

Attachment in Early Childhood

by Marjorie Grace

Psychological attachment influences not only our relationships with primary caregivers and later significant relationships and other social interactions, but also our internal senses of identity and the organization of our brains and neurological system (including how we respond emotionally to life experiences). Attachment helps develop a sense of safety, encourages socialization, stimulates intellectual and psychological growth, and influences identity.

When there has been a significant interruption in the attachment process, normal, healthy nurturing later on in childhood, no matter how good the quality of the parenting, is sometimes not enough for the development of secure attachment. Special interventions are needed that go beyond "what comes naturally" to help the parent-child relationship become more secure. We adults often think that if a child has advanced cortical development (as evidenced through language ability), we can talk to the child and help "fix" the problem. But loving parenting and sensitive conversation are simply not enough, and the absence of early attachment cannot be talked, loved or played away. We must intervene at the physiological level of early disruption, the point at which the damage occurred.

By definition, attachment is a deepening affectionate, psychological connection between two people that endures over time. Attachment is different from bonding, which begins in utero and has a physiological base. There is only one bond and that is with the birth mother. The bond prepares and sets the stage at the physiological level for later attachment. Attachment, on the other hand, is a reciprocal, bi-directional tie between two or more people which usually starts with one attachment figure and gradually broadens to others. Tiffany Field describes attachment as "a relationship that develops between two or more organisms as their behavioral and physiological systems become attuned to each other." For humans, attachment generally takes place in the first 8 to 36 months. Because it is interactively-based, the primary attachment can be transferred to another caregiver if the transfer is done with attention and planning.

A newborn baby begins life with a primitive, disorganized nervous system and must depend upon the caregiver to provide an environment that not only enables survival but that also facilitates the growth and development that will sustain life after infancy. Through recent brain research, scientists such as Bruce Perry have confirmed that early life experiences influence brain development in many more significant ways than had ever been thought possible. We now have scientific evidence suggesting

that attachment occurs during the same time the brain is going through rapid growth—the time when the neurons and synapses are selectively sorted out, determining which cells will remain and which will atrophy.

As an infant's neurological system becomes more organized, allowing increasingly purposeful action, he or she begins to participate in a social process which initiates attachment. Throughout the first year, hundreds of repetitious arousal-relaxation cycles occur. The baby signals by crying when hungry, wet, or uncomfortable and the mother responds by feeding, diapering, comforting, and snuggling, thus relieving the discomfort. The cycle is completed when the baby has been calmed and quieted. As a given cycle is completed, the baby will become calmly alert and attentive, gazing intently into the mother's eyes. A quality of synchronicity between the caregiver and infant in which is attuned to the other. They will breath in rhythm together, smile and vocalize responsively together. If play becomes more active, the baby will use the mother to regulate his or her arousal tolerance levels. Infants learn to trust that their needs for care and nurture will be met by the mother's availability and responsiveness. Their primitive brains become programmed for calming, security, and so on. In a secure environment with a healthy caregiver, the infant will have experienced repetitious arousal-relaxation cycles that have included motion, eye contact, lactose stimulation (and sucking), the caregiver's familiar smells and sounds; their interactions will have become a synchronized dance.

During the second year of life, the cycle becomes modified by the child's increasing mobility and verbal skills. The infant learns to accept and trust the structure, boundaries, limit-setting and control of the familiar caregiver. This learned structure is what allows the child to accept discipline and to develop a conscience later on. In the third year, the baby learns to incorporate parental limits and associated responses and develops the ability to handle separation from primary caregivers. In this year, children begin to set some limits for themselves and learn to trust themselves. They are able to spend longer periods of time apart from their caregivers and be more independent. Each of these stages must occur in proper sequence; one is a building block for the next stage.

When the initial process is interrupted through traumatic events in utero, prior to birth or after birth, attachment problems can occur. Maternal loss (at birth or later) is one trauma, as is maternal drug- or alcohol-abuse, physical abuse, neglect, etc. Even a mother's

inability to read her infant's signals, resulting in mismatched rhythms and expectations, can lead to attachment difficulties. And a child's ability to do his or her part in the attachment transactions can also influence the relationship. A child born with a developmental disability such as a hearing loss or a seizure disorder can have attachment difficulties. (Lack of secure attachment can also cause some developmental disabilities and learning disorders.) In the absence of a significant portion of these experiences, the attachment relationship becomes strained and the child is at risk of developing an attachment disorder. Without the benefit of a secure attachment relationship, the child doesn't learn to trust his caregiver to meet his basic needs for food, comfort, and safety, resulting in self-parenting, in a resistance to closeness and in the manipulation of others and the environment.

Many professionals have expressed the concern that the absolute term "unattached" is overused, preferring to view attachment as a continuum. It's rare that we see a child completely devoid of the experience of being in a relationship with some caring person. More commonly, children have attachment problems ranging from the insecure, avoidantly-attached (distancing) youngster, on one end of the continuum, to an insecure, anxiously-attached child on the opposite end, with the securely-attached child in the middle. In her research of infants and mothers, Mary Ainsworth described these three groups of infant-attachment patterns.

Securely-attached children will seek their primary caregivers when distressed, are easily comforted, become absorbed in play, are curious, and respond to environmental cues. They will protest when separated from the primary caregiver, then will calm down and enter into play, greeting the caregivers with pleasure upon their return.

Insecure, avoidantly-attached children will be friendlier with strangers than with their primary caregivers. They do not look to caregivers for comfort and will pay more attention to the environment than to people. They do not react when the primary caretaker leaves, and they pretend not to notice when he or she returns. Children in this group gradually become hostile, distant, socially isolated, less compliant with rules, and more expressive of negative emotions. As they grow older, they frequently are very independent, sullen and oppositional. They lack empathy, are angry, and reject nurturing. A disproportionate number of this group has been abused or neglected.

Insecure, anxiously-attached children will alternately seek proximity to and resist contact with caregivers. They have problems directing attention to the environment. When separated from the primary caregiver, they will not be readily comforted and will not easily enter into play. Upon return, the caregiver will be met with crying and distancing. Such children demonstrate an excess of anxiety and fear. As they grow older, they will cling and shadow adults, eager to please, and intrude on adult space. They may pout when limits are set, acting whiny, dependent, and demanding. They have separation problems, readily feel rejected or betrayed and may be regressive when craving love or affection. They will sabotage the relationship when parents are feeling emotionally close, alternatively trying to engage the parent through manipulative behavior when the parent is distant.

A number of behaviors could suggest a child may have an attachment disorder. They include difficulties maintaining eye contact, resistance to parental requests for affection, cruelty, destructiveness, lying about the obvious, stealing, preoccupation with fire and gore, learning delays, speech difficulties, lack of cause and effect thinking, delayed conscience development, and lack of

empathy. Interventions have been identified that help the child to develop healthy relationships after proper diagnosis.

Recent scientific work on brain development and trauma has found that very early-life memories may be stored at the sensory-motor level where self-regulation and self-identity are affected. Van der Kolk posits that in order to heal from trauma, people have to remember; otherwise they see and hear things others don't. He suggests that "If they don't remember, they don't know why their bodies keep playing tricks on them." Some evidence suggests social interaction (touching, smiling, cuddling, not just words) have greater effect on attachment than do actions that meet the child's essential physical needs. Ainsworth says that "The more social interactions an infant has with someone, the more strongly attached he becomes to that person," and goes on to say that "the most important part of mothering is social interactions, not routine care." An article in the "Wall Street Journal" (1994) quotes Ed Zigler of the Yale University Bush Center in Child Development and Social Policy, who says, "Drop the nonsense about quality time; it's quantity time that children need."

When dealing with an attachment-disordered child, it is helpful to modify various interventions to maximize their effectiveness.

At difficult moments, such children need to be kept close to an important adult; thus, caregivers might use a "think it over spot" close at hand rather than calling for a time-out in the child's room. A time-out is a reward to a distancing child. The more problematic the behavior, the closer the child needs to be to the adult. Reframe the behavior: "You're not having a good day. You need to stay close so I can help you make good decisions and have things work out better."

If there are troubles at school, help the child identify why it is that he's in school—to learn. Parents can provide a way for the child to be removed from school when he is not engaged in appropriate learning activities.

Unconditional positives, nurturing, frequent hugs are imperative so that the child feels loved regardless of the behavior. Parents can learn to use the techniques of One-Minute Scolding and "natural consequences."

A Northwest Media production describes Dr. Vera Fahlberg's suggestions for parents called "Supportive Control." Consistency and structure in parenting is primary, leavened with large doses of playfulness. Parents must develop a sense of humor, remembering to take good care of themselves and each other.

When more traditional parenting and therapy do not seem to help, the child may benefit from holding therapy. The ATTACH organization, formed in 1992, is now undertaking the project of developing standards for Attachment clinical work and training, utilizing both the Attachment Therapy (non-holding) and Holding Therapy models now in use around the country.

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