

**A. Attachment and Attachment Disorders*****Conceptual Framework***

Abused and neglected infants and young children are at high risk for developing insecure or maladaptive attachments. Early, prolonged, or traumatic separations from the primary caregiver have also been highly correlated with attachment disorders in children and youth [Levy & Orlans 1995; Bowlby 1973; Maccoby 1980]. When these attachment patterns are observed in infancy and early childhood, they tend to be durable, sometimes persisting through adolescence and into adulthood [Levy & Orlans 1995; Mussen, Conger, Kagan & Huston 1984; Maccoby 1980; Cline 1992; Isabella 1993].

Many children and youth who experience severe maltreatment and/or repeated or prolonged separations from their caregivers during early childhood exhibit serious attachment disorders. These disorders are characterized by an absence of meaningful attachments; superficiality in relationships; a vigorous avoidance of intimacy; rejection of overtures of affection and caring; a pervasive lack of trust; a strong need to control and manipulate others; and behaviors that include volatile anger, hostility, and cruelty to animals and other people [Levy & Orlans 1995; Cline 1992]. Attachment disorders and their associated behavior problems can seriously interfere with family adjustment in both foster and adoptive placements, and greatly increase the risk of placement disruption [Katz 1986; Pinderhughes & Rosenberg, 1990; Fahlberg 1991; Levy & Orlans 1995].

Some children who have experienced relatively deprived environments during infancy retain a capacity for recovery, and can develop healthy attachments, if

they are provided with a permanent, nurturing caregiver, and a stimulating environment early in life [Mussen et al. 1984]. Even children with intractable attachment disorders can sometimes be helped to learn trust and to develop meaningful interpersonal relationships with the proper therapy and the constant support of permanent, giving, and patient caregivers [Cline 1992; Levy & Orlans 1995; Fahlberg 1991].

Because the quality of early attachments has such a strong and enduring influence on children's social and emotional development, child welfare workers must be vigilant in identifying signs of attachment problems in children who have experienced maltreatment and/or separation. There might be attachment problems in children living with their own families, or in adoptive, foster, or relative placement. Workers should include interventions in family case plans that promote and strengthen healthy parent-child attachment, and that provide specialized therapy for children with attachment disorders.

### Healthy Attachment

An understanding of the importance of healthy attachment to all aspects of child development will further our understanding of the potentially traumatic consequences of maltreatment and traumatic separation on development.

Infant attachment refers to the earliest enduring social and emotional relationships very young children develop with the significant people in their lives. The propensity to develop attachment is a fundamental and inborn human trait. Positive attachment is widely believed to form the foundation for many

aspects of subsequent development [Maccoby 1980; Mussen 1984; Gardner 1978; Damon 1977; 1983].

An infant's first attachment is formed with its mother or other primary caregiver. Infants rapidly develop other attachments as well, usually with fathers, siblings, and extended family members. Attachment between a mother and her infant is a reciprocal process. The mother's caregiving behaviors of feeding, holding, nurturing, smiling, cuddling, and talking to the infant reinforce the infant's attachment to the mother. The infant's responses to its mother's care, including cooing, smiling, cuddling, and becoming quiet when held, strengthen the mother's attachment to the infant.

Children develop their strongest attachments to caregivers who are sensitive and quickly responsive to their needs. The caregiver recognizes and knows the meaning of the infant's verbal and nonverbal cues, and knows how to respond to these cues to meet the infant's physical and emotional needs. This includes feeding the infant when it is hungry; assuring the infant is warm, dry, and physically comfortable; and comforting and soothing the infant when it is distressed or frightened. When infants are tired, hungry, or distressed, they often cannot be comforted by anyone other than the caregiver who has historically recognized and responded to their signals of physical and emotional need. As they get older, children with healthy attachments can also be comforted by other supportive caregivers.

Engaging infants in play and other pleasurable social interactions also promotes the development of attachment. This is often the basis of attachments formed by infants with siblings, grandparents, and others who do not generally provide

primary care. Nurturance and pleasurable social interaction are both necessary predeterminants of attachment. Infants are also more likely to approach persons with whom they have attachments for play and interaction.

There is congruence in the literature about the effects of early attachment on many areas of child development [Ainsworth et al., 1978; Bowlby, 1970; Maccoby 1980; Mussen et al. 1984; Gardner 1978; Damon 1977; 1983].

First, a child's early attachment experiences have a profound effect on the child's later ability to form and maintain healthy interpersonal relationships. According to Erik Erikson [1959; 1963], the primary milestone in emotional development during the first year of life is the development of "basic trust." For Erikson, trust refers to infants' perception of the environment as a positive, generally responsive, nurturing and dependable place, as well as their sense of competence and confidence in their ability to act upon the environment to assure that their needs are met. The degree to which caregivers positively respond to cues and meet an infant's needs has a significant influence on both aspects of trust. For Erikson, an infant's early and continuous attachment to a dependable and nurturing caregiver is the single most important factor in the development of basic trust. Erikson also believes that infants' experiences with attachment influence their "world view," or basic attitude toward the world, which sets the tone for all future relationships and interactions with the environment. Thus, if early attachments are absent, unpredictable, or a source of pain, a child will be more likely to avoid intimacy in future relationships.

Healthy attachment promotes the development of language and other communication abilities. Social interaction between infants and their caregivers

stimulates the development of both verbal and nonverbal communications. Babbling, cooing, vocal interactions, and eye contact with caregivers are precursors to language development. Infants develop communication skills at an early age. Crying is an infant's first and primary means of communicating distress or discomfort. Within a few months, the infant's cries become differentiated, and most mothers can recognize tired cries, angry cries, frightened cries, or cries for attention. Timely nurturing responses by the caregiver to these and other cues from the infant further reinforce the infant's attempts to communicate. Children who have been neglected, abused, or abandoned by caregivers are often delayed in their development of language and other communication skills.

The nature of a child's attachments can affect the development of self-esteem. Through relationships with important others, a child learns that he is valued, worthwhile, and wanted. He is positively reinforced by the affection, caring, and protection he receives from those with whom he has close attachments. These positive relationships are critical in establishing the foundations of the child's sense of self. Healthy attachment is viewed by developmental psychologists as one of the most important foundations of healthy personality development. Children who do not feel loved and important often develop low self-esteem, and perceive themselves as inadequate in many ways. Children also identify with persons to whom they have close attachments. This is a primary way that attitudes and values are transmitted to the developing child.

Proximity to a primary caregiver affords a sense of security, which reduces anxiety in stressful situations. Infants and young children have few skills with which to cope with life stresses. As children grow, they develop more sophisticated coping strategies, and greater self-reliance in mastering life's tasks and challenges.

Infants and young children, however, must rely on the adults in their lives to protect them, and to remove the sources of stress. Children depend upon their primary caregivers to feed them, keep them warm, comfort them, reassure them, and protect them from harm. The child who has developed a strong attachment with a caregiver has a dependable source of security, which frees the child from unnecessary anxiety and fear. Children who are deprived of this security may display strong anxiety reactions to even minor stresses. If the anxiety state continues for a long period of time, it can interfere with the child's development in all domains.

Considerable early learning takes place through play and interaction with primary caregivers. Play stimulates a child's cognitive, physical, and social development. Children develop social skills such as sharing, cooperation, and negotiation through play with parents and siblings. Children are also encouraged by parents to learn and to repeat new skills and activities. For example, many children would likely never attempt to ride a two-wheel bicycle without training wheels were it not for a proud, cheering, encouraging parent. The child's trust in, and wish to please the parent, both aspects of healthy attachment, are significant factors in motivating the child to learn.

Finally, healthy attachment fosters the development of self-reliance and autonomy in children. The secure emotional base derived from healthy attachment promotes exploration, experimentation, and the development of self-confidence and self-reliance.

### Maladaptive Attachment

When the caregiving environment does not consistently meet an infant or young child's physical and emotional needs, maladaptive attachment is likely to result.

Ainsworth and her colleagues [1969; 1978] conducted seminal early research on variations in attachment behavior in infants using a technique called the "strange situation." One-year-old infants were observed first at home, and then again in a laboratory setting, where they were subjected to brief separations and reunions with their mothers. Their behavior in response to this separation was assessed. Most of the infants who were studied were found to be securely attached to their mothers. They related to their mothers in warm interaction; they used the mother as a safe base for exploration; they protested and cried upon separation; they showed pleasure when the mother returned; they were easy to console; and they clearly preferred the mother to a stranger.

However, some infants displayed behaviors that suggested their attachments to their mothers were quite different in nature. Ainsworth et al. [1969; 1978] described these attachment styles as anxious and insecure. Insecurely attached infants were divided into two categories; avoidant, and ambivalent or resistant. These insecurely attached infants demonstrated a variety of behaviors both in the presence of their caregivers and when separated from them. For example, the avoidant infants explored independently, but they did not use the mother as a safe base; they tended to ignore her. They showed little protest when separated from the mother, avoided contact when she returned, and did not discriminate between the mother and a stranger. By contrast, the ambivalent/resistant infants did not explore the environment at all prior to separation; they became severely

agitated and anxious during separation; and they simultaneously sought contact with the mother and pulled away from her upon her return.

Ainsworth et al. [1969; 1978] noted correlations between the caregiving behaviors of the mothers and the attachment styles displayed by their infants. Mothers of securely attached infants tended to be warmly responsive and available to their infants, and they attended readily to their infants' cues. Mothers of avoidant infants were more likely to be unresponsive and rejecting with their infants; they appeared to lack emotional warmth and expressiveness, and they avoided physical contact. Mothers of ambivalent infants tended to be inconsistent and unpredictable; they were available and responsive on some occasions, but not others.

A fourth style, labeled "disorganized-disoriented" was later described by Main and Solomon [1990]. The attachment behavior of these infants was confused and often contradictory. They approached the parent, but with a stiff body; they expressed intense anger, followed by a sudden dazed appearance; they failed to seek out the mother when frightened; they attempted to leave with a stranger rather than remain with the parent; and they often showed fear at the sight of the mother upon reunion. Lyons-Ruth et al. [1993] found that disorganized attachment patterns in infants increased in frequency as the severity of social risk factors increased in their families. Carlson et al. [1989] found that 82% of infants in their study sample of maltreating families exhibited disorganized-disoriented attachment. Crittendon's [1985] study results identified that mothers of disorganized-disoriented infants were often abusive or neglectful toward their infants, and Main and Hesse [1990] identified that many of the mothers of

disorganized-disoriented infants had themselves suffered physical and sexual abuse as children.

Some children with organic or neurological conditions may fail to develop strong attachments. Examples are children with autism, and some children who have been prenatally addicted to drugs, such as crack cocaine. Some children with organic problems are believed to be unable to accurately perceive, understand, and respond to external stimuli. They may not be able to signal their needs; they may experience excessive discomfort despite parental intervention; and they may not respond positively to their caregiver's interventions. Their caregivers often do not feel reinforced or competent in meeting their child's needs, and the child's unresponsiveness may contribute to emotional withdrawal by the caregiver.

While mental retardation may have an organic origin, we must not presume that children with mental retardation, even at severe or profound levels, cannot form attachments. Most children with mental retardation have the same needs for nurturance and affection as do all children, even though their manner of expressing and responding to such nurturance may be different from that of typical children.

The long-term effects of early attachment problems on later adjustment and behavior are not fully understood. Several studies have found sufficient correlations between early attachment style and later behavior to suggest that children with maladaptive attachments are likely to have a wide variety of behavior problems during preschool and school age [Lyons-Ruth 1993; Maccoby 1980; Levy & Orlans 1995]. Insecurely attached children are more often socially withdrawn, hesitant to participate in interactions and activities, and less curious.

They are easily frustrated in response to problems, seldom ask for help, and may be hostile and aggressive toward other children.

However, caution in interpreting this data is warranted. For example, while Lyons-Ruth found that 71% of preschool children with serious hostile and aggressive behavior had been classified during infancy as "disorganized" in their attachments, this group of highly aggressive children represented only a small percentage of a larger group of children who had been classified as "disorganized" in their early attachments. Even grossly pathological care does not always result in the development of attachment disorders. Some children are known to form stable attachments and social relationships even in the face of marked neglect or abuse [American Psychiatric Association 1994]. An appropriate conclusion is that maladaptive attachment increases the likelihood of later emotional and behavior problems, but does not, by itself, always cause them.

Mussen et al. [1984] also suggests that while the general classifications of insecure attachment may be accurate, several factors may reduce accuracy in determining the attachment style of any individual child. These factors include cultural differences in the expression of attachment and emotion; children's temperament and their general vulnerability to anxiety; and whether the parent supports autonomous and self-reliant behavior in the infant, or is highly protective. As an example, if an infant failed to react to brief separation from the mother, and also failed to respond to her upon return, the infant would likely be classified as avoidant in attachment style. An alternative explanation might be that the infant is sufficiently autonomous and secure in his attachment not to be threatened by a brief separation. Or, the child may have attended day care and

may be accustomed to being left by the parent. Mussen et al. [1984] also noted that children's attachment styles often varied during the first year, and the exhibition of certain "insecure" behaviors did not necessarily mean a child was insecurely attached. In order to accurately identify children with insecure attachments, the parent-child interaction should be observed over time, and in a variety of circumstances.

Research has also attempted to identify the relationship between caregiving behaviors of mothers and attachment outcomes in their infants. The results of these studies strongly link sensitive and responsive maternal caregiving with secure attachment in infants [Maccoby 1980; Mussen et al. 1984; Isabella 1993]. The precise relationships between other maternal styles and attachment outcomes are less well understood. Maternal rejection appears to be related to the development of avoidant attachment in infants. Rejecting mothers are often described as angry and hostile, controlling, and irritable. They may consistently oppose the infant's wishes, pervasively scold the infant, or forcibly interfere with the infant's activities [Ainsworth et al. 1978; Lyons-Ruth 1987]. Avoidant behavior by these infants is theorized to be a defensive and protective strategy. The determinants of resistant/ambivalent attachment are thought to include inconsistency and unpredictability in maternal behavior; that is, sensitive and responsive at times, and insensitive and unresponsive at others [Isabella 1993]. Maternal depression, hostility, and the presence of psychosocial problems appear to also increase the risk of disorganized-disoriented attachment [Lyons-Ruth et al. 1993].

In summary, the research suggests that maternal behavior is a potentially strong determinant of the nature of attachment in infants and children, but it is clearly

not the only factor. However, the strong association between sensitive and reciprocal caregiving and healthy attachment would suggest that child welfare workers should promote the development of healthy attachment as often as possible. And, the high correlation of maladaptive attachment in samples of abused and neglected children would also suggest that we regularly intervene to help maltreating parents learn to relate in more sensitive and responsive ways with their children

## *Application*

### Assessing and Promoting Secure Attachment

Child welfare workers should observe parents with their infants and young children to assess the quality of their caregiving behaviors, and should involve parents in learning more effective ways of meeting their children's needs.

The parental behaviors that promote secure attachment can be categorized as follows:

- The parent accurately recognizes the child's cues of distress and need, and quickly intervenes to provide comfort and remove stress.
- The parent provides the child with stimulation and initiates playful social interaction.
- The parent provides the child with contact comfort and closeness.

Each of these will be discussed separately, and specific parental interventions that promote secure attachment will be reviewed. While many of these activities will seem to be "common sense" to caseworkers who are parents themselves, it must be remembered that parents of maltreated children may need help in recognizing the importance of nurturing caregiving and in learning how to provide it.

- 1) *The parent accurately recognizes the child's cues of distress and need, and quickly intervenes to provide comfort and remove stress.*

Most parents quickly learn and respond to their children's expressions of need. Parents who have not experienced close attachments, or who lack parenting ability may need to be trained to recognize their children's cues, and to respond to them properly.

Crying usually indicates distress. Crying can have multiple meanings, and parents must learn how to differentiate them. According to Bowlby;

"Crying from hunger builds up slowly. When first heard it is of low intensity and arrhythmical; as time passes it becomes louder and rhythmical, an expiratory cry alternating with an inspiratory whistle. Crying from pain, on the other hand, is loud from the start. A sudden long and strong initial cry is followed by a long period of absolute silence, due to apnoea [lack of oxygen]; ultimately this gives way, and short gasping inhalations alternate with expiratory coughs...." [Bowlby 1969]

Fussiness is generally characterized by whimpering, wailing, and intermittent short cries. Eventually, this may progress to loud and constant crying. Fussiness can indicate early stages of hunger; discomfort because the baby has a wet or dirty diaper; indication that the baby is too cold or too hot; sleepiness (particularly if the baby has been awake for a while and rubs his eyes and face with fists); or because the baby desires attention. The caregiver should respond to crying or fussiness in the following manner:

- 1) Check for the source of discomfort, including a wet or dirty diaper, or skin that is hot or cold to the touch. Parents should understand that for the first several weeks, newborns often cry when they are unclothed, and will stop crying as soon as they are dressed or wrapped in a blanket. The infant may, therefore, cry when being bathed or diapered. This is eventually outgrown.
- 2) Determine whether the infant is likely to be hungry, based on the length of time since the last feeding and the amount of food taken. (Some parents mistakenly believe that every time their infant cries, this indicates hunger.) If attempts to feed the infant do not quickly resolve the fussiness, the infant is likely not hungry. Spitting food out or turning the head away from the bottle or spoon also suggests the child is not hungry. It is important to help parents understand that an infant's refusal to take food does not indicate rebelliousness or stubbornness. Force feeding can result in unproductive struggles between the parent and infant.
- 3) Pick up the infant and hold him upright on the shoulder. If the crying stops immediately, the infant may have simply wanted a change of

- scenery, stimulation, or physical comfort. To stimulate a bored infant, moving to a different room, changing position, providing new toys or visual stimulation, playing music, or talking may settle him.
- 4) Bowlby [1969] suggests that when the infant is not hungry, cold, or in pain, the most effective terminators of crying are: a) the sound of the mother's voice; b) nonnutritive sucking (a pacifier, a nipple, or sometimes water or juice in a bottle); and c) walking or rocking the baby. When infants are rocked, crying often ceases. Bowlby also describes research that suggested that infants who are rocked before they become distressed are often content longer, and that periodic rocking can prevent later crying.
  - 5) Parents must be taught to recognize signs of illness in the infant, including fever, congestion, and difficulty breathing.

Healthy infants also provide signals that they desire attention and personal interaction. For example, smiling signals an interest and a desire for social contact and requires a reciprocal smile from the caregiver. Babbling also signals an interest in social contact, and requires that the caregiver talk to the infant or involve him in face to face interaction.

A loud vocalization to attract attention in a not-yet-verbal child, or calling "Maaaa" or "Daaaa," is a signal that the child wants attention, and desires a response from the caregiver. The parent can respond verbally by saying "What?" or "I'm right here." Sometimes moving into the child's field of vision, establishing eye contact, and talking briefly may placate the infant. Additional calling might

require more focused attention, as well as some stroking of the child, talking for a minute, patting him, or playing briefly.

If the child raises her arms as the parent walks by, or after the child has locomoted toward the parent, this almost universally means "pick me up." After a brief period of cuddling and holding, the child can often be put back down and redirected.

*2) The parent provides the infant with stimulation and opportunities for playful social interaction.*

Interaction with the caregiver provides the infant with experiences that stimulate learning and strengthen attachment. Many activities can also be taught to older siblings. These activities include:

- The parent should place the infant in an infant seat or play pen, or on the floor on a blanket, so the infant can see and interact with family members. Generally, infants should be isolated only when sleeping or resting, or when they need quiet time or a reprieve from overstimulation.
- The parent should give the infant safe objects to explore, both visually and tactilely, including rattles, balls, colorful objects that the infant can transfer from hand to hand, blocks, crib toys and mobiles, bright and colorful pictures on the walls near the infant's bed, or other objects with interesting colors and shapes. Objects can have varying textures, such as sponge balls, fuzzy toys and blankets; and smooth, satiny cloths.

- The parent should initiate conversation with the infant and respond when he babbles. After the age of about three months, infants can be engaged in reciprocal vocalizing. The infant should be placed on his back, and the parent should make eye contact with him. The parent should smile and talk to the infant, then wait. The parent should keep prompting by talking to the infant. Eventually the infant will coo, babble, gurgle, or make some other vocalization when the parent's vocalizations stop. The parent then reinforces the infant's vocalizations by smiling, nodding, and saying things like, "Is that so?" "Tell me more," "Uh huh," "So what do you think?" or anything that comes to mind. Eventually, the infant will learn this reciprocal game and will find great pleasure in these "conversations."
- The parent should encourage play during regular caregiving activities, such as bathing, diaper changes, and dressing the infant. The parent can provide rubber toys in the bath; tickle the infant with the washcloth; or pour water from a cup onto the infant's tummy. Parents should use a face-to-face position, and talk with the infant while bathing and dressing her.
- The parent should address the infant with animation in the voice, and should avoid a monotone or harsh tones. The parent should vary the tone of voice and inflection to communicate interest and positive response. The caseworker can help the parent model and practice how to talk to an infant. It matters less what is said than how it is said. The worker can point out how infants will orient and attend to variations in expressiveness of the parent's voice.

- The parent should smile and encourage reciprocal smiling and laughing. Teach parents to play simple games, such as "patty cake" and "peek a boo," or to dance a toy or doll in front of the infant. After the infant is age six months, the parent can place a handkerchief or a light cloth over the infant's head for a few seconds, and then pull it off, and laugh. Older infants will learn to pull the cloth off themselves and laugh.
- Once the child has become mobile and can stand unassisted, the parent can encourage her to "dance" to music. The parent can model "dancing" by clapping hands, snapping fingers, swaying, moving, and taking the child's arms and moving them rhythmically. The parent can also dance, holding the child, being cautious not to overstimulate or bounce the child too heavily.
- After the child is nine months to one year old, learning words and names of objects is a game that can promote language development. The common "Where's your eyes? Here they are!" can be applied to almost all easily identifiable body parts (nose, mouth, ears, hands, feet, belly button). As the child begins to learn the names of objects, the game can be expanded to, "Where's the ball? Where's your bear?" A parent can also look at a magazine or book during quiet time with the child in her lap or sitting next to her, and can point out and name objects in the pictures. The parent can also help children develop language by commenting on the child's activities. For example, "You're sitting so quietly. Are you a happy baby?" "What a nice ball you have there." "Are you looking at the kitty? That's a nice kitty."

*3) The parent provides the infant with contact comfort and closeness.*

Parents should provide the infant with physical closeness and comfort in a manner that is consistent with the family's culture. Cultures differ in the degree of physical closeness that is appropriate. In many ways, western culture promotes more physical distance between parents and infants than do many other cultures. Consider the many societies in which infants are carried on their mother's backs (or fronts) in slings, or ride on her hip as the mother goes about her work. In many cultures, infants also sleep in the same bed with their mothers, both parents, or other siblings, until they are several years old.

Bowlby [1969] suggests that the need for physical proximity is innate. Infants universally approach their mothers, and follow them as soon as they are mobile. They often signal that they want to be picked up (the "arms up" behavior), or cry until they are held and cuddled.

Physical closeness can be promoted by the following:

- Keeping the infant in a playpen or infant seat in the same room with the mother, and frequently touching or gently patting.
- Laying the infant on the parent's lap while the parent is watching television, talking on the phone, reading, or sitting. The infant can also be placed next to the parent's lap on a couch or chair.

- Allowing a resting or sleepy infant to relax in the parent's arms; holding, cuddling, and rocking the infant. Or, bouncing the infant in the parent's lap, or holding the infant by the arms and standing her in the parent's lap.
- Holding the infant during feedings, or laying the infant on or next to the parent's lap. Feeding is an important time to promote attachment.  
Parents should not prop the infant's bottle in the crib and leave the room.

Parents may need help in recognizing the infant's cues regarding being held. Some infants, when busy or otherwise occupied, do not like the restriction of being held, and will protest, or wiggle or squirm to be put down. Some parents may experience this as rejection. The parent should be helped to learn to understand the infant's cues, and respond accordingly.

Caseworkers and other helpers can use several strategies to teach parents more effective caregiving skills, and to promote more secure attachment between parents and their infants and young children. These strategies include:

- While providing home-based services, caseworkers and homemakers can model more effective caregiving skills, and can provide guidance, coaching, support, and reassurance as parents try to learn and master these skills.
- Parents can be referred to infant stimulation programs, parent education programs, or parents-with-infants support groups offered through the child welfare agency or other local community agencies.

- Extended family members or volunteers (through church groups, community centers, etc.) can be engaged to work with parents and monitor the care of the child.
- If an infant or young child is in foster or kinship care placement, the foster or kinship caregiver can work directly with the parent in the placement setting. The substitute caregiver can model good caregiving, and can coach and support parents as they acquire these skills. Often, parents can eventually assume direct care of their infant in the placement setting. This is a valuable intervention to promote reunification.
- At times, parents' emotional problems may result in their ignoring or rejecting their infant. This is often the case in situations of failure to thrive. (See Section VI-B, "The Effects of Maltreatment on Infants and Toddlers," for a discussion of working with parents of failure to thrive infants.) The worker should assure that parents receive appropriate counseling in addition to training in parenting. At times, emotional problems may prevent parents from forming attachments to their children. Caseworkers should try to assure that these infants have regular access to a surrogate caregiver with whom they can form a strong attachment. This may be another family member who can assume primary care, active involvement of extended family members, or for children who cannot be protected at home, a foster, relative, or adoptive caregiver.

### Identifying Insecure Attachment in School-Age and Older Children

With our recent acknowledgment of the relationship of maladaptive attachment to later behavioral and emotional disorders, there is a tendency to label any children with behavior problems that suggest failure to appropriately relate to others as having "attachment disorders." Zeanah [1993] suggests that professionals have oversimplified the construct of attachment, and have wrongly applied labels originally developed for infants (e.g., "insecure," "avoidant," and "ambivalent/resistant") to children of all ages, and in a wide variety of circumstances. Additionally, children may exhibit attachment difficulties to greater or lesser degrees, depending upon their early attachment history, the consistency of caregivers in their lives, their innate temperaments, and the extent of maltreatment or separation trauma they have experienced. Many of these children may exhibit ambivalence or insecurity in their relationships with caregiving adults, but not all of them have "attachment disorders."

There are, however, children with a particular complex of behaviors that suggest fundamental disorders in their social and emotional development. They appear unable to form and maintain emotionally close, reciprocal relationships with significant others. This pattern is often related to a history of severe maltreatment and/or separation. The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition [American Psychiatric Association 1994] refers to this as Reactive Attachment Disorder of Infancy or Early Childhood. There are two typical manifestations of the disorder. Type I, the "Inhibited Type," appears to incorporate aspects of avoidant and ambivalent attachment. The children persistently fail to initiate or respond to social interactions in developmentally appropriate ways. These children are excessively inhibited, hypervigilant, and exhibit frozen watchfulness. They resist comfort or contact with others, or they show ambivalence, mixing approach and avoid responses. In Type II, the

"Disinhibited Type," the primary characteristic is indiscriminate sociability, or a lack of selectivity in the choice of attachment figures. These children respond with apparently equal trust and affection to known caregivers or strangers, and are often overly familiar with strangers. Their affectionate overtures are often experienced as superficial, phony, or manipulative.

Both types have been associated with "grossly pathological care that may take the form of persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection; persistent disregard of the child's basic physical needs; or repeated changes of primary caregiver that prevent formation of stable attachments [American Psychiatric Association 1994].

Cline [1992] has done extensive therapeutic work with children and youth who have serious attachment problems. He describes many of the common characteristics of this disorder in school age and adolescent children. Cline suggests these children are similar in many ways to character-disturbed adults, and without therapy, they often develop adult personality disorders. For example:

- They lack the ability to give and receive affection. They often do not allow themselves to be touched.
- They exhibit self-destructive behavior. They appear to "go out of their way to hurt themselves." Examples are: banging their heads repeatedly against a wall; burning themselves on objects they know to be hot; falling over on the pavement; or lighting matches and burning their own hands.

They are often described as "fearless," and their behavior confounds their caregivers.

- They exhibit senseless cruelty toward others. They are mean and destructive. One attachment-disordered child tried to drown the family cat in the washing machine; another tried to set his younger sister's hair on fire.
- They are generally insincere and manipulative. The word "phony" is often used by both parents and professionals to describe this trait.
- They often steal toys, money, and objects, and gorge or hoard food and sweets.
- They may have speech difficulties. Speech may be frequently unclear, slurred, or mumbled. The content may be jumbled. Answers to questions may be particularly ambiguous.
- They have extreme control problems. This may, at times, be complicated by thought disorders. They may be demanding and obnoxious, willful, and unwilling to let others control their behavior. Major battles for control between these children and their caregivers often result.
- They have no long-term friends. Other children do not tolerate the willful lack of respect and cruelty that they received from children with attachment disorders.

- They often demonstrate abnormalities in eye contact. Eye contact may be very intense or absent altogether.
- They are often preoccupied with blood, fire, and gore. They exhibit intense rage, often act as if they are "at war with the world." Many perceive themselves as inherently bad, and have been reported to identify themselves as evil.
- They exhibit superficial attractiveness and friendliness with strangers. They may appear attractive, winsome, bright, and loving; helpless, hopeless, and lost; or promising, creative, and intelligent; whichever front suits their needs at the time.
- They commonly lie in the face of absolute reality, often described as "bold-faced" lying. They lie even when they are caught in the middle of an act. One parent caught her son with his hands in her purse, taking money. She told him to leave her purse alone. He said emphatically, "I haven't touched your purse." Another mother told her son to let go of the dog's tail, and he said, "What dog?"
- They may exhibit various types of learning disorders. Some are thought to have underlying organic or neurological deficits, perhaps exacerbated by early deprivation [Cline 1992].

Cline also suggests that adults with reactive attachment disorders often retain the characteristics seen in children. The primary signs are lack of affectionate response to intimates; underlying rage and hate; a tendency to victimize others,

while perceiving themselves to be the victim; chronic lying; superficiality of responses; an overlying charm; and destructiveness toward other adults. They lack conscience. They are frequently classified as having antisocial or borderline personality disorders.

### Therapeutic Interventions for Children with Attachment Problems

From a therapeutic point of view, children with diagnosed attachment disorders, who have experienced consistently negative caregiving, and who have never experienced a positive attachment, are the most difficult to help. Treatment requires highly skilled, planful, intrusive, and consistent therapeutic interventions. Children whose attachments are insecure and ambivalent, but who have some prior experiences with positive attachment, are often easier to help. These children may benefit, in time, from permanence and consistently nurturing caregiving, although concurrent therapy may also be indicated.

Fahlberg [1991] suggests a variety of interventions that can strengthen children's attachments with their caregivers. Her strategies are referred to as the "arousal-relaxation cycle," the "positive interaction cycle," and "positive claiming." These strategies can be implemented by children's caregivers, or by therapists. While not always easy to implement, they have been shown to be successful in helping children with attachment problems.

#### *The Arousal-Relaxation Cycle*

This intervention is, simply, the parental response to a child in need, and relief of tension or stress for the child. This need-meeting behavior is one of the strong determinants of secure attachment in infants. The goal with the older child is the same. Caregivers are continually alert for signs that the child is experiencing distress. The child may communicate a need through cues such as crying, vocalization, and other expressions of unhappiness or discomfort. However, some children do not outwardly communicate their distress, and the caregivers must learn to read subtle cues that these children are in need. A child's need state is often accompanied by tension and anxiety. The relief of tension and anxiety that occurs when the need is met leads to contentment and comfort. Fahlberg suggests that the repeated, successful completion of this cycle promotes the development of trust, security, and attachment.

Lisa, age seven, provides a good example of a child who responded well to this intervention. Lisa had endured sexual abuse and several separations prior to her placement in a foster home. She exhibited charming superficiality in her attachments, combined with avoidant and pseudo-independent behavior. Typically, she did not signal her caregivers that she needed help. For example, Lisa would hurt herself playing, whimper quietly to herself, reject offers of help, then continue as if nothing had happened. Her foster mother understood how Lisa's background had contributed to her emotional distance, and she sought opportunities to nurture and care for Lisa. When Lisa hurt herself, the foster mother didn't ask permission to help her. She approached Lisa gently, refusing to be rejected or pushed away. She talked soothingly, wiped off Lisa's wounds, administered first aid when necessary, ignored Lisa's protests, and hugged her briefly before sending her off to play. Soon, Lisa's "injuries" became more

frequent, and less serious, and she began to cue her foster mother when she was hurt, often by crying loudly and running into the house. The foster mother found herself tending to numerous miniscule injuries, but she recognized that Lisa had learned not to "fear the helper," and she continued to nurture her to reinforce this behavior. Eventually, the foster mother was able to help Lisa understand she could ask for hugs and attention without hurting herself first, and to trust that such contact was not the precursor of abusive behavior by a caregiver.

Fahlberg also suggests that intervening in a positive, soothing, and supportive way after a child has had an intense, emotional outburst, such as a temper tantrum, or when the child is experiencing intense anxiety or depression, takes advantage of a brief period when the child is emotionally vulnerable and, therefore, more open to intervention. The adult's availability to provide emotional support, and to encourage the child to express feelings encourages the development of attachment.

Scott, age six, had been placed for adoption as an infant. The adoption was disrupted when Scott was five, and he was placed in foster care. The worker was able to ascertain that the adoptive family had never bonded to Scott, that they had frequently ignored him, and that he had often been locked in a room for hours at a time. When he began soiling, they decided to return him to the agency. Scott showed serious emotional and behavioral problems, and very disturbed attachment. He would approach the foster mother for affection, then change his mind and fight her; yet, he would scream in a panic if she left the house for even a short period of time. He would reject all attempts at affection. Scott had violent, raging tantrums, during which he would kick, scream, and roll on the floor. The foster mother learned that, when the worst of the tantrum was

over, she could cradle Scott and rock him for 15 minutes or more while he settled, and he would not fight her. In this manner, she was able to begin to establish a more nurturing relationship with him. In time, when he was sleepy or distressed, he began to climb onto her lap on his own.

### *The Positive Interaction Cycle*

When children with secure attachments meet new people, they often begin to establish a relationship through play and social interaction. In the positive interaction cycle, the caregiver promotes attachment by involving a child in pleasurable social interactions, such as playing, establishing eye contact, vocalization (singing, talking, cooing, reading), and other pleasurable contacts. Social attachment may be less threatening than physical affection or emotional intimacy. In time, the child may learn to trust the adult.

David, age two, had also been disrupted from adoptive placement as an infant. He appeared to have suffered severe emotional rejection. He avoided contact with people, and he rejected all overtures from his caregivers. He eventually developed a perfunctory relationship with his foster mother. He allowed her to feed, dress, and comfort him, but he did not reciprocate. He would have nothing to do with his new caseworker, and he ran and hid whenever she approached. The worker spent several weeks establishing a relationship with David by engaging him to play with her. She initially rewarded him with smiles for eye contact. She handed him interesting objects, which he took from her, and then quickly ran away. She talked to him, assuming he was listening, even though he did not respond. Eventually he was engaged to roll a ball with her and to play with other toys. After several weeks, the worker was able to take him into the

yard, for a walk down the block, and then, for a ride in the car. David eventually developed sufficient trust to let the worker hold him, and to turn to the worker for support when he was frightened. Because of this trust, he was able to use the worker for support during his subsequent adoptive placement. His adoptive family used similar strategies during preplacement visits to strengthen his attachment to them before he was placed. The worker also made sure that he was firmly established in his adoptive home before she began to slowly reduce her contacts, and eventually terminate her relationship with him.

### *Claiming Behavior*

Claiming behaviors are parental responses that communicate that a child is part of the family, belongs in a special relationship with family members, and is valued by other people. Claiming behaviors include: introducing the child to others as a member of the family; consciously including reference to the child in family histories; giving the child a special role or responsibility in family traditions; including the child in important family events; including the child's pictures in the family picture album; and other behaviors that clearly identify the child as belonging to the family.

Most healthy families engage in all three types of interactions as part of day-to-day life. Parents in abusing or neglecting families may need to be taught how to respond to their children in ways that promote attachment. The parents may, themselves, need to be helped to develop positive attachments with others. Often, the caseworker can help parents learn trust and confidence in other people through the casework relationship.

Professional help by therapists who are skilled in treating attachment disorders should be sought for children who demonstrate severe attachment problems, and for children who do not respond over time to attachment-strengthening interventions by their caregivers [See Cline 1992; Levy & Orlans 1995; Pinderhughes & Rosenberg 1990].