

The role of attachment in autism – a case study on attachment and its impact on behaviour

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1. Case overview

Parents are often far more distressed when their child is first diagnosed with autism than the child. This **cannot be explained by the child’s inability to understand** the consequences of such a disorder alone because most parents hearing this diagnosis for the first time have the same struggle. There seems to be another deeper nagging fear that can add to the parental distress: **“Was it my fault?”** Because if it is, then **“I need to fix it!”** This unfounded guilt can become a constant torment for these parents in addition to their higher stress levels. They can become so preoccupied with **fixing their child that ultimately the child’s emotional needs fall by the wayside.** For these dedicated, loving but guilt-ridden parents sometimes their distress needs to be addressed first before they can become helpful for their child.

The following case study illustrates how reducing the parent’s distress helped the child with autism. Using

the Circle of Security (COS) parenting program **increased the carer’s reflective capacity.** This approach increased her confidence in parenting and strengthened attachment, the relationship between a child and their caregivers. Ultimately, it brought back the joy in **their relationship and led to a reduction in the child’s self-harm behaviour.**

The case (names and some demographics are changed for confidentiality reasons)

Charlie is an 8-year-old boy who lives with his parents Adam, Eve and his 11-year-old sister Bea. He attends a specialised school for children with developmental disorder in year 3. Charlie has been diagnosed with autism Level 3, mild to moderate intellectual disability, severe attention deficit hyperactivity disorder (ADHD), general anxiety disorder, obsessive compulsive disorder and Tourette syndrome. His developmental age was that of a toddler.



The neurology team referred him for a 1-year history of self-harm characterised by head-banging. This was precipitated after he had a paediatric autoimmune neuropsychiatric syndrome (PANS) which was treated with intravenous immune globulin and steroids but his behaviour persisted. A multitude of behavioral, pharmacological and experimental interventions had **limited impact on his head banging. His parents' main concerns** were that Charlie will acquire brain damage secondary to the head banging. Furthermore, he was irritable, had insomnia and behavioural outbursts characterised by unpredictable physical aggression to his family. He was climbing and jumping off heights which the parents experienced as provocative behaviour. They presented to the local emergency department **on a few occasions for Charlie's agitation, harm to self and others** and on one occasion he was admitted under neurology for his behavioural difficulties.

2. Background Information

Adam and Eve both have university degrees and are very dedicated parents. They have tried a range of behavioural interventions with limited or worsening **effects on Charlie's behaviour including Applied Behavioural Analysis (ABA) and Time out** as well as other strategies such as holding therapy, chill out room and compression clothing.

Charlie has trialled a range of medications including but not limited to antipsychotics such as Risperidone, Quetiapine and Olanzapine, antidepressants such as Fluoxetine, Fluvoxamine and Venlafaxine, mood stabilisers such as Carbamazepine, Valproate and Lamotrigine, anti-hypertensives/anxiolytic medications such as Clonidine and Propranolol as well as Ritalin. All medications caused some form of (side) effects ranging from mild such as sedation to severe such as **Steven's Johnson syndrome. Medications needed to be reduced or ceased.** Eve also found that the medications did not address his head banging and frequently asked for trials of new medication or would change the dose herself, at times ceasing all medications. She also enquired about alternative treatments including but not limited to L-Theanine and currently cannabidiol oil.

Charlie's behaviour caused significant distress within the family system accompanied by feelings of helplessness, depression and grief. Eve had suffered from postnatal depression and felt to have limited support from her husband and own mother when she is feeling down. She was recently re-commenced on an SSRI (selective serotonin re-uptake inhibitor, antidepressant). Adam coped with anger directed at Charlie or **withdrawing and Bea tried to help out with Charlie's care** whilst minimising her own needs.

“This unfounded guilt can become a constant torment for these parents...”



3. Professionals involved

Charlie has a local paediatrician who prescribed most medications apart from neuroleptics. He also underwent CYP 450 enzyme testing which revealed a VAMP2 mutation. VAMP2 is believed to play a role in neurotransmitter release and mutations can manifest as neurodevelopmental disorder. However, it was unclear how much this contributed to the effects experienced on the diverse medications.

The neurology team remained involved by facilitating a **brief admission for Charlie's behavioural problems.** They referred him to Child and Adolescent Psychiatry, neurodevelopmental team. During that admission it became evident that carer support needed to be increased to counter carer fatigue.

Eve tended to call one of the neurodevelopmental **team's psychologists on a weekly basis to report on her issues with Charlie.** The team explained that medications alone was unlikely to change his behaviour. Psychoeducation was provided about the current available treatments for autism but there was no cure. Emotional co-regulation is important and in children with autism this means to structure their feelings. Other approaches such as family therapy, dyadic therapy

such as “watch, wait and wonder” as well as behavioural management programmes such as “Stepping Stones Triple P” were recommended but it seemed that it was difficult for the family to put them into practice. Practical solutions included the use of protective gear.

4. My perspective

The crux of the matter was that Eve was on a quest to cure her son’s autism whilst the neurodevelopmental team aimed to provide ‘a good enough’ quality of life. These divergent expectations nearly inevitably lead to mutual disappointment and re-enforced an ambivalent cooperation. Eve probably felt that no professional has helped her son enough. So she was hesitant to implement and found it difficult to trust the treating team enough to follow through with professional recommendations and instructions. It can be speculated that **changing medication doses without doctor’s approval was the only control Eve had over Charlie’s behaviour and health.** It can also be hypothesised that any of **Charlie’s behaviours is under scrutiny by both parents** because he did not meet their expectations and his negative emotions and behaviours were particularly distressing for Eve. This negative attention and the lack of boundaries may perpetuate some of his behaviours. Although so far the main attention was focused on Charlie, his behaviour seemed to worsen. Changing perspectives, caring for the carer, can lead to change and an attachment based intervention could be helpful not only for Charlie but also for Eve.

5. Intervention

Known first line treatments were exhausted. At times there was only partial implementation of those recommendations. Despite her ambivalence, Eve was able to accept that the neurodevelopmental disorder team would not recommend any medication changes whilst Charlie was on a cannabidiol trial. We recommended an attachment based therapy, Circle of Security (COS), as this has not been tried before and the author is a trained facilitator. Attachment is the relationship between a child and the caregiver, an instinct to seek **care from a specific person who can ensure one’s safety.** This care seeking behaviour can also be seen

amongst adults e.g. when Eve contacts her family or the therapist for support.

COS is not a treatment but a parent reflection model with eight chapters which are delivered in weekly sessions each lasting 90 minutes in a group model. It is recommended for children aged 4 months to 6 years old and uses graphic representations to focus on the **child’s needs. In short, the carer is the “secure base” from which the child leaves and also the “safe haven” to which the child returns.** Hence, the child moves in a **circle. When the child feels ok, it is on the “top circle”** meaning it leaves the carer to explore the environment. Whilst exploring, the child still needs the carer to watch, help, delight and enjoy with him/her. When the **child feels not ok, it is on the “bottom circle” and comes back to the carer needing the carer to protect, comfort, delight in them as well as organise the child’s feelings.** The carer is guided by principles to be always bigger, stronger, wiser and kind (BWSK) and follow the **child’s needs but to take charge when necessary. The carer also learns about his/her “state of mind” with the metaphor of the “shark music”, a carer’s background fear that may be triggered by a child’s behavior.** In this case, COS was provided via tele-health during the Covid-19 pandemic and as individual sessions with Eve to allow discussion of suspected underlying **grief about Charlie’s autism diagnosis, reduce risk of feeling guilty about other parent’s “better” relationship with their children, meeting Eve’s preference and improve engagement with the team.**

COS was provided over 4 months. Initially Eve missed 2 appointments and sought reassurance for medication doses she had changed. Clear boundaries were established between the role as a COS facilitator and the treating psychiatrist prescribing medication. During the first few sessions Eve also appeared distracted by attending to chores during the session. However, with increasing number of sessions Eve became increasingly engaged and she was very reflective and thoughtful throughout. Her regular phone calls to the **neurodevelopmental team’s psychologist eventually ceased and this was maintained even one year after COS had started.**

Eve felt that **Charlie’s high demands have reduced her time spent with Bea which led to feelings of guilt for Bea and resentment to Charlie.** This was further perpetuated by **Charlie’s physical aggression which frightened Eve.** In those moments she was not the BSWK carer but often became **“mean” towards Charlie** which then caused more feelings of guilt. She felt unable to provide safety for him and the family.

“an instinct to seek care from a specific person who can ensure one’s safety...”



Eve noticed the different parenting approaches to her children. With Bea, Eve wished for Bea coming to seek her proximity (bottom circle) but instead Bea was often on the top circle. With Charlie it was the opposite. Eve wished he would explore independently but instead he was often on the bottom circle. This insight already helped her to remain calmer in difficult situations and set boundaries whilst being mindful not to become mean. **Eve also identified that she struggled “being with” Charlie’s emotion of anger. This was a parenting style she had inherited from her own experience of being parented.** Eve was also able to re-interpret his **“provocative behaviours” of head-banging as Charlie’s attempt to initiate moments of her being with him and enjoy with him e.g. the joy he feels when he climbs the balustrade.** With this understanding she actually put a **mattress below the balustrade, much to her husband’s dismay as it may “invite” Charlie to jump, in case he fell off which has not happened so far.** She experienced Charlie’s protective gear, a helmet, as a **“game changer” as she was not anxious to take charge anymore.** Eve was more confident to set limits and if that led to Charlie being frustrated, she let him headbang

with the helmet on. However, this was hardly necessary because telling Charlie that she will put on the helmet for him was often sufficient to stop him from head-banging. She also made an effort to spend time with him when he was ok e.g. when he was watching TV. This was further re-enforced with Charlie becoming **more verbal e.g. saying “Mummy, kiss”.** **Eve also caught her “shark music” playing when Charlie had Tics** because she then anticipated aggression to himself and her. In those moments it was hard for her to take charge as she did not want to be mean but she tried to remain BWSK which increased her confidence when she was able to manage difficult situations with Charlie. Eve was eager to repair her relationship with Charlie and the mutually positive experiences improved their relationship significantly.

Eve’s calmness, firmness, reflectiveness and increased understanding of Charlie’s needs seem to be significant contributors to his overall improved behaviour. As a result, her perception of and attitude to Charlie changed. She is more able to tolerate his distressing behaviours and even finds practical solutions to make things as safe as possible for him.

At the end of the COS program, Charlie's improvement was noted by Adam, his paediatrician and was also reflected in his behaviour. His head-banging reduced in frequency and intensity to about 1-5x/day lasting up to 5 minutes without any injuries and can be triggered e.g. when he is anxious. His paediatrician could cease Charlie's antidepressant whilst increasing his anxiolytic slightly.

One year after starting COS, Charlie's head banging has reportedly been minimal. He remained mainly settled, even during neurological interviews, and Eve was reportedly doing well. He was also not on cannabidiol anymore. However, school did not allow Charlie to attend full days there due to anticipation of aggression to other children which has happened in the past. It is also likely related to change of teachers. His neurologist has started him on 4-Aminopyridine for his VAMP2 mutation to which he responded well so far.

6. Discussion

Eve's goal was to eliminate autism and if required

would sacrifice herself to achieve this. Hence, initially the neurodevelopmental team could not engage Eve because there was a lack of therapeutic agreement and any treatment approaches were doomed. Frustration grew on both sides which obfuscated the need to **address Eve's distress. Individual COS sessions provided a structure for Eve to ventilate her distress and frustration whilst allowing the team to examine her goals, hopes and barriers to treatment. COS was the framework into which basic psychotherapeutic approaches such as interpersonal or supportive therapy skills were built in on an as needed basis. It also allowed to tailor its use to the specific needs of the carer and the child, making it more practical. This approach improved understanding and engagement between Eve and the treating team. It also provided "informal" therapeutic support for the carer whilst focusing on the child. Supporting Eve in her parenting skills and reassuring her during setbacks increased her confidence to structure Charlie's feelings. Subsequently, this reduced the carer's distress and translated into a more positive and playful relationship between carer and child which improved the child's behaviour.**

COS aims to shift attachment style to a secure one. However, the practical main goal was improvement in **Charlie's behaviour so that his attachment style was not formally measured before and after COS intervention.**

There is limited research and understanding about attachment in children with autism. The majority of parents have the motivation and skills to form a secure

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attachment. Yet, in neuro-atypical children these skills alone may not be enough because of the underlying challenges that arise from autism. Children with autism have an attachment that is characteristic of much younger children, so they show more intense attachment behaviours and selectiveness to their primary carers (1). However, their behaviour, immature for **their chronological age, is 'mismatched' to their often neuro-typical physical growth** which may be even a further barrier to meet their attachment needs.

Teague et al (2) found that it is more likely that children with autism form insecure attachment which may have some neurological basis. Nevertheless, secure attachment serves the same function as in neuro-typical children and is a protective factor for social and **cognitive development. A mother's increased insight into this and acceptance of an autism diagnosis is likely to increase secure attachment.** There is some emerging but mixed results on attachment based interventions (1). They also have not been listed in the NICE guidelines, yet. Furthermore, COS has been developed for neuro-typical children and not primarily for children with autism.

Circle of Security for autism

In this case, Eve acted on a belief that autism is curable. Evidence-based practice indicates that autism is primarily a biological/genetic cause disorder for which there is no medically-based intervention (NICE, 2021) and a level of difference needs to be accepted. However there is growing evidence that psychoeducational programs can benefit developmental delays including Autism. Indeed, the recommended primary intervention for Autism is promoting emotional social skills (NICE, 2021). Many parents and clinicians also believe that the emotional and behavioural disturbance in autism is also caused by factors that are more biological than psychosocial. Our framework describes autism as a delay in the development of skills, and in particular emotional recognitions skills, inter-subjectivity skills, relationship problem solving skills and social skills (1, 3, 4).



The delays in these skills are also associated with a cognitive inflexibility which presents as stereotypic repetitiveness. There may also be additional delays in several other areas including intellect and communication. Historically significant harm was done by trying to treat autism with psychotherapy, as it was not effective. However young people with autism are children too, and although their challenges of adaptability often lead to an increased risk of emotional and behavioural disturbance, they may also become sensitive to emotional communication especially in the relationship with their primary attachment figure(s).

Albeit the development of their attachment may be delayed, they still need parents, not just to teach skills, but also reflect both behavioural skills and emotional skills through an awareness of intersubjectivity and co-regulation. COS provides a setting in which the nature of intersubjective connection and psychological awareness can be collaboratively examined in therapy. In this way COS and the examination of emotions and behaviour in the context of attachment can provide an alternative treatment when mainstream behaviour management and pharmacotherapy have failed. It may

need to be conducted by a clinician experienced with autism and its emotional and behavioural problems.

7. Practical Strategies

COS parenting program is rather experienced than explained. Professionals, parents or guardians can become COS facilitators by attending an approved course. However, for parents it may be more helpful to attend COS groups that are offered in various community settings. One needs to be aware that COS is usually provided as group sessions and it is not necessarily tailored for children with autism.

Carers should persistently aim to build a positive relationship with their children with autism although the varying degrees of impaired social reciprocity may negatively impact on a carer's confidence.

8. Follow-up learning

1. <https://www.circleofsecurityinternational.com>
2. <https://www.nice.org.uk/guidance/cg128>

9. Further Reading

1. Sigman M, Ungerer JA. Attachment behaviors in autistic children. *Journal of autism and developmental disorders*. 1984;14(3):231-44.
2. Teague SJ, Newman LK, Tonge BJ, Gray KM. Attachment and child behaviour and emotional problems in autism spectrum disorder with intellectual disability. *Journal of applied research in intellectual disabilities: JARID*. 2020;33(3):475-87.
3. Ratcliffe B, Wong M, Dossetor D, Hayes S. Teaching social-emotional skills to school-aged children with Autism Spectrum Disorder: A treatment versus control trial in 41 mainstream schools. *Research in Autism Spectrum Disorders*. 2014 8(12):1722-33.
4. Ratcliffe B, Wong M, Dossetor D, Hayes S. The Association Between Social Skills and Mental Health in School-Aged Children with Autism Spectrum Disorder, with and without Intellectual Disability. *Journal of autism and developmental disorders*. 2015;45(8).