Attachment Bonds (Bowlby & Ainsworth)

- An attachment bond contains all of the following elements:
- Emotional significance.
- Persistence across time and situations.
- The attachment figure is a specific other person and is NOT interchangeable.
- Desire for physical proximity to the attachment figure.
- Emotional distress in response to enforced separation.
- Comfort and safety is sought within the relationship.

An attachment bond is secure if an infant can reliably experience security / comfort / safety within it. This is critically dependent upon the infant perceiving the attachment figure as predictable, available, and competent. (Ainsworth) has described the attachment bond as reflecting the infant / young child's internal organization more than the actual interactional reality. This internal organization has been termed the child's Internal Working Model (IWM). IWM's are not limited to children however. We all have one. The IWM is the sum total of all that an individual has learned / believes about how he and others function and how the world works in general. IWM's work best when they are an accurate reflection of reality and can be revised as new experience warrants. Neither of these is the case with a child who has an attachment disorder.

Research has identified the key initial ingredients to an adult being seen as an attachment figure are the adult's responsiveness to crying, availability for social interaction of any kind, and allowing of clinging / following / related behaviors. However, attachment is greatly facilitated by the attachment figure repeatedly accurately reflecting the infant's internal state. This has variously been called attunement, empathy, or mirroring.

Contrary to popular mythology, infants are capable of more than one attachment. Multiple attachments are not equivalent, but are arranged in an internal hierarchy. The highest functioning infants have TWO working attachment bonds they can rely on. The quality of paternal, or other secondary attachments, primarily reflects the attachment skills of the relevant adult rather than a limitation in the infant's capacity to form multiple attachments. Children in institutions will attempt to form multiple attachments with their caretakers and typically select one caretaker to be the primary attachment figure. To date, we have no research data to inform us as to how the IWM of infants and young children, exposed to conflicting experiences with multiple potential attachment figures, is affected.

The basic physiological function of attachment is protection, and so attachment behaviors reliably increase physical proximity to the attachment figure (vs. the myriad distancing behaviors of children with an attachment disorder). Over time, an infant / young child assembles an expanding repertoire of behaviors for insuring proximity and protection. These various attachment behaviors are organized into an Attachment Behavioral System (ABS) that can be adjusted, over time, to changing internal and external conditions, such that the child can choose a useful behavior for the moment. It is the child's IWM that guides the choice of a particular attachment behavior in a given situation. The ABS of a child with Attachment Disorder (AD) has many fewer behavioral options and is applied quite rigidly so the same behaviors keep appearing over and over regardless of prior experience. In addition, since an AD child's goal is really distancing rather than attachment, the behavioral system could more accurately be named a Distancing Behavioral System (DBS). However, the basic function of both kinds of systems is the same- protection. AD children just see distance as offering them more protection than proximity.

The protection function is so basic that an infant will seek attachment regardless of whether the primary caretaker is adequately meeting the infant's physiological needs or not. Infants will readily seek to attach to destructive caretakers. The absence of a secure working attachment leaves an infant experiencing the world as devoid of protection and so he must fashion his own. This is a traumatic position for an infant to be in. Here is the origin of the high degree of correlation between attachment disorder and trauma. In other words, having an attachment disorder is traumatic in itself, regardless of anything else.

The quality of the initial attachment is enormously important, for it contours all subsequent development. Attachment has been identified as playing a vital role in all of the following:

- Developing relationships with others.
- Organization of the brain and nervous system.
- Identity and self-esteem.
- Speech and language development.
- Attaining full intellectual potential.
- Regulation of feelings and behavior.
- Acquiring a conscience.
- Developing a sense of time as continuous and sequential.

SUCCESSFUL ATTACHMENT IN THE PRESCHOOL YEARS

0-9 MONTHS

The indications that attachment is progressing in a healthy manner, or twisting off course, vary as an infant grows. In the first month of life, the basic developmental task to be achieved is the establishment of physiological rhythms. This prepares the way for attachment.

From months two to six, an infant experiences an expanding sense of feeling "one with the parent". There now appear a number of signs of an infant's developing attachment to her primary caretaker: smiling, making eye contact which expands from a few seconds to a few minutes during this period; a preoccupation with the parent's face; and making happy noises. This developmental period forms the basis for the emotional significance that eye contact will carry for the rest of life. By the sixth month, an attaching infant is showing the full range of emotions, is responsive to parental wooing, and initiates wooing exchanges.

By six or seven months, an infant has usually begun to experience stranger anxiety. Paradoxically, stranger anxiety is a "witness" that testifies to the strength of an infant's attachment to her parent. It is this attachment that defines everyone else as "strangers". Without an attachment, there are no strangers; everyone is of equal importance or, more accurately, of equal unimportance. Behaviorally, stranger anxiety manifests as distress in the presence of strangers and a checking back in with the parent for reassurance. Over the next two to three months, stranger anxiety intensifies before fading into its successor: separation anxiety.

9-15 MONTHS

Separation anxiety usually begins at nine to ten months, peaks between twelve and fifteen months, and can last until somewhere between twenty-four and thirty-six months. Separation anxiety emerges

out of the infant's growing awareness of separateness from his parent. It is yet further testimony to the strength of the infant's attachment.

There is a range of behavioral reactions to separation anxiety: some children cry in protest and cling to the parent; others withdraw from the world until the parent returns; still others protest by becoming angry and aggressive. While these behaviors may seem troublesome in the moment, they are proof that the work of attachment has proceeded well to this point.

The period of ten to eighteen months comprises the well known "love affair with the world". The fundamental developmental task is exploring the world while refining emerging motor skills. Attachment shows up here in the child repeatedly "checking in" with the parent in the midst of her explorations. A child will go to the edge of his comfort zone and return to check in with the parent before venturing out farther.

At this age children have already invested significant emotional energy in other family members beyond the initial primary caretaker. This reflects the value of that initial attachment in that the child naturally seeks to extend it. Despite this, a child generally turns to mother when hurt, tired, or sick; an indication that the primary attachment still predominates. Other signs of healthy attachment at this age are: experiencing joy in accomplishments, acceptance of comforting from others, and the beginning of self-comforting skills with the aid of cherished objects such as the well known blanket.

15-24 MONTHS

A child's exploration of the world increases his awareness of being separate from mother. For the fifteen to twenty-four month old, this greater awareness gives rise to wooing and coercion as well as shadowing and darting. Wooing is solicitous behavior designed to draw mother's attention. Wooing behaviors usually intensify with time; and at some point, mothers usually come to experience wooing as a coercive demand rather than as an invitation.

Like wooing, shadowing and darting are attempts by the toddler to reconcile the seeming impossible dilemma of extending autonomy while preserving attachment. Shadowing refers to a child's following the parents practically everywhere while darting refers to rapidly moving towards and away from the parent. Both are signs of healthy attachment.

24-36 MONTHS

The final building blocks of attachment are put in place between twenty-four and thirty-six months with the accomplishment of self and object constancy. Self constancy is the child's experience that she is, essentially, "who she is" across different emotional states and situations. Object constancy is the child's experience of others as predictable and available. Much of object constancy comes from a child's mental images of others. Self and object constancy serve to quiet separation anxiety as well as strengthen a child's ability to delay gratification and accept discipline. Self / object constancy is also the basis for accurate temporal perception. With it, time is experienced as a connected continuum, flowing from past into present and out into the future. Without it, time consists of so many discrete moments, each one disconnected from all others- one of the hallmarks of attachment disorder. When all goes well, the foundation for attachment is fully laid by thirty-six months.

3-5 YEARS

Egocentrism (everything in the child's world is somehow a reaction to her) dominates the thinking of this age period; and as a result, most if not all, 3-5 year-olds come to conclude that they caused their

abandonment by their birth parents. This is normal, and if things are going well, children will move through, and beyond this conclusion.

Children of this age organize their world on the basis of similarities much moreso than differences. Developing attachment manifests in the child noticing multiple likenesses between himself and his family and this nourishes a sense of belonging in, and to, his family.

Much of what children learn during this time period comes by way of imitation, or "trying on" the behavior of others, both real and fantasy figures. When children are attaching to parents, it is the parents that the child increasingly imitates as time goes on.

WHEN ATTACHMENT GOES AWRY

0-9 MONTHS

For the infant of zero to nine months, poor attachment appears as: poor reciprocal eye contact when gazed at or spoken to; lack of reciprocal smiling or noisemaking; resistance towards physical contact and comforting through pushing, kicking and arching away; frequent screaming and crying spells that lack any apparent cause and are quite immune to comforting (these are the beginnings of what may become intensive rage reactions); repetitive motions {headbanging, rocking} which are unsuccessful attempts at self-soothing; a lack of stranger anxiety which results in extreme precociousness that moves the infant towards an omnipotent position of not needing anyone because the child can handle it all; or an overwhelming stranger anxiety that can't be soothed and results in social withdrawal. It is the lack of stranger anxiety that is the seed of attachment disordered children's notorious indiscriminate friendliness.

9-15 MONTHS

In addition to the earlier symptoms, at this age, separation anxiety may intensify to the point that the child will not leave the parent. This blunts the normal curiosity to explore the world that comes with the ability to walk. If stranger anxiety never developed, then with the mobility of this age, the first incidences of indiscriminately approaching strangers may occur. Lack of effective self-soothing skills can manifest now as behavioral hyperactivity (which may eventually be mistaken for AD/HD). Frustration tolerance does not develop, and in its absence, toddlers begin assembling a repertoire of aggressive behaviors to both vent their frustration and get the world to bend to their wishes.

15-24 MONTHS

Attachment difficulties at this age mire the child in an inability to balance dependence and independence. Frozen in this dilemma, children either choose one of the two extremes and remain exclusively there, or ping-pong between them, never able to find a place of lasting comfortableness. The sense of "failing at life" begins to dawn at this age, and this generates anxiety and shame which usually appears as heightened aggressive behavior and protracted temper tantrums beyond that typical of the "terrible twos".

24-36 MONTHS

Weak or absent attachment in this age range usually precludes the development of self and object constancy. Without self constancy, children have no stable sense of themselves that they feel they can rely on. This riddles them with anxiety and leaves them frighteningly dependent on the external world for meeting all of their emotional needs. This is the breeding ground for the hypervigilance so

commonly found in attachment disordered children. In addition, they can neither give nor receive love, because there is "no one home" to give it or receive it.

Without object constancy, children experience all physical separations as absolute abandonment. They live within the prison of "out of sight, out of mind". If the other is not there physically, the other does not exist. This manifests as either incessant clinging and demandingness from which there is no relief for parents; or in a desperate attempt to live as if they are beyond needing anyone else. This renders others' comings and goings irrelevant.

Without self and object constancy, there is no experience of time as continuous. Instead, time is so many discrete moments, each one separated from all others. This is the basis for attachment disordered children's well known difficulties with cause and effect. To understand cause and effect, one has to be able to connect things across time. Children with attachment problems can't do this. What happens in any one moment has nothing to do with anything that happens in any other moment. Hence, cause does not get connected to effect, behavior does not get connected either to its precipitants or its consequences, there is no learning from experience… .

3 TO 5 YEARS

If there are attachment problems, children of this age get mired in the egocentric conviction that they were abandoned because of some intrinsic deficit of theirs. Instead of moving past it, they are likely to expand it such that they come to see themselves as a "jinx" who causes a variety of bad events to occur. This arrests thought at the level of magical thinking which becomes the basis for the well-known symptom of "crazy lying" as the child gets older.

Preschoolers may subsequently develop a terrifying fear of their own power as inherently damaging, which will infuse identity with shame. This will perpetuate an egocentric stance in the world well beyond the preschool years. Once shame gets woven into identity, changing it becomes a terrifying prospect as well, for then the child loses her sense of who she thinks she is. The result: the child is paralyzed in a nightmarish dilemma of being afraid of themselves AND afraid to change themselves. Such is one of the horrors that many attachment disordered children live with, day in-day out.

A faltering attachment will block the child from perceiving any sameness between herself and her family. This precludes experiencing any sense of belonging to the family (or anywhere else for that matter), leaving the child an "alien in an alien land". The child will evidence little or no "role-playing" of the parents and may exhibit a marked absence of any self-initiated play. Instead, what often emerges is a preference for deviant, aggressive, and powerful figures. These figures are commonly drawn from some media-driven fantasy realm.

ATTACHMENT DISORDER

When the attachment process does not go well, it is almost never because of any single cause; but because of multiple influences interacting. A number of risk factors have been identified as increasing the probability of attachment difficulties:

- Prenatal rejection of the infant.
- Intrauterine exposure to alcohol and /or drugs.
- An early history of loss / abandonment.
- A history of multiple caretakers, and/or multiple changes in living location early in the child's life.
- Failure to thrive; chronic illness or pain.

- Sensory processing deficits and developmental disorders that obstruct interaction with the environment.
- Physical and/or sexual abuse.
- Neglect.
- Extended or repeated hospitalizations {mother and / or child} during the child's first three years.
- Significant parental mental health problems including substance abuse.
- A history of harsh, overindulgent, or extremely inconsistent parenting.
- Chronic severe marital conflict.
- A significant temperamental misfit between parent and child.

While the majority of children with attachment difficulties are, expectably, found in the adoption and foster care systems, they are emerging in increasing numbers out of biologically intact families.

DIFFERENTIAL DIAGNOSIS

Attachment Disordered {AD} children are a diagnostic collage. Aspects of their functioning can be found in all of the following diagnostic categories:

- Attention Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Separation Anxiety Disorder
- Generalized anxiety disorder
- Post Traumatic Stress Disorder
- Dysthymic Disorder / Major Depression
- Bipolar Disorder / Cyclothymic Disorder

Because Attachment Disordered children present clinicians with a diagnostic array of possibilities, these children are not so much misdiagnosed as they are "partially diagnosed". One aspect of their functioning, typical of one of the above disorders, may catch a clinician's eye. The child is then given that diagnosis, and the larger Attachment Disorder picture gets lost as "the part is mistaken for the whole". Treatment is then based on the partial diagnosis, and this all but guarantees treatment failure.

THE ATTACHMENT DISORDER SPECTRUM

As is true with other mental health disorders, Attachment Disorder is not a discrete entity, but is a spectrum made up of a number of variants. The attachment spectrum ranges from the wholly unattached child at the severe end down to children at the mild end who, more accurately can be described as having attachment issues / insecurities vs. Attachment Disorder. Children with attachment issues can attach; they just cannot maintain it consistently across time as there are deficits in self and object constancy. Children with Separation Anxiety could be appropriately included here.

THE SUBTYPES OF ATTACHMENT DISORDER

- Anxious Attachment Disorder
- Avoidant Attachment Disorder
- Ambivalent Attachment Disorder

- Disorganized Attachment Disorder

GUIDELINES FOR LIVING AN ATTACHMENT DISORDERED LIFE

AD children will expend effort to "achieve" some or all of the following outcomes. To the AD child, generating these results is more motivating than any conventional idea of success or positive accomplishment.

- Being mysterious, unknown, and confusing to others.
- Ruining others' happiness because they find it intolerable to be around.
- Avoiding / dismissing any emotionally arousing experience regardless of the kind of emotion involved (with the exception of anger).
- Staying beyond the reach of anyone's complements or praise.
- Maintaining and enhancing their negative feelings about themselves.
- Presenting themselves as entirely self-sufficient and therefore not in need of anything from anybody.
- Nourishing their subjective sense of power by striving to win oppositional battles, seeking to influence the behavior and feelings of others, and being unresponsive to others' attempts to reach / influence them.
- Extending their power by claiming the very power to define reality itself ("crazy lying").
- Reinforcing their sense of entitlement by disparaging / attacking others for not giving them what they want.
- Avoiding ALL personal responsibility by playing the "victim role" when it is strategically convenient to do so.

REFERENCES

The Handbook of Attachment. Ed. by Jude Cassidy & Phillip Shaver.
Facilitating Developmental Attachment by Daniel Hughes.
Real Parents-Real Children by Holly van Gulden.