

# Being There

BY LYNNE MELCOMBE

When many people think of infant-parent attachment, they envision a mother and baby in a rocking chair, the mother gazing into the infant's eyes and singing softly. In reality, attachment between an infant and caregiver takes place at far less idyllic moments, such as at 4 am when a sleep-deprived mother walks the floor with a screaming child in her arms, rubbing the baby's back and uttering soothing sounds.

Secure attachment arises as a result of the child learning that a caregiver will predictably and consistently *be there*—to feed, to comfort, to protect, to play. Attachment theory suggests that the care an infant receives becomes a model around which the child's still-developing brain learns to organize his/her behaviour. Sensitive, responsive care will result in a secure attachment; inconsistent, rejecting, neglectful, or abusive care will produce a child who is insecurely attached or has other attachment difficulties. Although not written in stone, early attachment patterns strongly predict how the child will deal with other relationships throughout the life span.

This has clear implications for prevention of family violence. While not all children who live with family violence enter into violent relationships as adults, many do, because they are continuing to replicate the pattern of that first and most powerful relationship. Yet just as life can intervene to undermine secure attachment—for example, through tragic loss or exposure to violence—clinical interventions can

alter problematic attachment styles, providing perhaps the best hope we have of preventing family violence in the long term.

## The Gestation of an Idea

Attachment theory is about 60 years old; its "parents" were British child psychiatrist John Bowlby and American child psychologist Mary Ainsworth. (Ainsworth and Bowlby, 1991) Bowlby did his first systematic research at the London Child Guidance Clinic in 1944, where, in comparing 44 child thieves with a control group, he found that lack of a strong mother figure was more common among the thieves.

Ainsworth first worked with Bowlby in 1950 as a researcher at his Tavistock Clinic, where she observed that children who were separated from their parents by hospitalization went through three stages: distress, despair, and detachment. Although the child recovered on reunion, defense mechanisms remained, sometimes permanently.

Ainsworth and Bowlby continued their individual research and collaboration after she left Tavistock (in fact, for the rest of their lives.) In 1963, she launched a longitudinal study of the bonds between 15 mother-infant pairs in Baltimore, in which she originated

the landmark method of the *Strange Situation* and defined attachment classifications that are still used today. This research was aptly described by Robert Karen (1990):

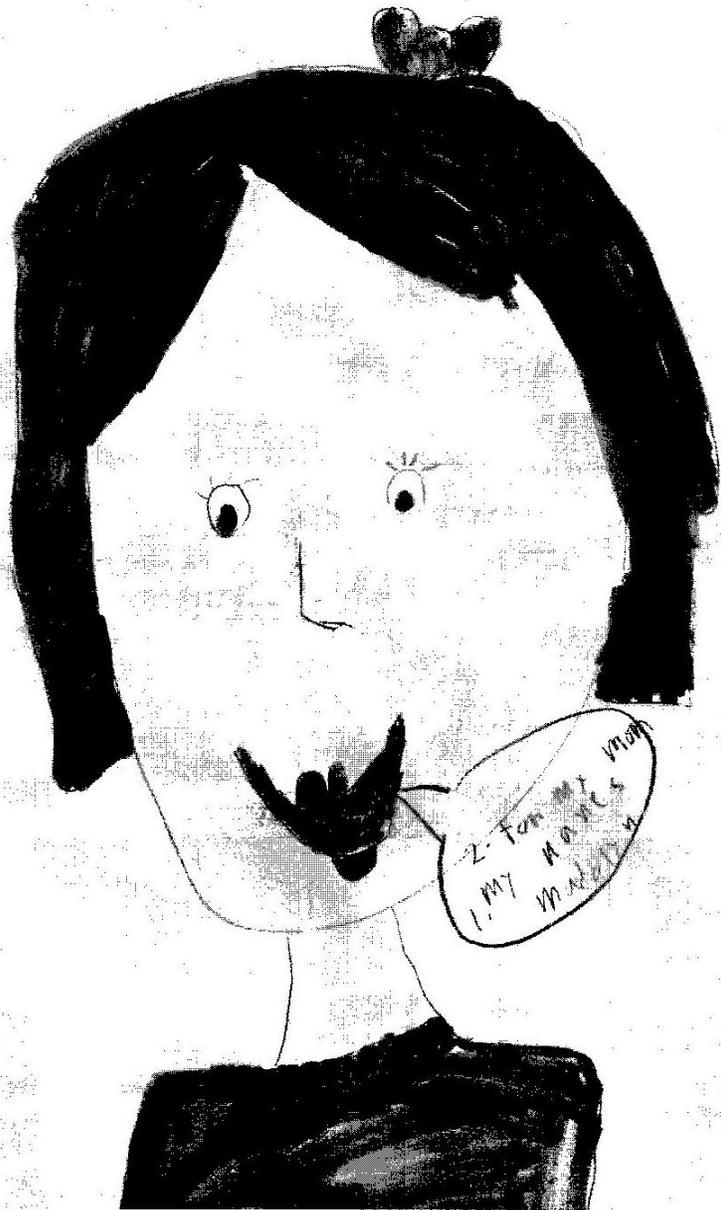
"In an approach that was extremely unusual at the time, researchers closely observed mothers and children in their homes, paying careful attention to each mother's style of responding to her infant in a number of fundamental areas: feeding, crying, cuddling, eye contact, and smiling. At 12 months the infant and his mother were taken to the lab and the infant was observed as the mother was separated from him. During two intervals a stranger was in the room; during another the baby was alone.

"Ainsworth spotted three distinct patterns in the babies' reactions. One group of infants protested or cried on separation, but when the mother returned, they greeted her with pleasure, frequently stretching out their arms to be picked up and molding to her body. They were relatively easy to console. Ainsworth

labeled this group 'securely attached.'

"She labeled the other two groups 'insecurely' or 'anxiously' attached. One group of anxious babies, called 'ambivalent,' tended to be clinging from the beginning and afraid to explore the room on their own. They became terribly anxious and agitated upon separation, often crying profusely. An

**Attachment patterns strongly predict how the child will deal with other relationships throughout the life span.**



ambivalent baby typically sought contact with his mother when she returned, but simultaneously arched away from her angrily, resisting all efforts to be soothed.

“The second group, called ‘avoidant,’ gave the impression of independence. They explored the new environ-

ment without using their mothers as a base, and they didn’t turn around to be certain of their mothers’ presence, as those labeled securely attached did. When the mother left, the avoidant infant didn’t seem affected. And on her return he snubbed or avoided her.

“... because Ainsworth’s team had

observed each of these mother-child pairs for 72 hours over the prior year, they were able to make specific associations between the babies’ attachment styles and the mothers’ styles of parenting. Mothers of securely attached children were found to be more responsive to the feeding signals and the crying of their infants, and to readily return the infant’s smiles. Mothers of anxiously attached children were inconsistent, unresponsive, or rejecting....”

To the classifications of secure, insecure-anxious/ambivalent, and insecure-avoidant, researchers have since added ‘disorganized attachment.’ In a Strange Situation, these babies respond with contradictory behaviours, such as walking toward the caregiver with the head averted, or crying while moving away from the caregiver; bizarre movements and postures that occur only when the caregiver is present; becoming still or moving in slow motion; apprehension directed at the caregiver; behaviours indicating disorientation, such as dazed wandering or rapid changes in affect. (Lyons-Ruth and Jacobvitz, 1999)

A child with disorganized attachment has no consistent or organized strategy for responding to stress because the person who should make him or her feel safe is frightening (such as an abusive parent) or is communicating fright (such as a parent who is being abused). These children (as did their parents) most often come from homes characterized by child maltreatment, by parental depression, bipolar disorder, substance abuse, and/or by unresolved trauma, grief, or loss. (Lyons-Ruth and Jacobvitz, 1999) This explains why some parents who were maltreated as children and profess a profound wish to do better than their parents, maltreat or

neglect their children as if it were beyond their power to change. Without therapeutic intervention, it often is.

(A notable exception involves adoption, especially of children adopted internationally and/or beyond infancy. Adopted children comprise two percent of the population but 50 to 80 percent of children with severely disordered attachment or reactive attachment disorder [RAD]. [Becker-Weidman, 2000a] The primary difference between disordered attachment and an attachment disorder is that in the former, “the child does express a preference for a particular attachment figure” while the latter is characterized by resistance to any attempts to establish attachment. [The Source, 1999])

## Attachment through the Life Span

Research over the past 40 years has supported that attachment styles established in childhood characterize relationships throughout childhood, adolescence, and into adulthood. Studies at the University of Minnesota’s Institute of Child Development have found that:

“... two-year-olds assessed as secure at 18 months were enthusiastic and persistent in solving easy tasks and effective in using maternal assistance when the tasks became more difficult. In contrast, their [anxious-ambivalent] counterparts tended to be frustrated and whiny. They found that preschoolers who had been judged securely attached as infants were significantly more flexible, curious, socially competent, and self-reliant than their [anxious-ambivalent] counterparts. The securely attached children were more sympathetic to the distress of their peers,

more assertive about what they wanted, and more likely to be leaders. Similar findings persisted through elementary school age.

“Some of the most intriguing Minnesota material, much of it since confirmed by other studies, concerned avoidant kids. They have proved far less able to engage in fantasy play than securely attached children, and when they have engaged in such play, it has often been characterized by irresolvable conflict. Children with histories of secure attachment tend to be neither victims nor exploiters when placed in pairs, but avoidant kids often victimize other insecurely attached children.” (Karen, 1990)

Another study showed that children with disorganized attachment had increased salivary levels of cortisol—a neuroendocrine hormone involved in the stress response—after brief separations from their attachment figures as compared with securely attached children. (Lyons-Ruth and Jacobvitz, 1999) Frequent, elevated levels of these hormones, which evolved to activate the fight-or-flight response only for short, occasional periods of time, can damage regions of the brain called the hippocampus and the corpus callosum. (Becker-Weidman, 2000b)

The corpus callosum divides the two hemispheres of the brain and conducts synaptic responses between them. A healthy brain requires integrated connection of the hemispheres to regulate emotion, correctly identify emotions in others, evaluate cause and

effect, and act with conscience. Abused and neglected children have smaller corpus callosa than others and less integration of the hemispheres, leading to reactivity and lack of empathy, foresight, and conscience.

The hippocampus is critical to memory; damage can cause individuals who experienced childhood abuse and neglect to have patchy, if any, memories of childhood. Without memory of traumatic experiences, it is later difficult to work them through. Moreover, this repeated elevation of stress hormones early in life can program the brain to react similarly in later years even to mild stressors. In other words, infants exposed to abuse and neglect become

children, teens, and adults who have big reactions to small events and who are difficult to be around, yet who most need the qualities that secure relationships can provide.

Following one sample of children into early and middle adolescence, Sroufe and Collins (1999) discovered remarkable parallels in the characteristics of secure and insecure children as they moved from childhood into adolescence and found that “both peer experiences and family experiences are strongly predictive of individual differences in adolescence. We have found significant continuity in peer competence based on teacher ratings from early elementary school ... through age 16.”

Other studies have gone further. Re-contacting the children in

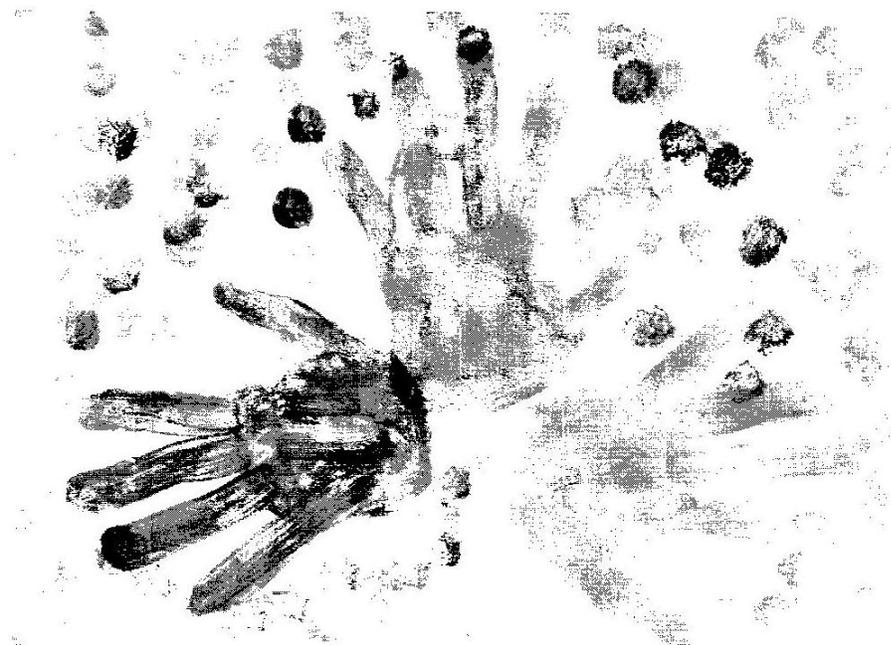
**Securely attached children tend to be neither victims nor exploiters, but avoidant kids children often bully other insecurely attached children.**

Ainsworth's original Baltimore group, Waters et al (undated) conducted in-depth Adult Attachment Interviews and found that, in a blinded evaluation, 72 percent of participants received the same attachment classification in adulthood as they had in infancy. Where classifications had changed, individuals had either shifted from secure to insecure due to a series of negative life events, or had worked through childhood issues, perhaps with a caring and sensitive partner, and shifted from insecure to secure. In most cases, however, secure and insecure individuals tend to choose partners and behave in relationships in ways that mirror the patterns established with their primary caregivers in infancy. (C4FD, 2000) It is even possible to predict, with 80-percent accuracy, a child's attachment classification at six years of age by assessing the birth mother's classification during pregnancy. (Becker-Weidman, 2000b)

This is where the hope in this research lies: research and clinical practice are increasingly revealing that careful intervention can shift attachment patterns at virtually every stage of life, with the prospect of replacing cycles of family violence with healthy, self-perpetuating family relationships.

## Attachment-based Programs: A Sample

*Modified Interaction Guidance:* Infant psychiatrist Dr. Diane Benoit of Sick Children's Hospital in Toronto employs and provides training in this individually based therapy designed to modify negative parental behaviours and increase positive ones. (Hardy, 2002) Parenting behaviours are assessed using the Atypical Maternal Behaviour Instrument for Assessment and Classification



(AMBIANCE) coding system. Modified Interaction Guidance begins with the caregiver and child engaging in a brief play session during which the caregiver is instructed to "play with your child the way you would at home." The play session is videotaped and the therapist and caregiver review the videotape together. For 90 percent of the review, the therapist points out instances in which the caregiver's interactions with the infant have been positive, focusing on the caregiver positioning herself on the same level as the child, having face-to-face interaction and eye contact, displaying a positive mood, and responding positively to the child's initiations. For 10 percent of the review, the therapist helps the parent focus on sub-optimal behaviours and how they affect the child. The caregiver is then assigned to spend 5 to 10 minutes daily interacting with the infant and practicing Wait, Watch, and Wonder skills: waiting for the child to initiate interaction, watching to see what the child does, wondering what the child is

thinking, and responding warmly when the child initiates interaction. Part of each session is spent discussing the caregiver's concerns and providing parenting education to the caregiver. This intervention successfully modifies relevant parenting behaviours within six to eight sessions for most families. (To contact Dr. Benoit, visit [www.sickkids.ca/imp](http://www.sickkids.ca/imp). To order a Wait, Watch, and Wonder manual, email [enerclich@hincksdellcrest.org](mailto:enerclich@hincksdellcrest.org).)

*Right From the Start:* Psychologist Dr. Alison Niccols (2000) of McMaster University in Hamilton, Ontario developed Right From the Start (RFTS) involving eight, weekly, group sessions for parents of children under two years. Niccols chose a group format for a variety of reasons: "First is the opportunity for social networking with other parents. Social support is an important contributor to family and child outcomes, and social isolation can adversely influence parenting.... Having contact with parents who are facing similar

## Hope for the Future

In 1990, Robert Karen wrote that, “in 20 years of Strange Situation research, stable middle-class American homes have consistently produced babies of whom about two-thirds are securely attached and one-third are insecurely attached. As these numbers suggest, being securely attached hardly ensures that babies will grow up free of neuroses or even of insecurities. It means only that they have been given confidence that someone will be there for them and that they are thus at least minimally capable of forming satisfying relationships and of passing on that ability to their children. But in unstable homes, where parents, often single, are under great stress, and where neglect or abuse is more common, this minimal bulwark is often missing and the numbers of insecure children swell.”

But there is hope. Attachment patterns are rooted in the brain, which is plastic, moldable, “use dependent.” (Perry and Marcellus, 2000) Although it is most easily molded in infancy, it remains capable of being retrained throughout life as individuals resolve old traumas and develop healthy relationships.

What’s needed for an attachment-based approach to be effective on a broad scale is motivation, not only on the part of the individuals directly concerned, but on the part of those who fund research and intervention. Insufficient funding may save a few dollars now, only to increase future costs in law enforcement, justice, health care, social services, and education. As tomorrow’s adults, today’s children are our single most important investment. We can handle that investment wisely by recognizing that supporting healthy

attachment at all ages is a way of supporting healthy parenting, healthy children, healthy families, and healthy communities, and in so doing it can move us a significant step closer to a society free of family violence.

*Written with assistance from Dr. Alison Niccols, Psychologist/Clinical Service and Research Development Leader in the Infant-Parent Program at McMaster Children’s Hospital, Hamilton Health Sciences, Ontario, and Assistant Clinical Professor in the Department of Psychiatry and Behavioural Neurosciences at McMaster University; and from Dr. Cindy Hardy, Registered Psychologist in the Psychology Program at the University of Northern British Columbia.*

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