) Attachment-informed practice with looked after children and young people The Institute for Research and Innovation in Social Services (Iriss) Insight 10 Scotland available from: www.iriss.org.uk/resources/insights/attachment-informed-practice-looked-after-children-young-people.

Golding K S and Hughes D A (2019) Healing relational trauma with attachment focussed interventions: dyadic developmental psychotherapy with children and families New York: W Norton and Co.

Hughes D, Golding K and Hudson J (2019) Healing relational trauma with attachment focussed interventions: dyadic developmental psychotherapy with children and families (155) New York: W Norton and Co.

Main, M and Solomon, J (1986) Discovery of a new, insecure-disorganized/disoriented attachment pattern In M. Yogman and T B Brazelton (eds) Affective development in infancy (95–124) New Jersey: Norwood.

Sivaratnam, C et al (2015) Attachment and emotion processing in children with autism spectrum disorders: neurobiological, neuroendocrine and neurocognitive considerations Journal of Autism and Developmental Disorders (2) 222–242.

Steele, W and Malchiodi, C A (2012) Trauma-informed practices with children and adolescents New York: Routledge.