Chapter 11

Understanding And Responding To Challenging Behaviour: Valuable Contributions From Attachment Theory

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The role of attachment in the development and maintenance of challenging behaviour in children and adolescents with intellectual disabilities has to date received little attention from traditional positive behaviour support approaches. However, emerging thinking and research within Attachment Theory is offering a perspective that focuses on socio-emotional relationships and the importance of security and safety when understanding why some children and adolescents with an intellectual disability engage in challenging behaviour. This chapter explores and elaborates on how this 'new' perspective can complement the current traditional positive behaviour support framework by conceptualising and responding to challenging behaviour more effectively.

Introduction

When responding to challenging behaviour, traditional interventions have come from behavioural approaches grounded in learning theory such as applied behaviour analysis and the positive behaviour support paradigm. Surprisingly little attention has been given to the child's pattern of attachment and the role it has in the development of challenging behaviour. It is argued in practice, that the more practitioners learn about the biopsychosocial concept the better equipped they are in developing effective treatment options that consider not only the child with the disability but their dyadic relationships with others and the contexts in which these interactions are occurring. Therefore, emerging research in the area of intellectual disability (ID) and the role of attachment in the occurrence of challenging behaviour (e.g., Janssen, Schuengel, & Stolk, 2002; Sterkenburg, Janssen, & Schuengel, 2008) may have a significant impact on how to design and deliver future interventions.

To various degrees, people of all ages, with or without a disability, depend on others for safety, security, and emotional support, especially at times of distress and discomfort but also in terms of developing social and intimate relationships. Interestingly, the central goal of

most disability services has been to foster independence (Clegg & Sheard, 2002). Clegg and Sheard (2002) proposed that Attachment Theory provided a conceptual base for a shift from this position because it theorised emotional development, not as a move to independence, but as a move from immature to mature dependence. More specifically, they refer to *challenging behaviour* as being a separation protest in individuals, noting that treating separation protest with behavioural intervention or medication does not address the problem, which is embedded in key relationships.

Similarly, Pickover (2002) argued that traditional behavioural approaches address the behaviour but may miss the importance that children place on maintaining their attachment systems. Sterkenburg et al. (2008) offered some incentive for this trend to change. These researchers found that providing attachment-based therapy combined with traditional behaviour intervention, as opposed to traditional behaviour intervention alone, decreased challenging behaviour and resulted in significantly more adaptive target behaviours.

Theoretical Underpinnings Of Traditional Behaviour Approaches

Emerson (2001) defined *challenging behaviour* as ‘culturally abnormal behaviours of such intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of, or result in the person being denied access to ordinary community facilities’ (p. 3). Positive behaviour support practices are arguably the most widely applied behaviour intervention approaches in disability services today. This approach uses educational methods to expand individuals’ behaviour repertoires and emphasises the importance of adapting their living environments to, first, enhance their quality of life and, second, to minimise their challenging behaviour (Carr et al., 2002). Underpinning this process is the comprehensive behavioural assessment, which investigates the past contexts and the current context in which the individual lives, works and

plays; their life experiences and life history i.e., developmental history; educational history with successes and failures; and family history with any losses and tragedies identified (Willis & LaVigna, 1996).

Theoretical Underpinnings For Attachment-based Intervention Approaches

Bowlby (1982) defined *attachment* as 'the disposition of the child to seek proximity to and contact with a specific figure and to do so in certain situations, notably when frightened, tired or ill' (p. 371). He argued that children need a reliable ongoing attachment to primary caregivers and that they suffer grievously, even irreparably, if the attachment is interrupted or lost. In later writings, he further elaborated that a successful attachment allows for security, whereas anxiety and jealousy develop from poor attachments, as does anger, grief, and depression (Bowlby, 1988).

Ainsworth and Wittig (as cited in Bretherton, 1992) demonstrated Bowlby's theory scientifically in the *Strange Situation* procedure. They were able to categorise the responses of toddlers to their mothers into three different attachment patterns referred to Insecure-Avoidant (A), Secure (B), Insecure-Ambivalent (C) classifications of attachment quality. This experiment also contributed the concept of the attachment figure as a *secure base* from which an infant can explore the world. The concept of *maternal sensitivity* to infant signals and its role in the development of infant-mother attachment patterns was another contribution of Ainsworth (as cited in Bretherton, 1992). Main and Solomon (1990) classified a fourth group of children as Disorganised (D), as they appeared to lack a coherent coping strategy for several seconds upon the attachment figure's return during the *Strange Situation* procedure before resuming either of the ABC classification attachment patterns.

Disorganised attachment is common in individuals with an ID, as they are more vulnerable to stress and use less effective coping strategies (Janssen et al., 2002). These

researchers have proposed a stress-attachment model of the development of challenging behaviour in children with ID. The model infers that when individuals with an ID face a situation that they perceive as stressful (e.g., risk of getting hurt, losing out or not being able to cope with demanding tasks), fail to find a behavioural solution to the situation and cannot use an attachment figure as a secure base, their physiological arousal builds up. Depending on the individuals' attachment patterns, this arousal may lead to a range of behavioural symptoms, such as aggressive behaviours, self-soothing behaviours, withdrawal, dissociative symptoms and in severe cases, self-injurious behaviours (De Schipper, Stolk, & Schuengel, 2006).

In her *Dynamic-Maturational Model (DMM) of Attachment Patterns,* Crittenden (1999; 2000a; 2000b) proposed that attachment should be conceptualised as promoting *safety*, rather than *security.* She emphasised the interaction between culture, maturation and context when trying to understand the organisation, function and development of attachment patterns in the face of threat and danger. She further proposed that separation and loss were special categories of *danger*, the primary organiser of human behaviour (Crittenden, 2008). She explained,

> …children who experience danger are expected to develop strategies that reduce the sorts of danger that they have experienced. When the danger is lack of parental response, adaptive strategies will elicit parental attention, even if this involves angry or risk-taking behaviour; when danger is parent hostility, adaptive strategies will reduce it (Crittenden, 1999, p. 146).

Clinical Considerations

Resilience is an important determinant for successful adjustment to having given birth to a child with a developmental delay. For many parents the initial experience may have been

difficult, even traumatic, but they are still able to adjust and successfully assume the role of attachment figures for their child. Other families struggle to overcome grief and loss issues associated with the birth of their child with a developmental delay. Combined with inadequacies in the child's innate signalling system, this hinders the dyadic process of communication and adjustment around the infant's safety and comfort that is so important for the development of an attuned relationship. For some parents the grief and loss issues may be so severe that they disclaim their baby (Bunce & Rickards, 2004). Hence, early screening for possible developmental delays or impairments and subsequent intervention for those children and families identified is vital.

Parenting is arguably the most important *job* in life. Still, relatively little attention is given to education and training in preparation for this role. Having a child with a developmental delay further complicates this role. Initially the parents may be able to cope, but as the child grows and becomes stronger, what was considered a tantrum could become so intense and so severe that the safety of the child and others are at risk.

For many families, parent-education programs such as Triple P – Positive Parenting Program® (Sanders, Mazzucchelli, & Studman, 2003) Signposts for Building Better Behaviour (Hudson, Cameron, & Matthews, 2008) and the Apex Behaviour Management Program (Hartog, as cited in Wiese, Stancliffe, & Hemsley, 2005) may meet their needs. Other families may require specialised support from a clinical team, particularly if the child has complex needs and behaviours or if there are complex family issues present. The key task is to build parental confidence in managing the child's behaviour by involving both parents early on and encouraging them to work as a team. At the same time, other supports should be in place for parents to assist this process such as counselling, access to respite, sibling support, education around communication, socialisation and engaging their child in play activities.

An important aspect of working with families is for clinicians to demonstrate empathy and an awareness of the families' unique situations. This allows for the development of connectedness and trust. Everybody has their own individual attachment history that affects emotional well-being and interpersonal relationships socio-emotionally and behaviourally. This is subsequently reflected in the individual's ability to deal with challenging situations with confidence. Becoming aware of this through self-reflection and in clinical supervision will allow clinicians to prepare themselves to work closely with children and families, even under difficult circumstances. Similarly, at the intervention level it is equally important to support parents and carers to become mindful of this and the ways that they can affect behavioural change through their positive interactions with the child or adolescent (Singh et al., 2006). In other words, the ways in which parents can offer a secure base from which their child or adolescent with ID can explore the world.

Arguably, for many mothers the attachment figure role is assumed with relative confidence from the time of the birth of their child or even earlier, during pregnancy. For others this may not be the case, due to their own attachment history and the context into which the child is born (e.g., disrupted family environment, difficulties in parenting, drug and alcohol use, post natal depression or other mental illness, or being unable to cope with their child being born with a disability). In these cases, multiple variables may be present and interrelated, requiring a more complex and multifaceted intervention approach.

Some children with an intellectual disability who display challenging behaviour have experienced trauma and abuse. Emotional abuse, neglect, sexual abuse, physical abuse, and exposure to domestic violence can interfere with the development of the child's attachment. Exposure to such traumatic events leads to losses in core capacities for self-regulation and interpersonal relatedness (Cook et al., 2005). In more severe cases, the child is likely to meet

the DSM-IV-TR (American Psychiatric Association, 2000) criteria for Reactive Attachment Disorder.

Intervention Approaches

Psychotherapy and psychoeduction are currently the two most frequently used treatment models for biological families with attachment disorders. Foster and adoptive families, on the other hand, need assistance to repair the child's negative internal representations by responding to their child's cues (Cornell & Hamrin, 2008). The psycho-educational model fits well with the positive behaviour support framework, as it focuses on increasing parental knowledge of child development, self-care, and relationship building. The psychotherapeutic model focuses on the child-parent attachment relationship and includes such approaches as Dyadic Developmental Psychotherapy (see Becker-Weidman, 2006) and Parent-Child Interaction Therapy (Bagner & Eyberg, 2007).

It is useful to view the family as a system within which there are a set of dyads (e.g., mother-child, father-child). Kozlowska and Hanney (2002) noted that observing children interacting with their parents and recognising the strategies children use within this dyadic relationship, provides valuable information about how the dyad has related in the past. This assists clinicians to formulate questions and hypotheses about attachment patterns and to plan family interventions. Video recording the parent-child interactions may prove a useful way of capturing these dyadic interactions. The Marte Meo approach utilises this technology as part of the therapeutic process (see Aarts, 2008).

Within the positive behaviour support framework, the *Multi-element Support Plan* (LaVigna & Willis, 1995) is the result of a comprehensive behavioural assessment. The plan has two major sections. The *proactive strategies* are designed to produce behavioural change over time and the *reactive strategies* are designed to manage the challenging behaviour at the

time it occurs (for an extensive elaboration on this treatment model, see LaVigna & Willis, 1995).

Challenging behaviours are broadly noted as being communicative in nature, i.e., the child is trying to tell us something through behavioural means. Ineffective communication from others is also likely to confuse and/or frustrate the child and subsequently create a context in which they do not feel safe. Hence, a primary objective for the clinician is to develop communication strategies that are clear, concise and are presented in a format that the child or adolescent with a disability can understand (e.g., using visual supports or augmentative and alternative communication systems), and that therefore should make them feel safer and more secure.

These communication strategies would also assist the child's communication partners to become more consistent and therefore promote the dyadic relationship. However, there are other aspects of communication that impact on behaviour, particularly non-verbal body language, facial expression, and tone of voice. The psychological messages embedded in communication from others can affect the responses of the child or adolescent with an ID. For example, being greeted with a warm, friendly smile in a relaxed manner is more likely to bring calmness and a sense of security to the child or adolescent than being greeted with a facial expression that suggests fear, anxiety or dislike. The clinician needs to be aware of this when developing interaction guidelines for parents and carers. These interaction guidelines should model secure base behaviours through sensitive responding (i.e., being clear and concise while being available, calm, empathic, consistent, reassuring, and predictable).

Many individuals with a disability and particularly those with Autism Spectrum Disorder (ASD) have significant sensory needs. They may be hypersensitive or hyposensitive to certain stimuli in their physical environments (e.g., excessive noise, heat, lights, touch, taste). Considering this, some environments can be quite stressful and frightening to the

person, for example, crowded and noisy shopping centres, flickering lights, hot vehicles, noisy playgrounds or classrooms, and clothing materials (Schaaf & Miller, 2005). To identify these needs, the clinician (usually an Occupational Therapist) conducts a sensory processing assessment and develops a sensory profile for the child. This profile guides parents and carers in meeting the child's identified sensory needs and thereby presumably being better positioned to be the child's secure base.

Realistically, the world is not always a safe place and from time to time, the individual with ID will be exposed to contexts, environments, and people that they may find frightening and stressful. Finding the balance between allowing the individual the freedom to explore and participate in life, at the same time as protecting them from *undue risks* can be challenging for parents and carers. Clinicians can support parents and carers by conducting risk assessments and developing risk management strategies for known and anticipated dangers.

The focus on positive programming within positive behaviour support approaches is to assist the person systematically to develop skills and competencies, which will contribute to social integration (LaVigna, Willis, & Donnellan, 1989). Of particular interest are the areas that often cause greatest concern and distress to the individual with ID such as problem-solving, changing circumstances, relationships, and dealing with strong emotions. Programs that aim to improve the individual's social skills, assertiveness, anger management and stress management skills are hoped to prevent the person from displaying challenging behaviour. However, as a caveat, it is important to note that an insecure attachment style may compound learning difficulties for children with intellectual disabilities, as they have less protective factors and resources to overcome the stress of an insecure attachment (Rosenstein & Horowitz, 1996). Hence, it is important that the learning environment is safe and positive with lots of encouragement and positive connotations provided by the 'teachers'.

A Case Example

In order to illustrate some of the experiences of individuals with developmental disabilities and their families, a hypothetical example is outlined below. This case example, emphasises the common threads or themes that are identified when using a set of attachment lenses to explore the attachment patterns in individuals with ID and their families (e.g., abandonment, danger, security).

Peter

Peter is a 13 year old boy with a mild intellectual disability (ID) and Autism Spectrum Disorder (ASD). A year ago, Peter's parents relinquished their care for him by deciding to not pick him up after an over night respite stay. They stated that they could no longer manage Peter at home safely, due to his aggressive behaviour, particularly towards his mum and little brother. Peter was temporarily accommodated in the respite centre.

Initially Peter easily became anxious and hit staff and other respite clients. In particular his anxiety and aggressive behaviours increased when new staff or agency staff were working with him. However, with targeted intervention Peter's behaviour has settled and decreased significantly since being away from home.

Peter visits his family home on the weekend, but the parents still have difficulties managing his behaviour. Peter's relationship with his family is tense and his parents are feeling guilty and anxious for having relinquished their care for him. They have expressed that they would like him to start having overnight stays at home on the weekend, but feel ambivalent about how they are going to cope. Peter has also expressed that he wants to move home again.

From an attachment theory perspective, the long-term goal for the clinical team supporting Peter would be to reunite him with his family and repair the disrupted attachments

to his parents and little brother. The short-term goal would be to assess Peter's immediate support needs and to develop a secure base for him. If Peter feels safe, he is less likely to become anxious and subsequently less likely to become aggressive.

Having an ASD, means that Peter is not likely to cope well with changes in his environment and lack of consistency in communication messages. Consequently, Peter is likely to respond well to behaviour intervention that provides him with consistent routines and a high level of predictability. Assessments may also provide information about his sensory and communication needs. An important aspect of the intervention would be to teach the parents strategies on how to communicate effectively with Peter and how to support him with his emotional regulation. The Behaviour Support Plan (LaVigna & Willis, 1995) would be the guiding tool for achieving this, in conjunction with a direct teaching approach, such as the Stepping Stones Triple P (Sanders, Mazzucchelli, & Studman, 2003).

Conclusion

Attachment Theory provides an additional set of lenses through which to view the child's challenging behaviour. It allows for a better understanding of the child's attachment history and any contributing factors such as. disrupted interpersonal relationships, grief and loss issues, and possible experiences of trauma and/or abuse. Consequently, the clinician will be in a better position to respond to the child's socio-emotional needs. That said, further research with this population is essential to provide a stronger evidence-base for this 'new' approach and to inform future direction for clinical services.

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