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COVID-19 IMPACTS – UNDERSTANDING AND SUPPORTING RELATIONSHIPS AND CAREGIVER-CHILD/YOUTH ATTACHMENT

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Disclaimer: This summary was prepared by Dr. Birinder Narang and not by the speakers.

Webinar Summary

Attachment Theory – Dr. Linda Uyeda

- **Attachment Theory (coined by Dr. John Bowlby)**
  - Attachment theory is a psychological model that helps us to understand how our earliest relationships leave a lasting effect on the rest of our lives
  - Internal working models: relationships, trust, dependence, emotional regulation
  - In times of stress, infants use their caregiver as a source of comfort to provide security to co-regulate their emotions
    - Secure Attachment
      - 1) occurs when a child feels like the caregiver is responsive 'enough of the time'; the child feels seen, valued, heard
    - Insecure Attachment
      - 2) Ambivalent/Anxious attachment – in an environment where cues are often misinterpreted or missed; the child may feel the need to turn up their emotions
      - 3) Avoidant/dismissive attachment – a child may learn that they need to turn their emotional expression down in order to stay connected to their caregivers
      - 4) Disorganized attachment – as a result of fearful or frightening behaviour in the caregiver, children's behaviour becomes disorganized; 'fear without solution' (Hesse and Main)

- Attachment patterns tend to be stable across the life span
    - In a North American sample:
        - 56% are securely attached
        - 24% are avoidantly attached
        - 20% are ambivalently attached
- Insecure attachment in infancy has been linked with illness in adulthood
    - Examples include:
        - Mental health disorders
        - Physical health problems (asthma, COPD, Hypertension)
        - Relationships struggles (with peers, co-workers, romantic relationships, physician-patient relationships)
    - Patterns of attachment may become inter-generational
- Our stress response becomes sensitized with early adversity
- Sympathetic Nervous System:
    - This response occurs with both physical and emotional stresses
    - "Fight or flight" response
- Parasympathetic Nervous System:
    - Reflexive, kicks in when we feel safe and feel protected
    - "Rest and digest" (ventral vagal)
    - "Freeze" (dorsal vagal) - extreme life threat
- Neurobiology of Adversity and Attachment Disruption:
    - Hippocampus – learning and memory; hippocampal volume may decrease
    - Amygdala – alarm/fear centre; trauma may increase activation
    - Prefrontal Cortex (PFC) – cognition, problem solving, rational thought; with excessive stress the PFC may become hypoactive
- Secure Attachment relationships enable:
    - Safe Haven – when children feel stress, they use caregivers to co-regulate their nervous system
    - Secure Base – when children feel safe and regulated they use us as a base to try new things that they may not be willing to do otherwise
- Early encoding involves explicit and implicit learning
    - Explicit learning:
        - Includes learning times tables, the last snack you had, the colour of your car, etc.
        - Tagged (i.e. "I remember that I learned those things")
    - Implicit learning:

        - Includes encoding emotional responses, procedural memory, and is largely subconscious
        - Not tagged (i.e. we don't remember we learned it)
        - Most of the learning that occurs before the age of 2 is encoded in this way by the right brain
    - Barriers to Secure Attachment:
        - Lengthy parent/child separations
        - Parent or child illness or disability
        - Parental insecurity
        - Excessive, prolonged stress in caregivers
        - Social determinants of health
        - Racism and inequality
    - "The antidote to trauma is security" – Dr. Sue Johnson

Attachment & It's Importance in the Medical World – Dr. Gilbert Lam

- **"The quality of the infant-parent attachment is a powerful predictor of a child's later social and emotional outcome."**
    - Those with secure attachment are more likely to grow into caring, thoughtful, reflective, emotionally and socially intelligent and resilient individuals who thrive in life
- **Infancy**
    - Insecure attachment is associated with:
        - Colic
        - Difficulty being comforted
        - Feeding difficulties
        - Failure to thrive
- **Preschool & school age**
    - Disorganized attachment is associated with:
        - Oppositional behaviours/emotional dysregulation
        - School issues/learning challenges
        - Development delays (especially speech)
        - Anxiety
        - Increased referrals for ADHD, Autism Spectrum Disorder, social anxiety, and speech delays
    - "Adults often make the mistake of believing that babies and children only want our attention when what they really want is connection." – Raising a Secure Child, Hoffman et al.

- **Adolescence**
    - Disorganized attachment is associated with:
        - Depression
        - Anxiety
        - Eating Disorders
        - Chronic diseases: poor management
        - Somatization: headaches, abdominal pain, etc.
    - "The more children feel safe and secure within their primary relationships, the more resilient they will be when facing the challenges that emerge."
- **Caregiver capacity**
    - Caregivers tend to parent how they were parented
    - Caregiver mental health: What happens when parents are emotionally unavailable for their children?
    - Disorganized attachment is over-represented in child maltreatment cases
- **Positive effects of parents using attachment theory:**
    - Decreased parent-child conflict
    - Stronger sense of impacting how their child feels and acts
    - More comfort/ease in parenting and a closer connection to the child
- **Reflect how attachment is relevant to your patients**
    - Particularly in Indigenous families, immigrants/refugees, parental separation, LGBTQ youth/parents, and children with medical complexities

Practical Strategies to Use at Different Ages and Stages – Dr. Ashley Miller & Dr. Jane Ryan

- **Attachment Needs are for:**
    - Acceptance
    - Closeness
    - Understanding
    - To feel important
    - To feel loved
    - Appreciation
    - To be heard
    - To be cared for
- **Attachment Fears**
    - We all have fears. They tend to fall into categories:

        - Rejection/Abandonment
        - Being a failure
        - Being unlovable
        - Being controlled
    - Attachment needn't just be to parents, but also to a community or a group
    - "The Power of Showing Up" – new book by Author Dan Siegel
        - Half of the battle is just being there. There is no such thing as perfect attunement. Do a reasonable job of being there to attain secure attachment. Models can be changed; it is not too late.
- **Pregnancy, Postpartum & Early Childhood**
    - Prenatally, the groundwork for attachment is already being laid – think of it is as a foundation.
        - To help support a strong foundation, you can screen for mental health, physical health, and consider the following:
            - Are there untreated psychiatric illnesses that could derail attachment?
            - What are the socio-economic concerns?
            - Do they have secure housing and food?
        - Address this with community support to help set up for success
    - Circle of Security resources are available (see Resources)
    - A strategy to build attachment: child-led play with your child for 20 minutes, 1x a week, with a shorter or longer duration depending on the age of the child. Just sit there and enjoy time with your child at your child's discretion.
- **Middle Childhood, Adolescence and Young Adulthood**
    - As children are getting older, parents may forget that they are still the secure base/secure haven for their child. When children venture out, they still need parents, even when they reject them at times.
    - You can screen children by asking them about their relationships with friends, parents, etc. Try to positively reinforce strong relationships.
    - We as physicians can act as attachment figures for our patients as well

Questions & Answers

Q: What are good resources that give a good overview of attachment theory and its applications?

A: List of resources:

- *Becoming Attached* by Robert Karen – reviews the history of Attachment Theory and outlines the 4 main attachment styles
- *Parenting from the Inside Out* by Dan Seigel – set up as a workbook

- *The Therapist Uncensored* – Podcast; contains a range of attachment based topics
- *Attachment Theory in Practice* by Dr. Sue Johnson
- For early years: the Touchpoint parenting course
- For ages 8-17: the Connect Parent program, based on home grown evidence by Dr. Moretti, a psychologist from SFU
    - There is an online program as well as programs for non-binary youth and Indigenous youth
- Motion Focused Family Therapy – this therapy is being run online through Foundry
- All of these are free and available

Q: How can I support a family where the child is demonstrating attachment distress, but caregivers are resistant to implementing change or acknowledging responsibility?

A: The first step is to remember the power of attachment and to look at other relationships. Don't ignore parental relationships. We are looking for strengths and are looking to provide strength-based care. Consider the following: Who is being consistent? How is that relationship being fostered? As a physician, you can model that consistent, secure, and safe relationship with parents and children. When they show signs of being ready, refer them to engage in parenting programs. Shame is often a barrier, but we can help dissolve the shame as it comes up. We must operate from the belief that every caregiver does want the best for their child.

If you create "islands of attachment" experiences with a physician, teacher, coach etc., even if they are in a situation that is unstable, that child is being exposed to something neurologically different so we can try to "buffer" that child from adverse experiences at home.

Approaching with curiosity can be important to help explore what is causing the child's behaviour.

Q: What can a parent do when a child is older and a play prescription may not be appropriate?

A: If a play prescription may not seem appropriate, be more creative. For example, if they are playing a video game, you can try to play with them.

Encourage patients to try nudging things in the right direction. Try to meet them in their world and invite them into your world.

Q: Is it always the fault of the parents? What proportion of children will have all the symptoms of insecure attachment even with parents who follow best practices from attachment theory?

A: Try to avoid language of there being "fault". We can't say that the way the caregiver parented a child will be due to a cause and effect, but we must assess the links. See if there is something that can be nurtured.

Attachment theory is not absolute, and it is a tendency for children to behave in a certain way in certain environments. Children with neurodiversity may have different behaviours. It is not unidirectional; the child also influences that parent/caregiver. If you have a child who is more dysregulated, it can be harder to connect with them. We want to come at it from a place of understanding.

Q: Does attachment theory look at the impact of a family breakup? What can primary care providers tell parents to pay attention to through this difficult time?

A: We must try to buffer children's experience through adverse experiences. We can be there for our children emotionally to give them space to express themselves.

Try to avoid talking about cause and effect; there is a long story of what has happened, including epigenetics, but the whole point is to help the child. There may be a lot of shame and emotions involved, and we must navigate that to align with the parent to implement change via the parent.

There will always be a question of "what else can we do?" The goal is to strengthen attachment.

Q: What about children who have ASD/ADHD or other mental health concerns? What do we do? What do we say to parents?

A: Attachment is the lens through which we manage these patients. The child could have these comorbidities, but what really helps with effective management is positive parenting, sleep routines, predictable routines, etc. The parent must be there in a predictable way to help the child navigate these concerns.

Sometimes treating ADHD with a stimulant can help with the attachment as behaviours become more managed.

Q: The BC lifetime prevention schedule includes screening for vision, weight etc., but does not include screening for socioeconomic status, ACE, or signs of insecure attachment. What needs to be done to make sure evidence-based screening is done in primary care?

A: When we elevate our knowledge of attachment theory and understanding, we have a better idea of what is going on. Regarding screening, there are validated research questionnaires however the panel did not know of specific questionnaires that would be used in clinical practice.

In primary care, longitudinal care helps as it enables you to know their history and family background, and as you identify issues, you have that background knowledge available to help identify risk factors. The relationship itself can be the intervention that enables the healing and provides the knowledge to flourish.

By understanding attachment and the styles, you will start to see patterns within families when conflict arises. It can also be helpful to be aware of our own patterns, when we become stressed, to prevent escalating situations. Be in tune to what language the parents use to describe their children.

Q: Please discuss different presentations of attachment in neurodiverse patients or patients who have medical complexities.

A: The patient may not be able to have the same communication with their caregiver as we may assume they have. It comes down to the relationship that we have with these families and working in a collaborative way. Try to understand how the child communicates if they have an impairment.

When there are multiple diagnoses, we must put that constellation together – but even with that picture, when there are secure and regulated parents, that child will do better and will return to baseline quicker and more frequently when they become dysregulated.

There are resources such as "family development workers" and support through the Ministries of Children and Family Development or Child and Youth Mental Health.

Q: How do you discuss attachment and explain the impact of disrupted attachment with adolescent patients who are gaining insight and making sense of their relationships with caregivers, especially when there is conflict and sources of stress?

A: It is really all about talking to teens about their relationships. Most teens would much rather talk about their friends than themselves anyway, so this works well.

Use a lot of validation with the teen about what they are feeling and normalizing. Teens tend to blame themselves; they would rather do that rather than blame their parents.

Be respectful of the central role of the parent. Remember that you can change attachment security.

Q: We have friends who offered much love, security, play time and validated all 5 of their children's needs. Yet, one child became disruptive and very mean towards several other children in the community. How would you handle this in the context of attachment theory?

A: "No 2 children have the same parents, even if they have the same mother and father" – Gabor Mate.

You never know the microclimate of the family, nor their traumas. There are mental health concerns and temperamental differences. You can leverage the power of supportive caregiver relationships, but you can't prevent things, even if we all do our best. Avoid blame and don't oversimplify causality.

Sometimes the power of metaphor and symbolism can help convey message to parents quickly, i.e. "the dance" – it can be like describing a dance between a parent and child.

Q: Is attachment theory the same as attachment parenting?

A: To develop secure attachment, one does **not** need to be "on 24/7" and "parent as perfectly as possible". Attachment parenting adheres to certain practices (baby wearing, co-sleeping, breastfeeding, etc.) which do not automatically result in secure attachment. Creating security can be achieved with or without these practices depending on how the child receives this care. For instance, if a child sleeps better in a side-car bed or in a crib across the room or nearby, forcing them to co-sleep may disrupt the secure bond.

Secure attachment requires both secure base and safe haven; it is about supporting exploration as much as it is welcoming children in for comfort.

Attachment parenting and attachment theory are different. Attachment parenting is not based on attachment theory and can be confused.

Q: Adults other than parents can buffer the lack of parental attachment. Can another relative, such as a grandparent, mitigate the lack of parental attachment without the child living with them?

A: We don't know if it mitigates it completely, but it supports children if they have more quality relationships around them.

Q: We know research demonstrates risks of insecure attachment among marginalized populations, but what does the literature demonstrate on risks of insecure attachment among populations with high socio-economic demographics, such as double income families and high earning professionals?

A: Some of the weaknesses in literature are that they are conducted using cis-gender, heteronormative, white families so we do know the quality of attachment affects all socioeconomic groups. This suggest that these attachment patterns do not only occur in marginalized populations; we must be mindful in how we perceive risk as clinicians.

Q: What are some practical ways we can become attuned and care for children when they are dysregulated that helps maintain a secure child-caregiver attachment?

A: We know infants and young children do not come with their prefrontal cortex fully formed. Through their experiences their nervous system is shaped and formed. The adult is almost acting as an external prefrontal context for the child which is why it is so important that the adult be regulated first. Self-care is so important for the adult caretaking a child. When a caregiver is better supported and cared for the child also benefits.

Q: What are some strategies we can perform in the moment as caregivers that might help create a secure attachment with a child that is exhibiting disruptive behaviours such as violence and aggression towards others?

A: Safe haven and secure base principles can help frame an approach. Creating safety first is so important. No child truly wants to believe that they are totally in control. So as an adult holding the secure base of safety, make sure that the other children and you as an adult are safe, then provide safe haven. By addressing the behaviour rather than focusing on negative aspects of the child, learning moments are created. The behaviour becomes the focus. Praise children when they are engaging in desirable, pro-social behaviour.

Q: Can children have different attachments to different people?

A: They can have different attachments. Part of the understanding is that it is a tendency to behave in a certain way in a certain environment. It is a bidirectional relationship.

Q: Are there local attachment-based programs I can send parents to if they are open to it?

A: The main ones are Circle of Security parenting for younger kids, Touchpoints and Connect Parent Group for middle childhood to teen age groups, and for teens there is emotion-focused family therapy (which is a parent group).

Parent support groups such as Family Support Institute are also in place and intended for parents of kids with neurodiversity and intellectual disabilities.

Q: Could it be that children who are more colicky and have more difficult temperaments or characteristics are more challenging to offer consistent attachment or do not respond as much to attachment practices and need more than what most parents are able to provide, even as competent parents in general?

A: Absolutely; it is a two-way street. There is literature to support that even with difficult temperaments, we can still see attachment security vs attachment insecurity. They interact but one does not fully explain the other.

Thanks to the speakers on the video:

- **Dr. Gilbert Lam,** Pediatrician; Outreach in Whitehorse, Yukon; Member of Adverse Childhood Experiences Working Group, Doctors of BC; Member of Mindfulness Council, BC Children's Hospital
- **Dr. Ashley Miller,** Child and Adolescent Psychiatrist; Clinical Associate Professor of Psychiatry, UBC
- **Dr. Jane Ryan,** Child and Adolescent Psychiatrist
- **Dr. Linda Uyeda**, Family Physician

- **Dr. Shirley Sze**, Family Physician; Co-Chair of Child and Youth Mental Health and Substance Use Community of Practice