Attachment Disorders:
Implications for Child Welfare Practice

Sonia Russell

This paper addresses a number of issues relating to welfare planning for children with serious disorders of attachment, including problems in relation to natural families, implications for caregivers of behavioural aspects of attachment disorders, and difficulties in implementing 'permanency planning' principles. Historical trends and cycles in policy formulation are referred to, and some suggestions are made with regard to directions for treatment and future planning of services.

On reading the paper by Christine Zsizsmann, Chatra Weerasinghe, and Noelle Belcher **'Under-socialized Conduct and Attachment Disorders: A Child psychiatric team experience with a developmental and systems approach' (*Children Australia* Volume 16 (2) 1991)** I have been encouraged to respond with some comments based on my experience of working for some twenty-five years as a clinical psychologist in the field of child welfare. Much of this work has occurred within residential care settings for children and has involved planning for children in terms of options such as family reunification, family substitute care, adoption, and long term professional care. The group of children described by the Travancore team in the above-mentioned paper has certainly occupied a great deal of the time and energies of care-givers and case planners in the statutory arena and is likely to continue to do so. In this paper, I will present some case material and some observations from my experience which may hopefully contribute to the very difficult area of permanency planning for these children.

Zsizsmann et al. have described in detail a clinical pattern of disturbed caregiving in the first year of a child's life with consequent failure of the child to develop trust in adults and a secure sense of self. As this pattern continues there is a lack of internalisation of secure adult controls and the child exhibits a range of out of control behaviours and emotions which increasingly test the skills and patience of caregivers and educators. These children appear to lack the capacity for reciprocity in relationships, responsiveness to teaching by adults, conscience development, and they do not respond as other children to the normal processes of socialisation. Unfortunately, as the Travancore team has stated, neither do they respond well to traditional therapies, and attempts to address the problems at the level at which they developed, ie. in the first year of life imply rather radical treatment strategies.

Natural Families

One of the obvious difficulties in the area of case planning for these children is the fact that the natural family context is likely to be problematic in a number of ways. It is frequently the case that the children's parents have received poor parenting themselves, and relationships between them as parenting couples are often transitory and violent. Workers involved will often conclude that this current 'family' is unlikely to be able to care for the child adequately, let alone cope with the special demands and needs which emerge as the child gets older. However it can be very difficult to make a clear decision that permanency planning will be implemented by placing the child away from the family.

While it is generally acknowledged that there is a clear relationship between a number of risk factors in disturbed family situations (such as personality disorder in parents, overt family violence, numerous separations etc.) and a negative outcome in terms of childrens' emotional adjustment (Wolkind and Rutter 1985) statutory intervention cannot necessarily follow. Action to remove children from the care of their parents can only be justified in terms of failure to meet minimum requirements for adequate care, not in terms of the most desirable standard of care which will meet the child's needs.

There is often a great deal of frustration expressed by professional workers closest to the child if there is prevarication, undue time delay due to consideration of parents' rights, and prolonged confusion as to what will be the final outcome of the case planning processes, and appeals. Sometimes if is difficult for workers at this stage to be both supportive of parents in their caregiving role, and mindful of what appear to be the best interests of the child.

If the decision is made that the child should be placed in an alternative form of permanent care, it is recommended by the Travancore team and by therapists sensitive to the issues of children coming to terms with separation and loss, that the parents should

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be part of a clear communication to the child that this is the plan. However the reality is, that in many cases, parents are not fully prepared to give up their rights as parents. Many have undoubtedly experienced the protective and therapeutic interventions of social workers in clarifying case plans as coercive, intrusive, and as imposing values in regard to family functioning which are not shared by the family themselves. In these circumstances it is unrealistic to expect parents to help their children come to terms with the fact that they must be relinquished by their own family on a permanent basis.

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It is to be hoped that the new legislation contained in the Victorian Children and Young Person's Act 1989, will give greater support to the permanency planning goal of avoiding indefinite 'welfare drift' for children, and I certainly agree that at some point it is necessary to act decisively in ensuring adequate guardianship provisions for children whose parents cannot provide this. It is also appropriate to counsel parents in relation to the best interests of themselves and their children. However it is naive to expect that these processes will not in some cases leave some unresolved conflict of interests, and be experienced as coercive by parents.

During the early 1970s when I became intensively involved in three residential care programmes specialising in the care of 'hard to place' children, the dominant belief was that there was a need to be extremely cautious in placing emotionally damaged children in substitute families. This was especially the case for children five years and older, who had memories of, and attachments to, their own parents. Conventional wisdom had it that it was important for these children to 'work through' the loss of these relationships before a further family placement could succeed. I believe that today many of these children would be diagnosed as having 'attachment disorders' and that the correct description is mostly not of a child who 'lacks attachment' but rather that the attachment behaviour manifested by the child can be described as ambivalent, superficial, egocentric and unreliable. The same could be said for the quality of the parent's attachment to the child. It could be argued that what is being described is not 'true attachment', but for practical purposes these idealisations do seem to have a bearing on subsequent attitudes towards caregivers, and the concept which the child has of him or herself and their place in the world. This is certainly confirmed by my direct experience in therapeutic play sessions with many children. In cases where children have memories of being cared for by parents in or after the third year of life, boys will frequently identify with fathers and girls with their mothers, however abusively or neglectfully they have been treated.

In my experience, the best way for children in this situation to come to terms with the realities of why they cannot again be cared for at home, has not been to arrange meetings with children, and perhaps family members as well, where these reasons are explained, but to allow some further direct experience of the realities of the care environment at home. If it then becomes clear that the reality is that the home environment is toxic to the development of the child, and ideally, if the parents then appreciate the real difficulties they have in caring for this child, there should be decisive action in the case planning arena to confirm a new direction for planning. At this point, the children will not be required to understand and believe what they are being told by adults, but will rather have formed their own opinions on the basis of reality testing.

However, if there are still unavoidable delays in case plan implementation, it is important to avoid further retesting of the situation at a later point if a new case worker cannot appreciate from the records the full significance of what happened previously. In practice this can occur again and again.

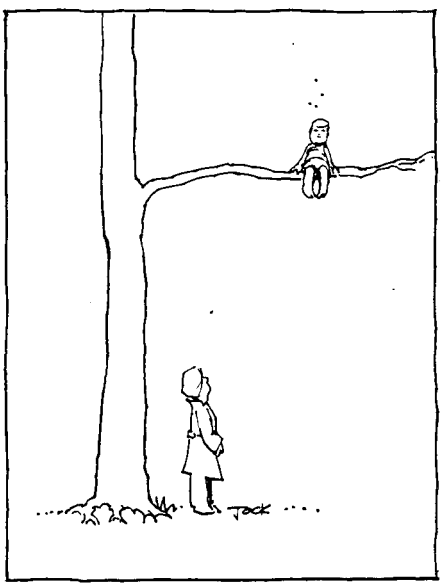
If the separation between the child and the parents has occurred at an earlier stage, before the third year of life, the quality of attachment behaviour seen in the child's relationship with adults generally is likely to be less idealising and more obviously indiscriminate, than is observed with older children who have some ambivalent attachment to natural parents. However, it has certainly emerged in a number of cases that parents who have consented to the removal of children at a very young age on a permanent basis, may have strong regrets about this, feelings of attachment to the child, and resentment regarding the processes which have occurred. Successful reunifications between such children and their parents, after several substitute family placements have been tried and failed, are not at all unknown. It seems unlikely that the exhortations of professionals for decisive action, once and for all, to completely rule out any future caring role for natural parents will ever be finally correct in every case (especially where the legal possibility of appeal remains).

Changing Fashions and Beliefs in Child Welfare

Several historians in the field of child welfare, (Howe and Swain 1989, Jaggs, 1991, Wolins M. and Piliavin, 1964) have emphasized that for the past century and a half, fashions and beliefs in the field of child welfare have changed in a cyclical pattern. Thus the emphasis has alternated between support for natural families, support for foster families and institutional solutions for the care of children in severely problematic family situations. Each generation discovers anew the reasons why the dominant solution espoused by the previous generation has not worked well for some children and families. Children with disorders of attachment, especially in the older age group have always posed a special challenge.

Following the period in the early seventies when there was a conservative approach to family placement of the more disturbed and older children, there was an abrupt change in the late seventies coinciding with the 'permanency planning' movement both in

Australia and overseas. Under newly established programs in Victoria, previously institutionalised children up to twelve years of age were placed in specially selected and trained families. While many 'special needs' placements have undoubtedly been highly successful, current practice seems to emphasise greater success in recruiting caregivers and making placements for preschool children, and much has been learned about the matching process between child and caregiver. The reality has been, and will continue to be that for a percentage of children 'permanency planning' means a series of foster care and adoptive placements, institutional placements, and some attempts at re-unification with natural families.



A further example of a striking shift in policy over the past two decades has been the move from active discouragement by the Victorian Social Welfare Department in the late 70s and early 80s of 'specific' applications by prospective foster parents, to the current approach that recognises that, in fact, the most successful placements of difficult older children are often made in families where there has been some existing caregiving relationship between the child and the family (personal communication, Special Needs Adoption worker). This again highlights the inherent difficulties both in making successful family placements for some children, and in making categorical prescriptions regarding practice guidelines. Both the above-mentioned policies were formulated on the basis of practice experience.

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Currently there is interest developing in Australia in a program which has originated in New Zealand under the title of Family Decision Making. This program actively encourages extended family members' participation in decision making regarding the custody of children where there are protective concerns in relation to care given by the immediate family (reported in CWAV Newsletter, vol 5 (3) 1990). Clearly there is nothing new about the practice of children being cared for in the extended family context, and there are undoubtedly difficulties with extended family placements which have been identified in the past. However, the notion that extended family members should be actively recruited to exercise responsibility for decision making with regard to children, and given legal support for this is an exciting new departure from recent practice, which promises new (and cost-effective) opportunities for abused and neglected children.

'Attachment disorder' - what does this mean for caregivers?

As mentioned above, in the context of relationships with natural parents, in my opinion, the term "lack of attachment" is misleading. Children from very abusive early backgrounds with the range of antisocial and disturbed behaviours enumerated by Foster Cline and the Travancore team do seem to become attached to particular caregivers. This involves intense proximity seeking, being clearly influenced by the opinions and directions of the caregiver, and certainly professing to the caregiver and others a highly idealised kind of attachment. However, the influence of the attachment object mostly fails to extend beyond the sphere of their immediate physical presence. Thus these are children whose behaviour will markedly deteriorate if the caregiver is on leave, and in situations outside the home such as at school.

It seems that the essential problem is not so much a lack of attachment as a lack of sustained and reliable trust in relationships with caregiving adults, and this in turn leads to poor internalisation of ideals and values, and poor socialisation generally. Thus the child may be demanding, exhibit low frustration tolerance, high levels of aggression, and a generally self-centred approach to living, especially when away from the direct influence of the containing caregiver.

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There is no doubt that a rostered staffing model has proved to be the most reliably stress free arrangement for caregivers. Even in well supported family group homes with married couples acting as caregivers in a community setting, there has in my experience very frequently sooner or later been a severe breach of trust between child and caregiver. These incidents have often been unexpected and highly disappointing to caregivers, and may have occurred after two or three years of apparently satisfactory relationships. Stealing from caregivers, or reporting negative information such as abusive care to others outside the agency are examples of such breaches of trust. These behaviours are of course frequently reported by foster and adoptive families as well.

Apart from severe breaches of trust as described above, there are other ways in which these children may be difficult

to live with. Typically they are restless, inconsequential and overactive, having poor comprehension of the need of adults for personal space. They are intensely demanding, and likely to be destructive of caregivers' personal property intentionally or unintentionally. They require constant supervision, especially in company with peers and may have difficulty settling to sleep. They are prone to intense emotional outbursts and may articulate very clearly the abuse, losses etc. that they have suffered.

Caregivers must be assertive in their approach to child management, and yet be accepting, tolerant and forgiving so that they do not become disturbed or outraged by bizarre, unpredictable and immature behaviours. These behaviours may feature more prominently in the initial stages of placement, but they may also persist for several years.

It is my strong opinion that, in general, there has been too little attention given to the needs, rights, and to realistic expectations of caregivers of severely disturbed children. In practical terms it is inexpedient to conduct child welfare services in this way, if only because of the loss of caregiving personnel due to burn-out, stress leave and retirement from the field. It also seems important for humanitarian reasons to at least recognise the cost which is incurred on caregivers and their families when things go seriously wrong, both in professional and voluntary care settings.

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Of course the care of children with attachment problems does bring its rewards, and I have been privileged to work with many outstanding and, in fact, inspiring caregivers who appear to have thoroughly enjoyed their role for most of the time. Whilst acknowledging the special difficulties and needs of the children in their care, these caregivers have accepted the children and related to them for by far the most part as normal, healthy and enjoyable individuals.

However, for most of these caregivers there have been one or two children for whom the decision has had to be made that it is time to move on, when the behaviour of the child has become uncontainable. This has in the long run often been a far more destructive process to the caregiver and their family, than to the child himself or herself.

Treatment Options: A Case Illustration – DAVID

This case illustrates the application of a cognitive behavioural approach to the management of difficult behaviour, which also had the aim of achieving some internalisation of values incompatible with uncontrolled aggressive behaviour and stealing. The aim of the program was to extend the influence of the caregiver to whom David was attached beyond her immediate sphere of influence, which is a typical problem in the care of children with attachment disorders.

Background

David was the fifth boy in his family. He was born prematurely and spent much of his first year in hospital. His father, a violent man, left the family and his mother had extreme difficulty in coping with the care of her five children. David was placed in foster care where he was described as a strange, unresponsive child. His mother was encouraged to sign consent forms for adoption when he was two years old, as she was living in a series of refuges and could barely cope with the care of the other four children. David was adopted by a childless couple. This placement ended when his adoptive mother suffered a 'nervous breakdown' due, in part, to the extreme antipathy which she claimed had developed between herself and David. He was aggressive towards pets and other children, disobedient, and lacked affection in his relationships with his parents.

In the residential setting, David, at the age of five, presented as a physically small, appealing little boy. He was wilfully destructive, disobedient, and aggressive to other children, especially when not directly under observation by a staff member. He stole objects continually and indiscriminately. These behaviours were accentuated in the kindergarten setting. It was said that David did not appear to learn from consequences, or to fear punishment.

David was cared for by a group of six rostered staff. After a few weeks a mutual attachment developed between David and the supervising worker, and his behaviour became generally reasonably contained in her presence. A cognitive-behavioural program focused on the modification of David's hitting behaviour and also his stealing behaviour was devised. This initially involved issuing David with a 'Playfighter's Certificate'. David greatly enjoyed rough play with staff and children but would very quickly inflict injury on others, appearing unaware of the need to avoid poking sticks into peoples' eyes, and other forms of dangerous assault. The certificate allowed for specified forms of play, and was withdrawn if there was any breach of a set of very clear rules for the conduct of 'playfighting'.

As clinical psychologist, I met regularly with David and his caregiver to review progress with the program, and to clarify continually his understanding of the rules and the reasons for them. A similar program was instituted addressing the issue of stealing. This began with a great deal of clarification with David and his caregiver of the definition of words such as stealing, borrowing, collecting, finding, picking up etc. David was encouraged to make legal as opposed to illegal collections of objects. Simple charts were used recording instances of all the above behaviours.

Over time, David became very proud of the fact that his Playfighter's Certificate was very rarely withdrawn, and he managed to retain it during a period when the supervising caregiver was on leave. However, we did find that unless continuous attention was given to the stealing program as well, this habit tended to return.

I believe that there is a definite role for behavioural interventions such as briefly described above in assisting children in placement where there are still major socialisation issues, but where there is a rudimentary attachment developing between the child

and the caregiver. Although such attachments can appear to be intense, as experience has shown, without extra attention to socialisation issues, the attachment itself cannot be expected to mediate instant conscience development.

Finally it should be mentioned that David was eventually successfully restored to the care of his natural mother. He was particularly delighted to be reunited with his four brothers, all of whom bear a striking physical resemblance to David. He now has two younger siblings.

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For the future, the following issues seem important.

1. That succeeding generations of practitioners do not continue the cycle of rediscovering 'new" solutions to the complex problems of planning care for children with attachment disorders, without being aware of the extent to which these solutions have been tried before, and of the likely associated problems. There needs to be some degree of trust and respect between generations of child welfare practitioners, as well as encouragement to each new generation to be innovative and clear- sighted in approaching current social problems.
2. Enthusiasm for policies in welfare practice which appear to be well supported by current social and psychological theories must be tempered with close observation of the realities of outcomes, and the effect on the broader social context. A relevant example is the need to be clearly aware of what is being asked of voluntary caregivers if foster care and adoption programs are expected to take on the major responsibility for long term out of home placement of children.
3. Research based on close observation is needed to further clarify the exact nature of children's behaviour disorders and the intervention strategies that are effective. Such studies should ideally encompass large samples of clients and controls, and include a longitudinal component.
4. After many years of work in this field I have reluctantly come to agree with the concept of the 'least deleterious solution' (Goldstein et el. 1973) as opposed to the 'optimal' solution in planning for children with serious attachment disorders. To some extent the ideals of continuity and permanency of care may have to be compromised in order to give the best possible service to some children. However I also believe that it is important for children to have adults in their lives who offer continuity of concern and responsibility, and that this role can sometimes be assumed by the staff of voluntary non-government agencies who have traditionally been involved in the provision of long term care.