Rethinking Residential Care: 
Targeting Disorders of Attachment

Golden Opportunities: Building on Foundations to Enrich the Future
American Association of Children’s Residential Treatment Centers (AACRC)
50th Annual Meeting
November 2, 2006
The Drake Hotel, Chicago, IL

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Attachment and the Work of the Connections Program

**Background**
Within the Commonwealth of Massachusetts and throughout the United States there is a population of children that resists the common modes of psychotherapy, dumbfounds psychiatric treatment centers, and quite often leaves foster and adoptive families in a state of despair. These are children suffering from various disorders of attachment. We know these children not only by there diagnoses – many times they are without one – but because despite our care and concern and despite the myriad behavior plans we implement, their behavior continues stagnate or even deteriorate.

Common sense and clinical experience suggests that these children, most often characterized by histories of recurrent interpersonal trauma, profound neglect, and lack of familial connections, are not well served by residential treatment. In fact, the very nature of residential treatment (many children / few caretakers, behavior plans based on relationship, rotating staff to “switch out” of situations, etc.) that can be so helpful to the child with schizophrenia or conduct disorder exacerbates the lack of attachment and connectedness experienced by these children.

This lack of basic attachment to at least on caring, consistent adult has profound implications for the child’s moral development, social functioning, self-esteem, and educational performance. Many times we as care providers have witnessed these children disrupt multiple times from perfectly structured and loving foster and adoptive homes – further exacerbating the lack of attachment.

Yet what is the solution? How do we break the cycle of failure if these children do not maintain themselves in foster and adoptive homes yet residential treatment exacerbates their disorder? This is the question that we chose to answer in the design and implementation of The Connections Program. We believe that residential treatment can be modified to meet the needs of children with disorders of attachment and can be a useful tool in creating lasting and stable home placements. This paper does not purport to be an in-depth explanation of attachment disorder – much has already been written on that subject. Rather, it is the author’s hope that it actively describes how residential treatment can be designed to ameliorate the symptoms of attachment disorder and increase success and provides resource information to the reader.

**Rationale**
At Walker our interest in attachment is a functional one – we’re interested in finding and developing real, working attachment relationships for children. The key to these relationships is reciprocal interaction, or “rhythm.” These types of relationships can take place in a broad-range of locations: parent, caregiver, sibling, peer, community, physical location, etc. The goal is to move children from risk to resiliency.

**Process of Change**
The need for a residential treatment program designed specifically for this subgroup of the Walker population only became apparent over time as referrals from state agencies increased. Once the need had been established a multidisciplinary team was formed to begin deconstructing our current program and establishing the framework for the program to come. This team, which

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included upper-level managers as well as direct care workers, stayed intact throughout the first two years of the program’s development.

This team used a logic model as an organizational framework for program development.

**Attachment**

The team process began with adapting a working definition of attachment. The section below was key in shaping agency thought and is taken largely from the influential work, *Attachment, trauma, and healing: Understanding and treating attachment disorder in children and families*, (Levy and Orlans, 1998).

For our purposes then, attachment is the deep and enduring connection between a child and caregiver in the first several years of life. It profoundly influences every component of the human condition – mind, body, emotions, relationships, and values. Attachment is not something that parents do to their children; rather, it is something that children and parents create together, in an ongoing, reciprocal relationship.

Attachment to a protective and loving caregiver who provides guidance and support is a basic human need, rooted in millions of years of human development. We have an instinct to attach: babies instinctively reach out for the safety of the “secure base” with caregivers; parents instinctively protect and nurture their offspring. Attachment is a physiological, emotional, cognitive, and social phenomenon. Instinctual attachment behaviors in the baby are activated by cues or signals from the caregiver. Thus, the attachment process is defined as a “mutual regulatory system,” in which the baby and caregiver influence one another over time.

Several Important Functions of Attachment for Children --

1. To learn basic trust and reciprocity that serve as a template for all future emotional relationships;
2. To explore the environment with feelings of safety and security (“secure base”), which leads to healthy cognitive and social development;
3. To develop the ability to self-regulate, which results in effective management of impulses and emotions;
4. To create a foundation for the formation of an identity that includes a sense of competency, self-worth, and a balance between dependency and autonomy;
5. To establish a prosocial moral framework that involved empathy, compassion, and conscience;
6. To generate a core belief system that comprises cognitive appraisals of self, caregivers, others, and life in general; and
7. To provide a defense against stress and trauma, which incorporates resourcefulness and resilience.

**Attachment Needs**

Secure attachment can only be established in the context of a relationship that includes nurturing touch, safe holding, eye contact, smile, positive affect, and need fulfillment:
1. **Touch** – For millions of years, mothers have held babies “in arms,” providing nurturing touch and safe containment. The communication transmitted through touch is the most powerful way to establish a human relationship. Secure attachment involves loving and caring touch, as well as sensitive and appropriate limits and boundaries. Without touch children can die; with abusive touch and/or little loving and nurturing touch, children develop severe biopsychological problems and an aversion to the very touch and closeness they desperately need.

2. **Eye contact** – A newborn can focus his or her eyes on object 7-12 inches away, the exact distance needed to make eye contact in arms. The caregiver-infant gaze is a primary releaser for the development of secure attachment and is synonymous with closeness and intimacy. Securely attached children are able to communicate and connect through eye contact. Children with attachment disorder are incapable of using eye contact for closeness and positive communication; they use their gaze to manipulate, seduce, control, or threaten.

3. **Smile and positive affect** – The baby’s smile is an instinctive response that attracts the attention of the caregiver and encourages an ongoing positive caregiver response. The caregiver’s smile and positive affect help the baby feel safe and secure. The relationships between caregiver and a securely attached child are characterized by warmth, joy, and love. Caregivers and children with attachment disorder experience rejection, pain, fear, and anger.

4. **Need fulfillment** – Successful completion of the first-year-of-life attachment cycle leads to the development of secure attachment. The sensitive caregiver gratifies basic needs, which alleviate the child’s’ arousal and discomfort. Securely attached children learn to trust caregivers and authority and believe that their own needs are valid. Children with attachment disorder mistrust authority and develop negative self-perceptions. (“I am bad, defective, and unlovable.”)

**Solutions: Three-dimensional approach** –

1. **Attachment-focused assessment and diagnosis** – Diagnosis rests on four pillars:
   a. Signs and symptoms
      i. Observation
      ii. Psychometric assessments
   b. Review of early history and previous assessments
   c. Review of previous diagnoses and treatment
   d. Assessment of parents’ attachment histories/styles

2. **Training for caregivers and childcare staff** –
   a. Teaching of specialized parenting skills
   b. Assistance with navigating “the system”
   c. Multi-family Alliance for the Treatment of Abuse and Neglect
3. **Treatment** – Effective treatment involves creating secure attachments patterns (i.e., teaching attachment behaviors); systemic, holistic, and integrative interventions; and utilizing a developmental structure (Revisit, revise, revitalize).

a. **Creating secure attachment patterns** – The primary therapeutic goal is to facilitate secure attachment in the parent-child relationship. To achieve this goal we must recreate the elements of secure attachment that were unavailable in the child’s early developmental stages. This can take place through direct teaching of attachment behaviors and/or creating a holding and nurturing environment. Walker does not practice “rebirthing” techniques or holding therapy of any kind.

b. **Systemic interventions** – Attachment develops in the context of overlapping relationship systems, including parent-child, marital, family, extended kin, and community. For example, the quality of the mother-infant relationship is influenced by behaviors and attitudes of the father. Thus, effective treatment must address the various social systems in the life of the child and family.

c. **Holistic and integrative interventions** – Treatment focuses on mind, body, behaviors emotions, relationships, and morality. Therapeutic interventions and strategies are varied: experiential, psychoeducational, cognitive, and skill based. The holistic approach is based on the concept that many factors interact to create both health and dysfunction.

d. **Revisit, revise, revitalize** – Treatment is developmental, requiring the successful completion of each stage, which in turn builds upon the next. Attachment trauma is first revisited to address core issues. Next, the therapist facilitates revisions in belief systems, choices, relationship patterns, and coping skills. Lastly, revitalization includes celebrating achievements, cementing positive changes, and enhancing hope for the future.
Creating Effective Milieu Treatment –

Once the agency management and clinical treatment teams agreed on a theoretical foundation for treatment the agency began the process of analyzing our current intensive residential treatment programs and the individual assumptions about how such a program should be run. The management team included direct care workers in this process and employed them in completing a lengthy functional analysis of each part of the residential day. The goal of this exercise was to break apart each moment of the day and see where the program encouraged the development of functional attachment behaviors and where such programming was lacking.

Effective milieu treatment is the center of the work at Walker and in the Connections Program. In his seminal book *The Other 23 Hours*, Walker’s founder, Dr. Al Treischman, posited that the “23 hours” outside of therapy – those hours spent living life and interacting with other humans – were where the most effective interpersonal change takes place. For this reason we take the “milieu environment” quite seriously at Connections and our aim was to craft an optimal designer environment that balances the requirements of institutional care and the needs of each individual child.

Changes to the Milieu –

1. **Environmental** – As much as possible, the Connections Program strives for the environment of the milieu to mirror the community environment to which we are preparing the children to move. Decorations, furniture, food, and structure have the feel of a “home” rather than an institution. This is more than a philosophy of care, but is important in preventing children from becoming accustomed to institutional life and losing the ability to live outside of the treatment setting.

2. **Management Structure** – From the very beginning of the program it was recognized that the natural split between the residential managers and the clinical staff furthered the children’s ability to split situations and avoid intimate interactions. Staff expressed frustration with receiving differing messages around child behavior from clinical staff and residential managers. To eliminate this split and provide greater continuity of care, clinical and managerial roles where combined in the position of the Program Director for Connections. This combined position allowed greater clinical supervision for child care staff as well as greater integration of the clinical staff into the everyday functioning of the milieu.

3. **Treatment Coordinator** – The position of Treatment Coordinator was created for the program to function as a *de facto* “House Parent.” While today’s residential treatment programs rarely employ traditional house parents, we wanted to establish a position that met the needs that were traditionally filled by house parents. This person was responsible for accompanying children to appointments, coordinating special events, and most importantly, creating a relationship of co-parenting with each child’s family resource. To that end, the Treatment Coordinator was charged with breaking the artificial barrier
between the community and the residence and was often in adoptive parent’s homes, or inviting families to participate in a meal or their child’s bedtime at Walker.

4. **Sacred Space** – In order for children to be able to integrate the interpersonal lessons of the day it is necessary to provide ample opportunity for “Sacred Space” that encourages calm, quiet, and connection with others. This differs from quiet room time as it is embarked upon as a group and techniques are actively taught to the children by the child care or clinical staff. On Connections residences we hold a weekly group meeting entitled “Sacred Meeting” with all children and staff from both shifts. This is a time for community building and support as well as an opportunity for character education. Each meeting includes a time of focus on a specific personal trait and time for children to work on a “life book” that is their record of who they are as a person.

5. **Community Integration** – Despite behavior it is important for this group of children to be involved in the community. While trips into the community are generally the norm in residential treatment, on Connections we strive to take this one step further by forming formal relationships with local houses of worship, YMCAs, and sports associations and leaning on them to provide community entry points for our children. For example, The Congregational Church of Needham provides volunteer “visiting families” for our children without any current family resource. These visiting families provide the children with a window into normative family life as well as a place to visit outside of Walker.

6. **In Loco Parentis Interactions and Supervision** – At all times staff is expected to role model the behaviors we ask of our children. At the same time they have the very difficult job of acting as parents to these children and fulfilling all the roles that come with that job – nurturer, disciplinarian, housemaid, nurse, etc.

For our children with attachment difficulties, the staff is also asked to engage the children in emotionally reciprocal relationships. This is perhaps the most important role of the Connections childcare worker. Many, if not all of our children have primary difficulty in the realm of interpersonal relationship. Resolution of this difficulty is imperative if the children are to successfully live outside of an institution. Assigning children an adult as their “Mentor” encourages this.

The Mentor has a maximum of two children assigned to him or her for whom the Mentor is responsible. The Mentor is asked to actively engage these two children in a close relationship. This works against the attachment-disordered child’s natural propensity to have multiple yet shallow relationships. The child must repeatedly turn to the same Mentor for care and nurturance. At times the Mentor may participate in the child’s therapy sessions and would be an important part of introducing the child to a new foster/adoptive family.

It is recognized that encouraging personal connections between child care staff and specific children is not common in residential treatment and – in the case of some agencies – is actively discouraged. However, in the case of this group of children it
provides the only opportunity for them to practice the functional and interpersonal skills related to attachment.

One might rightly assume that this is very taxing on the child care staff who become engaged in a reciprocal relationship with the children and are pulled to emotional highs and lows. For this reason the staff in the program require intensive individual and group supervision (one hour per week) to make sure that appropriate boundaries are maintained.

Experience has shown that the childcare staff has increased empathy for parents and an increased understanding of attachment related-issues with the children.

7. **Parent Resource Involvement** – Equally as important as child care staff assuming parenting roles is actual involvement of parent resources for each child. In the Connections Program parents are encouraged to think of the residence as an extension of their own home. They are invited to join dinners, participate in bedtime routines, run activities, and are given keycards to the residences. This has the dual purpose of allowing the parents to observe and learn from the childcare worker’s interactions with the children, allowing for in the moment instruction of the parent, and minimizes the split children create between parents and residential staff. When children present with troubling behavior the parents may be included on speakerphone to strategize the consequences. Again this allows multiple opportunities outside of family therapy for the teaching of parenting skills. Parents also report liking this approach, as they feel empowered in front of their children.

8. **Language** – Children who have experienced trauma and neglect often present with poor language processing. The teaching of social pragmatics for daily living and for close relationships is a key element of working with this population of children. In addition, the staff of the Connections Program actively removed all institutional language from interactions with children. Word and phrases such as “take space” and “settle your body” are replaced with more specific and descriptive language, e.g., “I think you need to leave the group until you stand still and face me while we’re talking.” In line with the teaching of social and attachment pragmatics, adults are continually clarifying for children which decisions are child decisions and which are in the realm of adults. For example, “James, you need to put your jacket on, that’s an adult decision, not a decision that 7 year olds get to make.”

An important part of attachment development is teaching children the language and social pragmatics of attachment – this returns to our overall idea of attachment as a series of functional behaviors. For example, children are asked to make eye contact when speaking and explicitly instructed in how greetings for family members and other adults differ (hugs versus handshakes).

9. **Behavioral systems** – Effective discipline and consequences work to encourage positive, adoptive behavior while discouraging maladaptive, anti-social behaviors. While there are many theories about behavior management, each with their adherents, perhaps the most important and least considered aspect is how discipline and consequences are delivered.
In delivering consequences the staff must model appropriate social behaviors. Children with histories of abuse and neglect often have a poor ability to read facial, verbal, and social cues. Adults must be careful to deliver consequences in a fashion that is clearly connected to the behavior and where their emotions are explained or easily readable. This does not mean that staff must not express emotion; rather, they need to explain their emotion to the children. For example, “Greg, I’m feeling frustrated right now because you’re not at the dinner table. I’m not really angry, but I’m starting to have angry feelings.” It is important for children to know how their behavior impacts others.

Consequences (and rewards) should not be known ahead of time by the child and should not be applied in a pattern that is predictable to the child. It has been our experiences that if this group of children is aware what consequences apply to which behaviors, that they will misbehave up to the point of consequence; or, they once they reach the point of consequence they have “nothing to lose” and their behavior totally decompenses. Behavioral theories teach us that random reinforcement and random deterrents are most effective over the long term. The staff and management should be in agreement ahead of time to what consequences are to be implemented – this just should not be relayed to the children. Few “star charts” are found on Connections as they tend to be useless over time. For similar reasons, many if not all of the Connections children are moved off of the typical walker level system for behavior.

Staff is never allowed to strike, humiliate, demean, curse at, or embarrass the children. This behavior is not tolerated from the children and it is certainly not tolerate from the staff. Actions such as these may stop a particular behavior in the short-term, but it also teaches the children that “he who is most powerful” is in charge and that adults are to be feared and not trusted. Our children present with many obnoxious behaviors that have been taught to them or that they devalued as means of survival. Our job is to be teachers and guides towards prosocial and positive behaviors. This does not mean that negative behaviors go without punishment. However, it does mean that our emphasis is on rewarding positive behaviors.

Children are never locked away or secluded. When children’s actions or words “offend” the community we seek to correct them and restore them to their standing in the community. This may mean that they lose privileges such as going on trips or watching television. Typically a child would also have to write apologies to the person that he or she offended or find some way to earn back trust or the cost of an item that was destroyed. Staff work very hard not to use time out or “room time” as a consequence, as it only tends to feed into the child’s avoidance of relationships.

If a staff person notices that a child is becoming upset or agitated, he or she might ask the child to go for a walk or to talk about what is bothering him. By doing this many conflicts are avoided and children are taught alternate mechanisms for coping with the trouble in their life. If a child does need to leave the group it is ideally with an adult.
10. **Behavioral Assessment and Behavior Plans** – Each child has an “Individual Crisis Management Plan” (ICMP) that is specifically designed to address that child’s particular behaviors. The goal in these plans is two-fold:
   a. To provide consistency in how staff address a particular child’s behaviors;
   b. To be a functional behavior assessment that pushes staff to address the underlying causes of behavior rather than just the “symptoms.”

For instance, rather than simply punish a child that has a great deal of difficulty at bedtime, an ICMP would push staff to examine what the factors are that contribute to this difficulty. Was this child abused at bedtime? Can bedtime be altered to encourage a more positive experience?

11. **Structure of Programming** – Due to the chaotic environments from which many of our children come, they often have little ability to structure themselves – their interactions, their personal care, and the events of their day. By building a structure into the day we provide predictability and reduce stress, thereby allowing the childcare staff more opportunities to provide individualized care. Special care was given to making sure that the daily routine met the attachment goals of the children.

The daily schedule is broken down into 30 – 60 minute intervals and is presented to the children at the beginning of the staffing shift. Presenting the days’ events to the children and allowing input where appropriate, is important in creating a schedule that motivates children to move forward through their day. For instance, most children in Connections have difficulty doing their chores. For this reason the childcare staff will purposely plan a desired activity to follow chores. By doing this the children not only have something to look forward to, but also become self-motivated to complete their chores. Self-motivation leads to self-agency, feelings of competence and ultimately to behavioral change.

**Sample Weekday Schedule**

- **3pm – Children return from school**
- **3 – 3:30pm – Roomtime**
  - Roomtime is an opportunity for children to learn to entertain themselves, complete homework, and socialize with peers and clean their rooms. It is, however, structured. Children must be in their rooms and must only call for staff for bathroom or safety issues.
  - Prior to each transition in the schedule children are given 10 and 5 minute verbal warnings so that they can prepare themselves.
- **3:30 – 3:45pm – Group Meeting**
  - Group meeting is a time for adults to transfer expectations, present the days’ schedule, and to provide a forum for positive community building. At this time children and staff review their behaviors, both positive and negative, and set personal goals for the remainder of the day.
- **3:45 – 4pm – Snack**

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Many of our children have been deprived of food in their past. While meals and snacks are served at specific times throughout the day, fruit is available to children whenever they are hungry.

- **4 – 4:30pm – Afternoon Activity**
  - Activities should encourage creativity, be developmentally appropriate, and engaging. While this can be an arts and crafts activity, it is also a time for children to be taken to the community to practice newly acquired skills. For instance, using allowance to purchase candy or a toy at a local store teaches important lessons involving math, interpersonal social skills, and the value of money. Every activity, large or small, should be looked at as a teaching opportunity.

- **4:40 – 5pm – Movie/TV**
  - This could also be an additional roomtime. The purpose of this is to allow children to regroup from the excitement of the activity and to prepare themselves for the next meeting and dinner.

- **5 – 5:15pm – Group Meeting / Dinner Expectations / Wash Hands**
  - This is a brief meeting to review behavior and prepare for dinner.

- **5:15 – 6pm – Dinner**
  - In addition to the main course, children must have a fruit or vegetable. This teaches healthy eating habits while still allowing for some personal choice.
  - Childcare staff is expected to sit at the table and eat with the children. This makes behavioral control easier and promotes a community/family feel to the environment. Staff is asked to take advantage of this opportunity to teach social skills by promoting conversation and table manners amongst the children.

- **6 – 6:30pm – Roomtime**
  - The after dinner roomtime is the opportunity for children to bathe and complete their assigned chore. Children earn a small, weekly allowance based upon completion of their chore. At Connections we are more prone to reward positive behavior, such as chore completion, than to punish the absence of positive behavior. This teaches the value of work and self-agency.
  - Children to not advance from this roomtime until homework and chores are complete and their bedroom is clean.

- **6:30 – 6:45pm – Brief Group Meeting**

- **6:45 – 7:30pm – Evening Activity and Snack**

- **7:30 – 10pm – Bedtimes**
Bedtime is perhaps the most important part of the day. This is a time for nurturance, personal attention, review of the day with each child, and promotion of hopefulness for the day to come. For many of the children at Connections bedtime is also fearful due to past abuse histories. Staff takes the needs of the individual into account as they prepare children for bed.

Bedtimes are staggered with the youngest children going to bed first. This is both developmentally appropriate and it allows the staff to give waiting to go to bed must be quietly watching television, reading, or playing with a toy.

- Children are asked to brush their teeth and clean up for bedtime.
- Children should then go to their bed and wait quietly for staff to arrive. During this time they may be playing quietly on their bed. Lights are dimmed and soft music is set to play.

Each child gets 10-15 minutes of “Personal Time” where they can choose to have a staff person read to them, sing to them, or play quietly with them. After this time all toys are put away and lights are turned off. Depending on the age of the child, staff may staff in the bedroom doorway until the child falls to sleep.

**Ongoing work**

Few programs like Connections are currently in existence. This is likely due to the difficulty of the population and the amount of resources that must be devoted to experimental nature of the work. At Walker we have experienced setbacks, but also continue to expand and develop the program. In the future we plan to develop a comprehensive and ecological Assessment of Attachment Need, in order to better serve individual needs.

We have witnessed many positive results from our program yet would benefit from more outcome based research to support our claims. Such services will be developed as limited resources allow.
The bibliography below represents a selection of articles and other media that were helpful in the formation of our program.


This important parameter reviews the current status of reactive attachment disorder with regard to assessment and treatment.


Creeden, K. Attachment & Trauma: brain based interventions, [www.communityprograminnovations.com](http://www.communityprograminnovations.com).


This qualitative study examines residential childcare workers’ styles of engaging adolescent clients. Findings demonstrate the complexity inherent in residential treatment and illuminate barriers to optimal staff-client relationships. Suggestions are offered for improvement of agency policies and for future research.


This article discusses current perspective on attachment disorder specifically in these areas- differential diagnosis and discriminant validity, clinical assessments vs. academic research, attachment based treatments, and alternative and complementary therapies.


→Contains checklists for assessing attachment in children.


