Positive Solutions in Practice

Office of the Senior Practitioner

Attachment and Trauma in People with an Intellectual Disability | October 2008

The experience of trauma and attachment is a very important issue that impacts on many people with a disability. According to researchers, disability can increase one's vulnerability to abuse. For example children with any type of disability are 3.44 times more likely to be a victim of some type of abuse as compared to children without disabilities[1]. They also found that of all types of disability, children with behaviour disorders and children with intellectual disability were both at an increased risk for all three forms of abuse (neglect, physical and sexual abuse) compared to those children with other types of disabilities (speech/language, hearing impairments)[2]. Taken from these studies neglect is the most common form of abuse, followed by physical, sexual and emotional abuse.

In addition to this people with an intellectual disability have historically been subject to high levels of institutionalisation, often from childhood and well into old age. Studies have found that natural families present less risk of abuse for children than institutional alternatives[3]. If this is the case then people with an intellectual disability will be at much higher risk of experiencing some form of abuse whilst in institutional care.

As a result of this abuse many people with an intellectual disability will experience some form of associated trauma. Although some people with an intellectual disability may have difficulties reporting their trauma experiences (due to verbal communication difficulties), a change in their behaviour may indicate their distress, in addition to difficulties with interacting with other people whom they may no longer trust.

The consequences of abuse and traumatic experience can be devastating in the short and long term for anyone, particularly for people with an intellectual disability. The topic of attachment, trauma and interventions is highly pertinent and it is important therefore to enhance awareness of these issues across the disability service system, through specific education and training.

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[1] Sullivan, P., & Knutson, J. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect, 24* (10), 1257-1273.

[2] Sullivan, P., & Knutson, J. (1998). The association between child maltreatment and disabilities in a hospital-based epidemiological study. *Child Abuse & Neglect, 22* (4), 271-288.

[3] Rindfleisch, N., & Rabb, J. (1998). How much of a problem is residential maltreatment in child welfare institutions. *Child Abuse & Neglect, 8* (1), 33-40.

What is Attachment?

We are all born with the need and ability to form an attachment (close relationship or bond) to others, because this is what protects us from danger (provides safety) and assists us in obtaining the necessities of life (food and shelter). For example, a new born infant forms a strong bond with their mother because their mother is usually the initial primary source of their food and comfort. This means that infants will seek to maintain closeness with their mother who is available to the infant and aware of what the infant wants (i.e. knows when the baby is hungry, tired or uncomfortable).

The concept of Attachment

A young child will try to maintain closeness (proximity maintenance) to their mother or primary carer because it makes them feel secure and safe. When they are separated they often get upset and distressed (separation distress – like when a child is dropped off by their parent for the first day of school) because they no longer have their 'safe haven' readily available. The greater the feeling of safety with someone the more a child will explore their environment, to return at times of need. For example a child will go and play with toys and other children but will return immediately to their primary carer/attachment figure if they become frightened or are hurt. Once they are calm again they have the confidence to leave their primary carer (secure base and safe haven) and venture out into their environment for further play.

Other types of Attachment

Infants and other people in their lives (like their fathers or other primary carers) will also make close attachments with each other. These attachments to others are made throughout life as an infant develops into eventual adulthood. For example a child may make close relationships with their carer at day-care, an adolescent develops close bonds with peers at school and adults develop romantic relationships.

Why are Attachment experiences so important?

It is the primary carer-child attachment experience that sets the scene for all subsequent relationships that a child will develop in the future. Studies have found that children who have experienced early problems with bonding with their primary carer can go on to develop a variety of physical, emotional and social problems[4].

What factors can disrupt Attachment?

Early life experiences that can disrupt the bonding between a child and primary carer can include neglect, abuse, inconsistent parenting and other significant life stressors or trauma (i.e. institutionalisation, loss of a primary carer, frequent changes in caregivers, serious illness).

What happens if Attachment is disrupted?

When a child is prevented from developing their first relationship normally they will develop a particular set of thoughts, feelings and behaviours that will influence how they interact with others (make attachments) and also how they think about themselves, other people and the world around them. This set of thoughts, feelings and behaviours is referred to as an internal working model.

Internal Working Models

If a child has experienced negative attachment to their primary carer they are likely to develop traumatic internal beliefs about themselves, others and the world. This will impact upon their ability to maintain attention, interpret information, manage their own behaviour and regulate their emotions[5]. Of note is that we are usually unaware of our own internal working model and therefore not aware of why we interact with people in particular ways.

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[4] Levy, T.M., & Orlans, M. (1998). *Attachment Trauma & Healing: Understanding and Treating Attachment Disorder in Children and Families.* Washington (DC): CWLA Press.

[5] Levy, T.M., & Orlans, M. (1998). *Attachment Trauma & Healing: Understanding and Treating Attachment Disorder in Children and Families*. Washington (DC): CWLA Press.

The critical periods for forming Attachments

The most critical developmental period is between birth and the age of 3 because 90% of the brain has developed by this time[6]. Childhood is therefore a very important period in the development of attachment patterns or styles of relating to other people. The most important thing to remember is that early life experiences, particularly the types of relationships we form with significant others, sets the scene for later life.

Children and adolescents who are not able to successfully develop a good relationship with their first main caregiver have essentially learnt that they can't rely on others to look after them and are more likely to be placed into out of home care due to a range of behaviours of concern (i.e. breaking rules, physically aggressive towards carers) and emotional difficulties[7].

What sort of Attachment patterns or styles are there?

In studies of attachment styles of community samples of middle class families the majority of people have a secure attachment style[8 9]. The rest fall into three categories of insecure attachment styles; Avoidant, Anxious and Disorganised. Each insecure style has overlapping descriptive categories which are reported here in brackets.

Secure Attachment

People with a secure attachment style are usually confident when interacting with others in social situations, they think positively about themselves, can function independently and are good at expressing and managing their feelings.[10] Those with *insecure* attachment can display certain characteristics within three different styles.

Insecure Attachment [11 12]

1. *Avoidant (Dismissing)* – think positively about themselves but have a negative view of the world and those around them. They tend to avoid help seeking behaviours and are dismissive of any strong emotionally involved relationships. They may avoid social interactions. They also experience low levels of anxiety because of their high self esteem (positive view of self and negative view of others).
2. *Anxious (Ambivalent/Preoccupied/Resistant)* – think negatively about themselves but tend to think that other people are good. Because of these views they lack confidence in their own abilities to cope with problems without assistance from others, which may include wanting others to make decisions for them. They can be preoccupied with relationships. They can express their emotions but are poor at managing their feelings. They tend to be highly anxious when interacting with others (negative view of self, positive view of others).
3. *Fearful (Disorganised/Disorientated/Unresolved)* – they have a negative view of themselves and others, low self confidence, fear being rejected by others and are unable to adequately express how they are feeling. They are highly anxious when around others so tend to avoid social situations (negative view of self and negative view of others).

People with an insecure attachment style, may exhibit a range of behaviours of concern and problematic ways of interacting with those around them. It is important to remember that they may have developed a 'traumatic' belief about themselves, other people and their environment that influences their relationships, feelings and interactions. They are also not aware of why they feel or act in the way they do.

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[6] Perry, B. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The neurosequential model of therapeutics. In Nancy Boyd (Ed), *Working with Traumatized Youth in Child Welfare*. New York: Guilford Press.

[7] O'Niell, C. (2000). Adoption, permanent care and foster care: Home-based care in and beyond the 1990's. *Journal of Paediatric and Child Health, 36*, 415-417.

[8] Ainsworth, M.D.S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, NJ: Lawrence Erlbaum.

[9] Main, M., & Soloman, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. T. Greenberg, D. Cichetti, & E. M. Cummings (Eds), *Attachment in the Preschool Years: Theory, Research, and Intervention* (pp. 121-160). Chicago and London: University of Chicago Press.

[10] Bartholomew, K., & Horowitz, L.M. (1991). Attachment styles among adults: A test of a four category model. *Journal of Personality and Social Psychology, 61*, 226-244.

[11] Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships, 7,* 147-178.

[12] Brennan, K.A., Clark, C.L., & Shaver, P.R. (1998). Self report measurement of adult attachment.. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment Theory and Close Relationships* (pp. 46-76). New York: Guilford Press.

How does trauma impact upon attachment?

Trauma can be a physical, emotional or psychological experience resulting from an extremely stressful and/or life threatening situation. The traumatic event can affect someone's ability to cope with stress and make them feel overwhelmed. The negative effects may not occur immediately but can be delayed by weeks or even years. People can also react differently to the same event and therefore may not be traumatised by the same situation.

For people who do not have an intellectual disability it is easier to understand why something distressing may have happened, in addition to deciding how best to cope with the situation. For someone with an intellectual disability their ability to fully understand why something may have happened, the consequences for themselves and others and also engaging in decision making or problem solving around the use of coping strategies to assist them in dealing with the stress or trauma may be compromised. Therefore what someone with an intellectual disability perceives as traumatic may not be as stressful for someone without an intellectual disability.

Dr Bruce Perry, a Neuropsychiatrist from the United States, has conducted a substantial amount of work in relation to the brain development of mistreated and traumatised children[13]. Dr Perry found that children who have been traumatised can not think, remember or problem-solve in the same way as children who were not traumatised. He has also highlighted that the brain of someone who has experienced trauma during key developmental periods, will automatically use the more basic areas of their brain. This means they will use more reactive 'flight or fight' (run or fight to protect themselves) areas of the brain, rather than more complex areas that use thinking, problem solving and emotional regulation.

Example: Someone who has been abused as a child might be very sensitive to interactions with others as an adult, because they are fearful of other people hurting them. They may be fearful of people even in situations in which they do not need to be scared. Their brain will react from the lower levels of the brain, so they may either run away or fight the person (flight or fight response) or in some cases tune out or withdraw into themselves (dissociate). These people are constantly in a state of fear even in normal situations and will react without using the higher areas of the brain that usually assist us with problem solving, managing our emotions and verbal communication.

What might this mean for someone with an intellectual disability who has previously experienced some form of trauma or significant loss during the development period? They are likely to behave in an immature manner in situations where they feel that their personal safety is threatened (even in situations in which they have no reason to be fearful). This means that the less complex areas of the brain will be functioning, causing them to be reactive and emotional. Essentially they will revert to behaving at a developmental level that does not match their chronological age or expected emotional level.

Example: Terry

Terry was physically abused when he was a child and now he gets scared if he hears someone yelling. That is, Terry may misread the person's tone of voice and body language as a potential threat and become fearful. He might suddenly lash out aggressively as part of an automatic response to keep himself safe.

[13] Perry, B. (2004). *Maltreatment and the developing child: How early childhood experience shapes child and culture*. The Margaret McCain Lecture Series. London: The Centre for Children and Families in the Justice System.

Why is it that not all people who have experienced trauma exhibit behaviours of concern or have problems interacting with others?

Not all people who have experienced trauma go on to develop significant or long term attachment problems. A number of studies focusing on "resiliency" (the ability to 'bounce back' from difficult life experiences), have found that there are some particular protective factors that help them recover from stressful or traumatic experiences.

These protective factors include sociability, intelligence, communication skills and confidence, other relationships within a family, the family's ability to provide emotional support during times of stress and the community supports available to them (i.e. school, church, accepting community).[14]

What can we do to help support someone with an intellectual disability who has experienced trauma and has difficulties making healthy attachments to others?

The way that someone views themselves, other people and the world around them (their internal working model) is not set in concrete, it can change. For someone with difficulties making healthy relationships with others this will mean they need to experience an ongoing positive relationship that is accepting and different to their previous experiences.

In residential and other day to day support settings staff play a key role in positively influencing the person's daily experiences. This means that support workers can provide a 'secure' attachment relationship. It is important that staff can respond sensitively to the needs of the person with an intellectual disability. In addition they need to ensure that residential and other environments are safe, predictable and promote development and exploration.[15]

It is important that staff are aware and know about any traumatic experiences that may have occurred in someone's life. For someone with an intellectual disability this may include multiple caregivers, institutionalisation, loss of a carer and sudden changes to environment or routine.

The best ways to help a person who has been traumatised in the past include:

- Sensory activities (touch, hear, taste, smell and sight),
- Movement activities (moving the body like going for a walk) and slow patterns of movement involving concentration (like drawing, painting or puzzles).

So if someone reacts aggressively towards others or does not respond to verbal re-directions, helping them to focus on something using one of their senses or supporting them in going for a walk (*motor*) may de-escalate their behaviour. A good analysis of the function of the behaviour (FBA[16]) in addition to a sensory assessment (please contact the OSP for further information about sensory assessments) would also need to be done prior to choosing appropriate strategies.

Getting the person with an intellectual disability to understand the reasons why they are acting in a particular way towards others is not helpful; remember people are often not aware of their own beliefs about themselves, others and the world around them.

Remember that if an adult with an intellectual disability is acting in a way that is at a lower emotional level than their actual age, you will need to match your interactions and responses to their appropriate functioning level. This does not mean that you should treat them like a child. It means that they may not be able to use the more complicated areas of their brain that use thinking, decision making, problem solving and emotional regulation, so talking to them is unlikely to be effective while they are presenting in this way. Sensory or movement activities may be more effective in assisting them to calm down. Once calmer, they will be able to engage in verbal communcation.

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[14] Werner, E., & Smith, R. (1992). *Overcoming the Odds: High-Risk Children from Birth to Adulthood*. New York: Cornell University Press.

[15] De Schipper, C.J., Stolk, J., & Schuengel, C. (2006). Professional caretakers as attachment figures in day care centres for children with intellectual disabilities and behaviour problems. *Research in Developmental Disabilities, 27*, 203-216.

[16] OSP Positive Solutions in Practice. *Getting It Right From the Start: The Value of Good Assessment*. Issue No. 3, 2008. www.dhs.vic.gov.au/ds/osp

Case example: John

John is a 35 year old male with a mild level of intellectual disability who was physically abused as a child by his parents. He has since lived in several residential placements, which have all broken down because of his tendency to become very angry and hit out at others when he is stopped from doing something that he wants to do. Staff used to try to talk to John and remind him to use his anger management strategies. This would usually end up in John pacing around the room and then throwing himself on the floor where he would proceed to repeatedly hit his head against the floor. After a functional behaviour assessment, staff found that John's favourite music and bean bag made him relax. With this approach the aggressive outburst would quickly stop and he would return to a state in which he could verbally interact with staff again. Once he could verbally interact again, staff would review the sensory strategies with John ready for the next time he became angry.

Carers or staff could also assist the person with an intellectual disability to make their own choices and gain a sense of control and ownership over things within their immediate environment. This might simply mean that they get to decorate or paint their bedroom.

Case example: John

In the case of John, instead of telling him what the consequences of his aggressive behaviour towards others will be (i.e. restrictive interventions or loss of privileges) he could be given alternative choices of things to engage in such as giving him the choice to relax in his bean bag or go outside into the garden for a walk.

We may also gain ideas of particular factors that are impacting upon the person's ongoing attachment difficulties through observation of the ways in which the person is interacting with others. For example they may not know how to start or maintain a conversation with someone, have a poor understanding of personal space, lack basic problem solving or decision making strategies or have limited relaxation strategies. They may simply never have had a good role model to learn these types of basic skills. These skills can be taught either in a formal intervention or through daily role modelling and positive reinforcement for appropriate behaviour.

Case example: John

In the time leading up to John's aggressive outbursts he was observed to get red in the face and started breathing in a very short and fast manner. He was taught to identify this warning sign and use a slow breathing technique. He was also assisted with decision making strategies, such as telling staff he needed to go to his room to calm down before he got too frustrated.

One of the most important things for support staff to take notice of is how they themselves react to the person with an intellectual disability particularly when they are displaying behaviours of concern or they are 'just being difficult'. We can accidentally fall into the trap of reinforcing the person's unhelpful views of self, others and the world and strengthen their attachment problems in the way that we respond to them. This happens frequently when people have many different services involved in providing support (i.e. Disability Services, Mental Health, Day Placement, and Accommodation Services).

The development of attachment skills might initially begin by the development of an attachment to a pet. This involves taking care of the pet, giving them attention and learning how to interact appropriately with them. Once the person has successfully done this they could be assisted to progressively attach to a key support person.

Case example:

Recent developments in the United Kingdom have found that some people with Autism have been able to develop positive relationships with companion dogs. Initial case studies have reported that the persons have been able to interact positively and have shown high levels of care and concern for the dogs. In turn the dogs have provided consistent company and in some cases have been trained like guide dogs to ensure that the person has remained safe when crossing roads and when negotiating other community hazards.

Finally it is most important to remember that any intervention needs to be based on a careful functional behaviour assessment (including sensory and communication assessment) and a thorough understanding of the person's history (i.e. traumatic experiences, institutionalisation, and multiple changes to care givers). The ways in which we support someone with an intellectual disability and additional attachment difficulties must also be person centred and have the active supportive involvement of those working with them across all settings.

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