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Attachment and its Implications for Children's Development

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This thesis is submitted in partial fulfilment of the requirements

for the degree of

Doctor Of Psychology (Clinical)

Deakin University

June, 2003.

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Abstract

The attachment that develops between an infant and his primary caregiver is defined as a reciprocal and enduring, emotional and physical connection that develops over time as a product of the interaction between the pair (Ainsworth, 1973). This is a relationship typically formed between an infant and his mother, as it is she who generally plays the role of primary caregiver in a child's life. Whilst this relationship has long been held to be a 'special' relationship, it is only in recent years that full recognition has been given to the importance of early attachment. Attachment is seen as necessary for the social and emotional development of the infant. Severing of attachment or the inability of an infant to form such a relationship in the first place is seen to have a significantly detrimental effect on the infant's development in these areas. Though only a relatively new concept, understanding of attachment has developed greatly over the past seventy years. Beginning with its introduction by John Bowlby, who provided the theoretical underpinnings for this relationship, attachment then passed to Mary Salter Ainsworth and her colleagues who helped to provide the empirical evidence for Bowlby's theories. Finally the focus of attachment work broadened to include the impact of attachment on the development of future relationships.

This clinical portfolio will begin with an overview of these three broad phases of attachment with particular focus on the impact of attachment on a child's development. This will be followed by four case studies, each addressing a particular issues related to the understanding of attachment and its impact on a child's development. The four issues to be addressed in each of the case studies include, 'Attachment and Disability', 'Inhibited Attachment' 'Disinhibited Attachment', and 'Attachment and ADHD (Attention Deficit, Hyperactivity Disorder). Included in each

of the case studies is a literature review examining the specific issue raised within the case. The final chapter of this portfolio will provide a summary and discussion of the role of attachment in a child's development.

Acknowledgements

This clinical portfolio is a product of the varying experiences I have encountered as part of my placements within the doctoral course. Each placement provided me with a new and exciting opportunity to learn about the psychological development of children and adults and of course the importance of attachment. My thanks goes to everyone involved in assisting my placements to run smoothly and allowing me to develop my understanding of clinical psychology. I would like to thank each of my placement supervisors, in particular Helen Kambouridis, Glenda Newell, Anne Cumming, Lindy O'Neill and Ross King. I also thank Erika Leonard and Kaye Illingsworth for their assistance both with supervision and assisting to organise the placements. I would like to thank the placement organisations for their support and for allowing me the opportunity to learn from their highly skilled staff. I thank David Mellor for his feedback on this portfolio. I would also like to thank the children and their families who I saw as part of my placements, each of whom have demonstrated to me the importance of relationships and families. Finally, to all who have supported and assisted me throughout the entirety of this course, and in particular my extremely supportive, encouraging and accommodating family.

All identifying information reported in this thesis regarding clients, professionals and agencies has been altered to protect the individual's or organisation's identity.

CHAPTER 1 – ATTACHMENT THEORY AND ITS ROLE IN CHILDREN’S DEVELOPMENT

“From time immemorial mothers and poets have been alive to the distress caused to a child by loss of his mother; but it is only in the last fifty years that, by fits and starts science has awoken to it” (Bowlby, 1971, p. 46).

It is only within the past century that the medical and psychological community has given recognition to the importance of the relationship that develops between a child and his primary caregiver. Not only does this relationship play an important role during infancy, but it also influences the entirety of a child’s life. Today the relationship between an infant and his primary caregiver is viewed within the framework of attachment theory, a framework provided by John Bowlby during the 20th Century. The main focus of this clinical portfolio is to address attachment between an infant and his primary caregiver and how this impacts on his development in infancy and childhood. First, however, this chapter will provide a broad overview of the development of attachment theory. This will be followed by four cases studies, presented in the four subsequent chapters. Each of these will address a specific issue related to attachment theory. The final chapter will provide an overview of the issues raised in these cases and a discussion of the implications for clinical work with children.

1.1 Historical Background to Attachment Theory

In the thirteenth century Emperor Frederick von Parma II conducted an experiment examining language development in young children. Frederick was

interested in which language children would speak if all their physical needs were provided for, but they were restricted from verbal or physical interaction of any form with other humans. Emperor Frederick never found the answer to his question, as all of the children died, though they were not shown to be suffering any disease or illness (Matteoli, 1999). It is suggested that this early study provided the first indication of how the lack of physical, social and emotional interaction can have a negative impact on a child's development (James, 1994). One of the first and most important relationships to develop in most species is between an infant and his primary caregiver, typically the biological mother (Ainsworth, 1973)¹. While the relationship between a mother and her baby has long been held to be a special relationship, the true significance of this relationship for the social and emotional development of an infant has only recently been recognised within the medical profession and society in general (Ainsworth & Marvin, 1995; Bowlby, 1969; Fonagy, 2001; Karen, 1994). The 20th century set the stage for an ongoing examination of the mother/infant relationship. Whilst this examination has involved contributions from a variety of sources, particular credit is deservedly given to John Bowlby. Bowlby provided a theoretical framework with which to understand the relationship that forms between an infant and his mother and introduced the term 'attachment' to conceptualise this relationship.

From its introduction, attachment theory has made great progression, passing through a number of different phases. Greenberg, Cicchetti & Cummings (1990), broke the progression of the scientific world's examination of attachment into three

¹ Whilst it is acknowledged that the primary caregiver is not always the mother, for ease of reading either the term primary caregiver or mother will be used. Similarly, infants will be referred to as he, though it is acknowledged that this refers to either a male or female infant, this will help to minimise confusion when both mother and child are mentioned in the same sentence and the pronoun she is required.

distinct phases. Phase one focuses on Bowlby's work regarding attachment. It is during this phase that interest in mother/infant relationships developed and attachment theory was born. This interest was triggered through professionals' observations of what was seen to be negative side effects for an infant who has endured long-term separation from his mother either through hospitalisation or institutionalisation. From this introduction, the work around attachment moved beyond the impact of long-term separation from the mother and instead focused on and examined the role of the mother/infant relationship in a child's everyday development. This second phase focuses on the work performed by Mary Salter Ainsworth and her colleagues, who created a tool called the 'strange situation' to examine the mother/infant relationship. The first two phases identified by Greenberg et al., (1990) focus on the role of attachment in infancy. The third and final phase of the development of attachment moves beyond infancy and examines instead the role of attachment in a child's future relationships. This begins with an examination of the stability of the primary attachment and how a child's early attachment experiences can create a prototype for the development of later relationships. This introductory chapter will briefly address each of these three phases of attachment theory in order to examine the development of attachment theory and the role it plays in a child's social and emotional development, behaviour and the child's ability to form other relationships.

1.2 Phase One: Origin of Attachment Theory

During the 20th century there were a number of workers in child-focused fields simultaneously exploring the relationship between infants and their mothers. More specifically, these investigations explored the impact on an infant, of either

never developing a relationship with a primary caregiver or long-term separation from the mother once an attachment has developed (Bowlby, 1988). The vital importance of such investigations arose from the quite common practice in the western world to isolate or provide only minimal physical and emotional contact to children who were either hospitalised or institutionalised (Karen, 1994). Within institutions, children typically did not have one person to care for them consistently enough to develop a relationship with that person (Ainsworth, Blehar, Waters & Wall, 1978). These children were generally waiting to be adopted and so had no family to form a relationship with. Further, there was insufficient funding in institutions to allow staff to provide children with individual care (Karen, 1994). Within hospital settings regulations either prohibited parents from visiting their child, or these visits were kept to a minimum, such as once a week. This was to prevent parents from disturbing the smooth routine set up by nurses (Bowlby, 1988; Karen, 1994). Staff were also instructed to minimise their contact with child patients, in order to reduce the risk of cross infection (Karen, 1994). In some cases these children, who were often only two or three years old, were hospitalised for extensive periods of time (i.e., six – twelve months), with little social or physical interaction.

Long periods of hospitalisation were seen to cause great distress to young children. In 1943 a psychiatrist, Harry Edelston, reported on the emotional damage caused to children by such hospitalisation, which he defined as ‘hospitalisation trauma’ (Karen, 1994). Associated with hospitalisation were longer, rather than shorter periods of recuperation as compared to a child treated at home. At this time a number of professionals were also reporting on what they were observing to be the detrimental impact on children, of long periods of hospitalisation or institutionalisation. This included observations reported by five prominent clinicians.

David Levy, a psychoanalyst reported on a child whom he believed to be incapable of real emotional affection after having spent the first six years of her life shifting from one foster home to another. Loretta Bender, head of a child psychiatric unit, encountered a number of children who were waiting to be adopted and described as severely behaviourally disturbed. Harry Bakwin, a paediatrician, wrote a report on why infants, isolated from human touch in hospital wards, did not thrive as they would at home. Bill Goldfarb, a psychologist, found in a series of studies that institutionalised children had major deficits not only in their ability to form relationships but also their cognitive functioning. Finally, René Spitz, a psychoanalyst, produced a film documenting the depression, hopelessness and unresponsiveness of infants separated from their mother's for long periods of time (Bowlby, 1988; Fonagy, 2001; Karen, 1994).

Though working independently, each of these clinicians drew similar conclusions about the causation of the distress, or lack of social and emotional development, they were observing in these children. These conclusions suggested that it was the interruption to the mother/infant relationship that caused the detrimental effects observed in these infants (Bowlby, 1988). While these clinicians were presenting their observations to their own separate parts of the medical community, and despite the obvious trauma experienced by the infants in each of the reported observations, those involved in running child departments in hospitals or institutions largely ignored these observations (Bowlby, 1988; Karen, 1994). It was not until Bowlby began to draw this information together, under his attachment theory that the medical community began to form an understanding of the true importance of the mother/infant relationship, and more importantly the impact on a child of an interruption to this relationship (Karen, 1994).

Bowlby's interest in the relationship between an infant and his mother is thought to have stemmed both from his own childhood experiences as well as his observations of children (Karen, 1994). Bowlby's own childhood was marked by a lack of emotional connection to his mother (Karen, 1994). Though beginning his university education in the field of medicine, during his late teenage years and early twenties Bowlby encountered a number of professionals involved in founding or running 'progressive schools' for maladjusted children within England (Bowlby, 1988; Fonagy, 2001). These schools were run by men who focused on meeting the needs of these children in a less traditional, that is non-authoritarian approach and understanding the causes of their maladjusted behaviour (Karen, 1994). Bowlby was attracted to this 'progressive' philosophy and as a consequence abandoned his medical studies to work on a volunteer basis with maladjusted children at one of these schools (Fonagy, 2001).

It was in his work at these schools that Bowlby encountered two boys who left a marked impression upon him. Bowlby was struck by the way the massive disruption in these boys' relationship with their mothers may actually have impacted upon their behavioural development (Bretherton, 1991; Fonagy, 2001; Karen, 1994). This drew Bowlby's attention to the importance of the mother/infant relationship and consequently he changed the direction of his education. At age 22 he began training in psychoanalysis (Fonagy, 2001; Karen, 1994). While educated under a psychoanalytic model, the predominant model of thinking at that time, Bowlby did not always agree with the psychoanalytic view, particularly in regards to the bond between an infant and his mother (Bowlby, 1969).

The psychoanalytic view proposed that the emotional bond between an infant and primary caregiver represented a secondary drive that formed as a result of a

caregivers' gratification of a child's oral (or physiological) needs (Fonagy, 2001). Bowlby's varying observations and experiences, however, led him to believe that this theory could not explain the formation or purpose of the mother/infant bond (Bowlby, 1969). Bowlby observed children forming bonds with mothers who were hostile or did not breast-feed them. In the absence of appropriate adult attachment figures, bonds were observed to develop between children. This was despite the fact that these children had no means of meeting each other's physiological needs (Fonagy, 2001; Karen, 1994). Further, work conducted by Bowlby and a colleague James Robertson examining the effect on a child's personality development of separation from the mother, inadvertently observed this separation to be far more distressing and detrimental for the child's overall development than they had imagined (Bowlby, 1969). This again suggested to Bowlby that attachment goes far beyond the role of simply meeting a child's physiological needs. Bowlby's vocal differing of views resulted in a great deal of tension between Bowlby and the psychoanalysts of his day (Ainsworth & Marvin, 1995; Fonagy, 2001).

Despite the variety of recorded observations and reports made in the 1930s and 1940s, detailing the detrimental effect of hospitalisation and institutionalisation on an infant, it was not until the 1950s, when Bowlby was asked to advise the World Health Organisation on the mental health of homeless children, that these observations were drawn together (Bowlby, 1969). This commission, triggered by the large number of children separated from their parents or orphaned as a consequence of the second World War, resulted in Bowlby compiling the findings of the professionals discussed above. In reviewing these various reports Bowlby observed a large degree of concurrence in what each of these professionals believed to be an important component underlying the mental health of an infant (Bowlby,

1988; Zeanah, 1996). That is “what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment.” (Bowlby, 1969, p. 12). However, whilst Bowlby and other researchers and practitioners were identifying the importance of the mother/infant relationship, the first official publication of this relationship under an attachment model was not until 1958, when Bowlby wrote a paper entitled “The Nature of a Child’s Tie to His Mother” (Ainsworth et al., 1978).

In accumulating these individual observations and reports a specific pattern of response was observed to be typical of children separated for substantial periods of time from their primary caregiver (Bowlby, 1973; Rutter, 1971). This pattern of response consisted of three phases, beginning with acute distress at the departure of the caregiver that results in a ‘protest’ phase where the infant tries all means possible to locate his mother. Following this phase the infant is observed to become miserable and withdrawn believing that the caregiver may not return, referred to as the ‘despair’ phase. Finally the infant is seen to lose all hope that the caregiver will return and with that they lose interest in the caregiver and move to the ‘detachment’ phase (Bowlby, 1973). Even on the mother’s return, the infant is still seen to demonstrate this loss of interest in her, at least initially. However, Bowlby suggested that should this separation be of only a short duration then the mother/infant relationship can generally be repaired. Alternatively, should this separation, without the provision of an appropriate substitute caregiver, be prolonged or should the infant never have the opportunity to form an attachment in the first place this may severely impact either the reparation of that relationship and/or the development of future relationships (Bowlby, 1973).

This research drew attention to and reinforced the importance of the mother/infant relationship. However, it did not explain the purpose of that relationship. In formulating an understanding of attachment Bowlby drew on theory and research from various streams of thinking including, psychoanalysis, developmental psychology, ethology (the biology of behaviour) as well as Darwin's theories on adaptation and survival (Ainsworth, 1973; Bowlby, 1969; Bowlby, 1988; Feeney, Hohaus, Noller & Alexander, 2001; Hess & Petrovich, 1991; Mitchell, 2000). Darwin's theories drew to Bowlby's attention the ability of infants to adapt to their environment in order to maximise their chances for survival, or more specifically, how infants use their primary caregivers to maximise their chances for survival (Mitchell, 2000). This thinking formed the basis of what Bowlby considered to be the purpose or function of attachment, that is, as a biological drive toward species survival through attachment to a primary caregiver who can provide protection, maximising the child's chance for survival (Bowlby, 1969; Fonagy, 2001; Karen, 1994; Slade, 1998).

Bowlby used work with both human and non-human infants to support his theory of attachment. This incorporated observations showing the detrimental effect to infants of separation from their primary caregiver (Bowlby, 1969; Karen, 1994). Further, Bowlby drew support from Darwin's theory of adaptation that proposed that each species has its own specific repertoire of instinctive behaviour that helps it to survive (Ainsworth, 1973; Bowlby, 1969). In addition, the work of ethologists with animal species provided support for the notion that infants attach for reasons other than simply to meet physiological needs (Karen, 1994). For example the work of Lorenz demonstrated that through a method of attachment referred to as imprinting, infants from certain species of birds could become attached to mother figures who

did not provide for their physiological needs (Bowlby, 1988; Fonagy, 2001). Scott and associates showed that puppies would approach, follow and interact with a man even if they have never seen one before and did not associate him with food (Bowlby, 1969). Finally, Harlow who conducted investigations with rhesus monkeys demonstrated the negative effect of maternal deprivation (Bowlby, 1988; Fonagy, 2001).

Attachment is operationalised between an infant and his primary caregiver through a specific set of attachment behaviours, the purpose of which is to assist the infant to ensure his survival and thus the survival of the species (Ainsworth, 1973; Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1969). The method through which survival is ensured is to gain and maintain proximity to the primary caregiver, who provides protection for the infant (Ainsworth et al., 1978; Bowlby, 1969). Three separate types of attachment behaviours have been identified to achieve this goal. These include *signalling* behaviours, such as crying, smiling and vocalising; *orientating* behaviours such as looking, following and approaching; and finally *active physical contact* behaviours such as clambering up, embracing and clinging (Ainsworth, 1973). When an infant is young, and immobile, it is not possible to actively seek proximity to the mother. However, attachment behaviours such as crying, vocalising and smiling act to motivate the parent to seek proximity with the infant (Karen, 1994; Schaffer & Emerson, 1964). With the development of their motor skills, the behaviours which children utilise alter. Infants, who can crawl or walk, can actively seek proximity to their primary caregiver, such as following and approaching, and can maintain that proximity through clambering up and clinging (Bowlby, 1969).

Attachment behaviours are not present at all times, rather their activation is typically based on alarm or distress in the infant, activated by factors either external or internal to the infant. External factors include absence or distance from the primary caregiver, rebuff or lack of responsiveness of the caregiver, or an alarming or frightening event. Internal factors include hunger, illness, pain and cold (Ainsworth et al., 1978; Bowlby, 1969). Bowlby believed that three main facts relating to the intermittent presence of attachment behaviours in both human and non-human infants provided further support for his theory on the biological underpinnings of attachment (Bowlby, 1969). First, observations of many species of animals showed that an isolated animal is under far greater risk of being attacked and seized by a predator than an animal that is part of a group, therefore validating the presence of these behaviours in the absence of the protective mother figure. Second, animals that are vulnerable by reason of age, size, or condition were observed to perform more intense attachment behaviour. Finally, attachment behaviour was observed to be at its highest intensity when infants are in situations of alarm, for example when a predator is sensed or suspected.

In response to the work performed by Bowlby and other clinicians to provide clear evidence of the detrimental effect of either separating an infant from his mother, or limiting the consistency of care available to an infant, alterations to the regulations of hospitals and institutions were made (Bowlby, 1988; Karen, 1994). Today the situation has reversed with parents encouraged to spend as much time as possible with their hospitalised child, thus the need for examination, exploration and understanding of the impact on an infant of long term separations from the primary caregiver has been diminished. However, this does not mean that attachment theory no longer had a role to play in understanding an infant's development. The following

section considers the second phase in attachment theory as outlined by Greenberg et al. (1990).

1.3 Phase Two: The Quality of the Attachment

The purpose of attachment as suggested by Bowlby (1969) is to maximise an infant's chance for survival. The means by which children enhance their survival is by gaining and maintaining proximity to their primary attachment figure. This is done through the use of attachment behaviours, which are activated when the infant is hurt, scared or in danger (Ainsworth, et al., 1978; Bowlby, 1969). While the observation of long-term separation from a parent sparked interest in the mother/infant relationship, the work reported in phase one did not establish what is necessary for attachment to form nor the role of attachment in everyday functioning, where long-term separations have not occurred. Addressing these issues is the focus of this second phase of attachment research. While Bowlby is credited as the pioneer of attachment theory, it is the work of other researchers that has provided both support for and further developed attachment theory (Bowlby, 1988; Greenberg et al., 1990; Karen, 1994). Specifically this work began with Mary Salter Ainsworth and her colleagues, who again focused on the relationship between an infant and his mother (the primary caregiver). However, there was also a notable difference in Ainsworth's work. Unlike the observational work conducted by Bowlby and other clinicians, this work involved structured research which aimed to examine the mother/infant relationship within a controlled setting (Ainsworth & Marvin, 1995).

It was through working with Bowlby that Ainsworth was exposed to the idea and theories of attachment; however, Bowlby was not her first introduction to the

relationship between an infant and his mother. While Bowlby was working in England, Ainsworth was undertaking her education in psychology in America. As part of her studies, Ainsworth came into contact with William Blatz. Blatz had developed a 'security' theory which suggested that when children feel secure they will interest themselves in and begin exploring their environment (Ainsworth & Marvin, 1995). Ainsworth advanced this theory to suggest that it is parents who provide this sense of security for their children and as such become a *secure base*, from which their children explore the world, and return to for protection should they become startled or frightened (Ainsworth, 1973; Bowlby, 1988; Karen, 1994). Following her start with Blatz in America, Ainsworth moved to England where she began working for Bowlby further fuelling her interest and understanding of the importance of a primary caregiver in an infant's development (Karen, 1994). It was a move to Uganda, however, that provided Ainsworth with first hand evidence for Bowlby's theories. In Uganda, Ainsworth spent considerable time observing the interaction between infants and their mothers in their own home. These observations highlighted to Ainsworth the importance of a mother to her child; however more significant was the fact that these infants were not simply passive or reactive to their environment, rather were often the initiative-takers (Ainsworth & Marvin, 1995). On her return to America, Ainsworth along with her colleagues used her observations to formulate a tool that provided a way to measure the quality of the mother/infant attachment. This tool was named the 'strange situation' (Ainsworth, et al., 1978).

The purpose of the strange situation tool was to examine the everyday interaction between an infant and his primary attachment figure (Ainsworth, et al., 1978). By examining this interaction Ainsworth and her colleagues believed that the quality of the attachment could be assessed (Karen, 1994). This tool required a

conceptualisation of the development of attachment beyond the work initiated by Bowlby. Ainsworth and her colleagues viewed attachment as a reciprocal, enduring, emotional and physical connection between an infant and his caregiver, developing as a product of the mother/infant interaction (Ainsworth, 1973; James, 1994; Sroufe & Waters, 1977). While an attachment relationship may develop between an infant and anyone who consistently provides his primary care, typically the biological mother provides this care (Ainsworth & Marvin, 1995). Ainsworth's observations of children's reactions both in the strange situation and during her previous work in Uganda drew her to conclude that it is not the behaviour of the caregiver that is important for attachment to develop. Rather, the development of attachment is based simply on the consistent presence of the primary caregiver with attachment developing even when it is to the detriment of the infant's own development and functioning (Ainsworth & Marvin, 1995; Ainsworth, et al., 1978; Feeney et al., 2001).

While the development of attachment is not dependent on the type of care provided, the quality of the attachment that develops is. Specifically four dimensions of maternal behaviour have been identified as playing an important role in the attachment quality. These include 'sensitivity', the ability to accurately, promptly and appropriately respond to the infant's signals; 'acceptance' of the child and the mothering role of responding to the infants needs; 'cooperation', which refers to the presence or absence of maternal behaviours that are intrusive or interfere with the child's exploration; and 'accessibility' to the child (De Wolff & van IJzendoorn, 1997). Of these four dimensions of behaviour, sensitivity and the consistency of that sensitivity over time is considered to play the most important role in the formation of attachment (Erickson, 1991). There are a number of factors that can influence the

mother's ability to be sensitive towards her child. These include the mother's own personal history, her cultural values, her belief systems about parental responsibilities, her understanding and expectations of child development and age appropriate behaviour, and the current situational stresses in her life (Thompson, 1997).

The development of attachment in infants is represented through specific attachment behaviours, including, signalling, orientating and active physical contact behaviours (Ainsworth, 1973; Bowlby, 1969). These behaviours are observed in infants as young as two months with the apparent purpose of gaining and maintaining proximity to an individual. However, at this point the infant is not selective about to whom these behaviours are directed (Ainsworth, 1963; Feeney, et al., 2001). It is not until these behaviours are enacted with the purpose of gaining and maintaining proximity to a *specific* caregiver that they are considered attachment behaviours (Bowlby, 1969). This selectivity is not observed until the infant is four to six months of age (Ainsworth, 1963; Feeney et al., 2001). At four to six months only one caregiver is the recipient of these attachment behaviours; however, from nine months of age the infant begins to seek out other attachment figures (Ainsworth, 1963). By 18 months of age infants generally have more than one attachment figure. While the formation of additional attachments actually acts to enhance the primary attachment, should the primary attachment prove unsatisfactory for the child's needs, then this secondary attachment can actually mediate or in some cases overcome the deficits of the primary attachment (Ainsworth & Marvin, 1995; Morelli & Tronick, 1991; Schaffer and Emerson, 1964).

While there is some level of attachment present from birth, the actual development of attachment is a cumulative product of the infant's experiences of

interacting with his caregiver, particularly over the first year of life (Isabella, 1993). As noted it is not until four to six months that infants become selective about to whom they seek proximity. This is in response to the infant's development of an internal representation of the attachment relationship. This internal representation of attachment is based on the infant's experience of his mother, including her sensitivity, acceptance, cooperation and accessibility (De Wolff & van IJzendoorn, 1997). As each infant's experience of interaction with his mother differs, so does his internal representation of that relationship. As a result, different styles of attachment can develop between an infant and his primary caregiver, along with the infant's use of attachment behaviours in that relationship (Ainsworth, et al., 1978).

The internal representation that an infant develops is thought to affect his everyday functioning. This is based on the notion that a child uses his mother as a secure base from which to explore the world. When a child feels that he can trust his mother to remain as the secure base, then he can freely to explore his environment, with the knowledge that he will be protected if things go awry (Ainsworth & Marvin, 1995; Bowlby, 1988). However, an infant who cannot trust his mother to provide that secure base for his protection must find an alternative way to balance the conflicting desires to both explore, whilst still maintaining his own protection and safety (James, 1994). Under such circumstances one of two things may happen. Either the child may cling to the parent, in fear of leaving her lest he should lose any chance of protection, or the infant may become completely reliant on his own ability to protect himself (Lieberman & Pawl, 1990).

The 'strange situation', originally devised in 1964, was the first tool designed with the purpose of examining the quality of the mother/infant attachment. The means by which it proposed to examine this attachment was through examination of

the interaction between an infant and his mother in a strange situation; the use of her as a secure base; and the infant's response to a brief separation from her (De Wolff & van IJzendoorn, 1997). This tool is based on the premise that the caregiver's response to the infant's actions in everyday situations has set up an overt set of attachment behaviours that reflect the internal working model of the attachment relationship (Lewis, Feiring, & Rosenthal, 2000). When the infant is placed in a strange situation, where there are potential dangers, these overt attachment behaviours should be heightened, allowing a clear picture of the nature of the attachment between an infant and his mother (Ainsworth et al., 1978).

In the first use of the 'strange situation' tool a study was performed on 26 mother/infant pairs (Ainsworth et al., 1978). The strange situation comprises a number of sequential stages all of which take place in a laboratory setting completely new to the infant. In the room, the 'strange situation', there are toys to play with and stage one involves the introduction and orientation of the mother and infant to this room. In the second stage the infant and mother are left alone in the room to allow the child the opportunity to explore the room. A stranger entering the room marks the third stage and during the fourth stage the mother leaves the room, leaving the infant alone with the stranger. In the fifth stage of the experiment the mother returns to the room, at which point the stranger leaves. After settling the child, if necessary, the mother places the infant on the floor again to encourage the resumption of their exploration, as instructed for the sixth stage. Once the child is settled, the mother again leaves the room, at which point the child is left alone for the first time. The stranger re-enters the room in the seventh stage and attempts to comfort the child, if necessary. In the eighth and final stage the mother returns and again is encouraged to comfort her child if necessary (Ainsworth et al., 1978). Whilst Ainsworth used this

tool to examine the child's response to each discreet stage of the strange situation, specific attention was paid to the child's responses to the reunion stages (Pastor, 1981).

The work conducted by Ainsworth and colleagues using the strange situation led her to believe that there are three main types of attachment that may develop between a primary caregiver and infant (Ainsworth et al., 1978): securely attached and insecurely attached, including insecure-avoidant and insecure-ambivalent (Ainsworth et al., 1978). Ainsworth identified these three groups as A (insecure-avoidant), B (secure) and C (insecure-ambivalent) (Ainsworth et al., 1978). Infants were classified into one of these groups based on their patterning of behaviour in the strange situation, including interaction with the mother, the stranger and willingness to explore (Ainsworth et al., 1978). Group B or securely attached infants were identified by their comfort in exploring their surroundings whilst in the presence of their mother. However, in exploring the room these infants were observed to use their mother as a secure base, that is checking occasionally on her availability and if necessary returning to her for protection. In response to their mother's departure these infants showed obvious distress (e.g., crying) and were happy to see her on her return. This delight at the reunification stage was demonstrated by activities such as greeting the mother, for example stretching out arms towards the mother. It was the pleasure at reunification stages and use of mother as a secure base that were the most distinctive differences between children with a secure attachment and those classified as insecurely attached (Ainsworth et al., 1978; Feeney et al., 2001)

Infants classified as group A or insecure-avoidant were categorised by their overly independent nature in the room. These infants did not appear to pay much heed to their mother and unlike securely attached infants, did not refer to her as their

secure base, or check on her availability. In response to their mother's departure, they showed little distress and would avoid or snub her on her return. While apparently displaying little distress this behaviour actually masks the desperate desire of these children to find comfort and protection in the attachment figure (Zeanah, 1996). Finally, group C infants, those classified as having an insecure-ambivalent attachment to their mother were identified by their clinginess towards their mother and their unwillingness and fear of exploring their surroundings, even when she was present. In response to the departure of their mother these infants became extremely distressed, however, unlike the securely attached infants, who were easily soothed by their mother on her return, these infants were particularly difficult to settle. It was noted that while these infants appeared to desire contact with their mother, at the same time they would resist contact with her, for example when their mothers were holding them, these infants would arch away from her in an angry manner (Ainsworth et al., 1978; Feeney et al., 2001).

The type of response demonstrated by infants in the strange situation reflects the infant's internal representation of his mother, built over time, on his everyday interaction experience with her (Bolen, 2000). As clear distinctions can be made between infants classified under each sub-type, so can distinctions be made between the behaviour of mothers towards their infants. Observations of the mother's behaviour provided a rationale for the internal representation a child develops of his mother. Mothers of infants classified as securely attached were observed to be more involved with their infant, more responsive to his signals and more appropriate and sensitive in their responses to their infant's signals. Further, these mothers were more positive in their affective expression towards their child and followed the infant's agenda, rather than their own (Isabella, 1993).

Mothers of infants categorised as insecure-avoidant were found to be the most rejecting of the three sub-types, with their behaviour towards their infant characterised by anger and resentment (Isabella, 1993). These mothers often failed to interact with their infant or if they did it was often in opposition to the infant's wishes, for example interrupting the infant with pervasive scolding or an irritable mood when the infant was attempting to explore, or ignoring the infant when they were seeking comfort (Isabella, 1993). Mothers of infants classified as insecure-ambivalent were also found to be frequently insensitive to their infant's signals. However, in contrast they also demonstrated the ability to be very sensitive on other occasions (Blehar, Lieberman & Ainsworth, 1977). These mothers demonstrated no aversion to close bodily contact with their infant, however, again this was inconsistently provided (Cassidy & Berlin, 1994). This contradictory behaviour was dependent on the mother's own moods or desires rather than the needs of the infant. Of all types of mothers, these were found to be the least involved and responsive and on occasions when they did respond it was found to be in a manner that was insufficient for the needs of their child. Further the interactions of these mothers were the most insensitive, that is at times when the infant did not want or require interaction (Blehar, Lieberman & Ainsworth, 1977).

The style of attachment formed between an infant and his mother has significant consequences for a child's development, especially in light of Ainsworth's secure base theory. Infants with a secure attachment have learnt that their primary caregiver is reliable as a secure base, therefore allowing the infant to explore. This promotes the development of a number of social, developmental and cognitive skills. The child is taught independence whilst still having a model for interaction with others and a source to promote and encourage cognitive

development. Further, these infants have experienced their mother as capable of responding consistently to their signals and so are encouraged to display these signals, for example crying at her departure and seeking contact on her return, with the knowledge that she will respond to their requests (Fonagy, Steele, Leigh, Kennedy, Mattoon, & Target, 1995; Raval, Goldberg, Atkinson, Benoit, Myhal, Poulton & Zwiers, 2001;). Having a caregiver respond to such needs helps teach an infant to both identify and manage his own needs over time (James, 1994).

Children with an insecure attachment (either avoidant or ambivalent) are required to alter the inherent, biologically driven pattern of exploration, to find a means to adjust to the lack of a safe base (James, 1994). The manner in which children alter the exploration patterns is dependent on their experiences of the mother. Infants classified as insecure-avoidant are unable to rely on their mother to provide the role of secure base. The rejection and independence displayed by these infants reflects that these infants have lost all hope that the mother will ever provide a secure base for them. As a result the attachment behaviours of the insecure-avoidant infant have become extinct due to a lack of reinforcement (Cassidy & Berlin, 1994). However, while these infants are observed to be apparently unconcerned about the whereabouts of their mother and independent in their exploration, they have no model on which to base interactions or exploration (Lieberman & Pawl, 1990). This strategy, of apparent indifference to the mother, is thought to have developed in order to maintain a level of equilibrium for the infant and to forestall the inevitable failure of their attempts to communicate with their mother (Fonagy, et al., 1995; Karen, 1994).

Infants with an insecure-ambivalent attachment have experienced interaction with a mother who is inconsistent, interacting at times that aren't suited to the child.

These infants develop feelings of ambivalence, anger, vigilance and helplessness and are uncertain whether their mother will be available should they need her. However, the inconsistent behaviour of these infants' mother intermittently reinforces the use of attachment behaviours, encouraging the infant to maximise their use of these behaviours (Cassidy & Berlin, 1994; Fonagy, et al., 1995). The tendency of these infants to cling to their mothers, rather than explore their surroundings, reflects their uncertainty that the mother will remain available (Byng-Hall, 1991). However, the observed attempts to seek proximity to the mother, whilst at the same time rejecting and pulling away from her reflects the contradictory emotions consuming these children, of wanting comfort, whilst knowing that the mother may not provide this comfort (Cassidy & Berlin, 1994). This desire to monitor the mother at all times can also result in a withdrawal and avoidance of all other social interaction. Consequently the child does not fully build social, cognitive or motor skills, stalling his development in each of these areas (Lieberman & Pawl, 1990).

While Ainsworth and colleagues proposed two forms of insecure attachment, more recently, an additional form has been proposed. This third category, identified by Main and Solomon (1986) is labelled insecure-disorganised attachment. This style of attachment is distinctly different from the other three forms of attachment. In each of the other forms of attachment, the child is shown to have a coherent strategy with which to deal with the stress of separation and reunion (Carlson, Cicchetti, Barnett & Braunwald, 1989; Raval, et al., 2001). Even infants with an insecure ambivalent or avoidant classification demonstrate a clear strategy that helps them to maintain a level of equilibrium, either by clinging to the mother or by ignoring the mother. However, the infant with an insecure-disorganised attachment, displays no coherent mechanism for coping (Carlson et al., 1989). Rather this form of attachment, most

commonly seen in children who have been maltreated, is believed to represent a contradiction in the infant's intention or plan (Main & Solomon, 1990). The contradictory behaviour of the insecure-disorganised infant's primary caregiver, who presents as helpless and ineffective in this role, results in strong conflicting motivations in the infant, to both seek comfort from the mother whilst retreating in an attempt to protect himself (Carlson et al., 1989). For children with any form of insecure attachment, the lack of response to their needs means that the child has no model to understand their own needs, or learn how to respond to them.

When an infant has developed a secure attachment, this allows them to freely explore, developing independence, competence and social skills (Bolen, 2000). As his mother is emotionally available to him, this infant develops expectations of the attachment figure as trustworthy, learns to identify needs within himself and how to respond to those needs (Bolen, 2000). Infants with an insecure attachment, on the other hand need to compromise between exploring their environment and ensuring the availability of their attachment figure. Whatever the form of insecure attachment, these infants learn that they cannot trust their primary caregiver to remain available (Bolen, 2000; Cassidy & Berlin, 1994). Further, these infants have no model for developing social skills, they are not encouraged to develop a healthy independence, and while focusing so intently on the availability of their caregiver these infants have less time and energy to explore and advance their cognitive and motor skills. The work performed by Ainsworth and colleagues using the 'strange situation' has provided both a structure for understanding the quality of attachment and the potential impact of that attachment on the infant's development. However, this work has focused primarily on attachment within the first year of life, leaving many

unanswered questions about the implications of early attachment relationships on a child's later development.

1.4 Phase Three: The Role of Early Attachments on Later Development

Whilst the second half of the first year of life is considered vital in the development of attachment, the influence of that attachment is not limited only to infancy or even early childhood. The attachment that develops in the first year of life is thought to have a significant impact on development throughout the lifespan including social, emotional, cognitive and physical development (Field, 1991; Grossman & Grossman, 1991; Sroufe, 1985; Waters, Wippman & Sroufe, 1979). The final phase of attachment theory presented in this introductory chapter aims to examine the impact of attachment across the lifecycle, including the stability over time of the primary attachment, the impact of that attachment on the formation of other relationships throughout the infant's life and the role of interventions in altering primary attachments.

The attachment that a child develops with his primary caregiver serves as a prototype for the development of later relationships (Ainsworth, 1983; Bolen, 2000; Sroufe, 1983). As a result the quality of that early attachment is crucial in determining the quality of the later relationships that an individual develops (Ainsworth, 1989; Bretherton & Waters 1985). This is because the interaction between an infant and his primary caregiver creates an internal representation of what a child should expect from the primary caregiver with these expectations extending to other people with whom the infant develops a relationship (Bolen, 2000). In particular, this internal representation influences the nature of the child's later intimate relationships in times of stress when the individual's survival

mechanisms are heightened (Lewis et al., 2000). However, the degree to which this primary attachment impacts on future relationships depends on the continuing stability of that primary attachment over time.

The stability of the initial mother/infant attachment over time is a controversial issue. Whilst longitudinal studies examining attachment across time have been limited (Lewis et al., 2000), a number of attempts have been made to use developmentally appropriate measures to assess attachment in either childhood, adolescence or adulthood. Of the studies that have found a method to measure attachment after infancy, the findings have been mixed in their support of the stability of attachment. First there is the research that supports the continued stability of an early attachment classification label at a variety of ages, including late infancy (Lamb, Thompson, Garnder & Charnov, 1985); middle childhood (i.e., six and ten years) (Cassidy & Berlin, 1994; Grossman & Grossman, 1991; Main & Cassidy, 1988) as well as in late adolescence (Van IJzendoorn, 1995). Studies reported within each of these papers indicated levels of consistency at or above 70% between classifications given in infancy through the strange situation tool and those given by modified, developmentally appropriate tools such as the Adult Attachment Interview (AAI, Main & Goldwyn, 1991).

In contrast other studies have found that the stability of infant/mother attachments is dependent on the stability of the child's caregiving environment (Belsky, Campbell, Cohn, & Moore, 1996). This includes the consistency of parental behaviour, the parental relationship and how these factors impact on the patterns of interaction between the infant and primary caregiver (Lewis et al., 2000). Each of these factors can be influenced by stressful life events impacting on the family (Lewis et al., 2000). One prime example of a stressful event that impacts on the

family and more specifically has been shown to impact on the stability of the caregiver/child attachment is divorce. Divorce not only has an impact on the parents, but also the children and in particular the emotional and social experiences within the family (Davies & Cummings, 1994). Studies examining the impact of divorce on attachment have shown that not only is divorce linked to higher rates of insecure attachments in late adolescence, but also that divorce is associated with changes in the attachment classification of children, that is from secure to insecure (Lewis et al., 2000; Zimmerman, Fremmer-Bombik, Spangler & Grossman, 1997). Whilst changes in nature of the attachment can be negative, that is from a secure to insecure attachment, the ability of the attachment relationship to alter is important and positive for intervention work aimed at repairing the mother/infant attachment. In framing this work in a family systems approach, therapists can work to alter the interaction patterns within the family, thus altering the nature of the attachment between an infant and his primary caregiver (Byng-Hall, 1991).

In cases where the primary attachment remains stable, what role does this attachment play in an infant's future relationships and social and emotional development? From the observations that sparked the initial interest in attachment, we have seen that deprivation of a secure early attachment relationship has a detrimental impact on children's emotional and social development and in turn, their ability to form other relationships (Bowlby, 1969). More recent research has confirmed these observations. Children with a secure attachment in infancy were found to be less dependent, more competent socially and more resilient than children classified as insecurely attached (Urban, Carlson, Egeland & Sroufe, 1991). They were also found to be better able to form relationships with other children and more likely to have at least one or more reliable and trustworthy friends than those who

were insecurely attached (Grossman & Grossman, 1991). Further, other researchers have reported higher self-esteem, greater curiosity, ability to cope with failure, persistence in problem solving and more purposeful interactions in children with a secure early attachment (Erickson, 1991; Maslin-Cole & Spieker, 1990; Pastor, 1981; Sroufe, 1985; Waters, Wippman, & Sroufe, 1979).

Whilst all children with an insecure early attachment classification are seen to have impaired social and emotional development, the degree of impairment differs according to the subtype of insecure attachment they have developed. Of insecurely attached infants, children with an insecure-ambivalent attachment were found to be least responsive to their peers (Pastor, 1981). This reflects their strong need to monitor the primary caregiver and ensure her continued availability. Infants with an insecure-avoidant attachment in contrast have received no reinforcement to continue seeking interaction with the primary caregiver (Cassidy, 1990). Children with an insecure-disorganised attachment classification have been found from a young age to be the most controlling of all attachment types (Main & Cassidy, 1988). This is a reflection of the role these infants typically play in the caregiver/infant relationship, where the helplessness of the primary caregiver means that the infant is forced to take on the parenting role (Main & Hesse, 1990).

1.5 Intervention

Understanding the quality of attachment between an infant and his primary caregiver is important for helping to understand and determine risk factors for psychopathology, poor social development and even for difficulties in cognitive development (Bowlby, 1988; Bretherton, 1991; Pastor, 1981; Sroufe, 1985). In understanding the quality of attachment in infancy, the possibility is available to

intervene and alter the quality of that attachment. While this introductory chapter has focused on one classification system for understanding the quality and impact of attachment, other systems of classification are also available. These include the DSM-IV (APA, 1994) and Zeanah (1996). Rather than discuss these classifications systems within the introductory chapter, which has served primarily to provide a historical overview, they have been addressed within the case studies following. In considering classification under Ainsworth system, stability of that classification is dependent on the stability of the child's environment and interactions with the attachment figure. Whilst it has been a number of years since Bowlby first sparked interest in attachment, it is only recently that attachment theory has begun to be applied in the form of a clinical intervention (Bacon & Richardson, 2001). Further, the best approach to intervening has not yet been determined and is dependent on the level of dysfunction in the attachment, or whether an attachment has been formed at all (Smyke, Dumitrescu, & Zeanah, 2002).

Of those interventions that have been explored, the main emphasis has been to alter the behaviour of the attachment figure towards the infant, specifically the sensitivity of the primary caregiver (van den Boom, 1997). A meta-analysis examining the different approaches to altering the attachment figure's sensitivity revealed that behaviourally orientated, short-term preventative interventions are more effective than longer, more intensive therapeutic approaches (van IJzendoorn, Juffer, & Duyvesteyn, 1995). In addition, the earlier intervention is implemented the more effective it is likely to be, as patterns of interaction between the caregiver and infant become more difficult to alter with the passing of time (Thompson, 1997). Assisting a caregiver to alter the sensitivity of her behaviour towards the infant requires more than simply providing guidance or instructions to the mother

(Ainsworth, 1973). Rather, either a group or individual approach that allows the caregiver to implement and practice alternative forms of interaction is more effective (Ainsworth, 1973; Marvin, Cooper, Hoffman & Powell, 2002).

Summary

Attachment denotes the special relationship that develops between an infant and his primary caregiver. Whilst little is required on the part of the caregiver for that attachment to develop, the quality of the attachment is dependent on the consistency of the attachment figure's sensitivity, acceptance, cooperation and accessibility towards the child (Ainsworth & Marvin, 1995; De Wolff & van IJzendoorn, 1997). The quality of the attachment that develops between an infant and his primary caregiver has significant implications for the infant's social and emotional development, both in the short and long term. Whilst typically stable over time the mother/infant attachment is not impervious to change, either negative or positive. This means that there is the potential for interventions to alter the nature of the interaction patterns within the relationship. However, to alter the nature and quality of attachment, dysfunction within the relationship needs to be recognised in the first place and appropriate intervention needs to be applied. The following four chapters in this portfolio will address some of the specific issues related to identifying attachment disturbances, the impact of these disturbances and ways to alter or intervene in the relationship to assist the attachment figure and infant or child to develop a better quality of attachment. Further, they will provide a case study to illustrate the relevance of these issues. Finally, a discussion of the issues raised will be provided.

CHAPTER 2 – THE IMPACT OF AN ORGANIC BIRTH DISORDER ON INFANT/CAREGIVER ATTACHMENT

A secure attachment between an infant and his primary caregiver has been shown to be imperative to the infant's development. During the first six months of life the infant begins orientating himself to his environment and the people who provide care for him. The second six months of life are marked as the phase when an attachment with an individual caregiver is observed. Four specific areas of maternal behaviour are identified as being particularly important for the development of a secure attachment between an infant and his primary caregiver, in this case the mother (De Wolff & van IJzendoorn, 1997). Whilst much of the previous research and thus the introductory chapter of this thesis has focused primarily on the role of the mother and her contribution to the pattern of interaction that develops, it is also important to consider factors related to the infant in understanding the development of the attachment. Rather than viewing attachment as a pattern of interaction directed by the caregiver, this alternative view recognises attachment as a dyadic relationship, in which both parties contribute to the development of the patterns of interaction within the attachment relationship (Raval, et al., 2001). However, it is noted that this is not an equal partnership, rather the parent must compensate for the child's level of development (van den Boom, 1997).

In understanding the infant's role in attachment there are a number of factors within the infant considered to impact the formation of attachment. Specifically, alternative hypotheses have focused primarily on the infant related factors such as temperament (Goldsmith & Alansky, 1987; Lewis & Feiring, 1989). However, it is also important to understand the impact of an infant with atypical development and

how this may affect the mother's ability or willingness to promote maternal behaviours necessary for the development of a secure attachment. Though this is an area which has received very little focus, the atypical development of infants with specific disorders may impact on the typical developmental stages of attachment and the infant's role in the development of those stages. That is, as a child develops they become more active in promoting attachment behaviours that gain and maintain the proximity of the caregiver as well as more aware of the situations that require proximity to the caregiver (Bowlby, 1969). The case study presented in this chapter will provide an example of an infant with atypical development in the form of Down syndrome, and the impact of this disorder on both the mother and the infant in the development of attachment.

One in every six to seven hundred babies born in Australia has a chromosomal defect resulting in the disorder commonly referred to as Down syndrome (Down Syndrome Association Victoria, 2000). Down syndrome, a condition involving both physical and intellectual disabilities, is caused by a trisomy of the 21st chromosome (Encarta, 1999). The level of disability associated with this condition varies for each child, ranging from minor to severe cognitive and physical disabilities. As with other forms of disability, society has typically held a negative view of the abilities and worth of individual suffering from Down syndrome. Many sufferers were locked up in mental institutions, especially as they got older, stronger and more difficult to control, and doctors often recommended at the birth that parents find an institution for their child and tell family members that the baby was stillborn (Stratford & Gunn, 1996). From the 1970s society's view began to change, and with that change has come much encouragement for parents to raise their child with Down syndrome or any other form of disability at home as per a child without a disability.

As a result the focus of professionals attempting to identify, categorise and understand the attachment between an infant and his mother have been required to start considering the role of attachment when the infant involved is suffering some form of disability. In these cases professionals need to focus not only on the parent's ability to cater and respond to their child's needs, but also ability of the infant to communicate those needs and utilise the attachment behaviours outlined in the introductory chapter.

Down syndrome is one of only a few disorders recognisable at birth, or diagnosable before birth. This is due to the constellation of physical features, including a small round head with a high, flattened forehead and fissured, dry lips and tongue associated with the disorder (Saenz, 1999). If these symptoms are detected at birth, or prior to birth, as they often are, then genetic karyotyping is used to confirm the diagnosis (Saenz, 1999). This holds both advantages and disadvantages for the parents and the infant. The advantages include the ability to prepare the parent for their child's disability and to implement intervention, both for the parent and the infant, from the time of the birth. Parents can be provided with information and support to help them to adjust to the fact that their child has a disability (Trumble, 1993). In addition, early intervention to assist in managing and understanding the needs of the infant can begin at this very early stage. Alternatively, this may also be a disadvantage for the infant. Even when provided with information and support about their infant's disability, parents and in light of this paper, mothers, may have difficulty accepting their infant's obvious disability. Consequently, at this early and important stage of bonding between the mother and her infant, the mother may have difficulty accepting her child's disability, which may in turn impair the mother's ability to provide care that is sensitive, cooperative, accepting and

accessible to the infant, behaviours which are mediated by the mother's state of mind towards her child (Main, Kaplan & Cassidy, 1985). Whilst this may not impede the infant from forming an attachment to his mother, it may have significant consequences for the quality of that attachment.

As with all children, the importance of attachment for the cognitive, social and emotional development is also highlighted with children with Down syndrome. With the common practice in the late 20th century to raise children with disabilities in the home, rather than place them in institutions "the developmental pattern for this syndrome has moved away from a prognosis of severe/profound retardation to a mild/moderate level of disability." (Farran, 1990, p. 527). Home- and community-reared Down syndrome children have been found to reach developmental milestones well in advance of the traditional expectations set forth in the late 1940s to early 1960s (Gibson & Harris, 1988). Even without other forms of intervention, it has been found that even simple changes such as greater interactions with carers and the ability to form an attachment despite the quality of that attachment improves the prognosis for children with Down syndrome as with all children (Ainsworth, Bell & Stayton, 1971; Clarke-Stewart, 1973).

Not only is it factors on the part of the parent which may jeopardise the quality of the attachment that is formed, rather there are a number of additional conditions commonly associated with the disorder which can affect the developing attachment. Whilst some of these associated conditions develop in later childhood or early adolescence, at least two major conditions may develop in infancy, including cardiac and gastrointestinal complaints. With regards to cardiac problems, approximately 40% of infants develop a congenital heart disease, which requires surgical intervention and which still remains a major killer of children with Down

syndrome, despite this intervention (Trumble, 1993). The incidence of gastrointestinal difficulties is less, however, figures still suggest that at least 12% of infants suffer abnormalities in the gastrointestinal tract, which require surgical intervention (Trumble, 1993). With a higher risk of death in infancy and intrusive surgical interventions required, the child may spend considerable time in hospital, hampering not only the development of attachment but also the parents' ability to allow themselves to become emotionally connected to their child when they fear, or there is the risk the child may die. Further the parents' ability to engage in everyday interaction with their child may become secondary to other medical interventions. For example an infant, who has a gastrointestinal tract problem, may have to be fed through alternative means, such as a tube directly into their stomach. This not only interferes in the potential bonding experience of breastfeeding, but is also time consuming, leaving little time for other forms of interaction.

In contrast to research in the field of attachment in general, much of the work examining attachment between infants with Down syndrome and their parents has focused on the role of the infant in the development of that attachment (Coggins & Morrison, 1981). The focus on the infant's role in the formation of attachment has highlighted a debate triggered by Zigler and Balla (1982), labelled the developmental-difference controversy. The developmental side of this debate suggests that children with disability do not differ in the cognitive, social, interactional processes they use, however, there is a delay in the development of these processes. The difference side of the debate however, suggests that there is a difference in the cognitive, social, interactional processes of children or infants with and without disabilities (Fyffe, 1996; Milgrim, 1973; Weiss, Weisz & Bromfield, 1986; Weisz, Yeates & Zigler, 1982). This latter theory suggests that the differences

in the type of attachment that develops between an infant with a disability and his mother are due to differences in the infant's development.

Research examining the development of attachment behaviours in infants with Down syndrome suggests that the developmental theory is applicable to this population (Cicchetti & Serafica, 1981; Thompson, Cicchetti, Lamb & Malkin, 1985). That is, both children with and without disabilities proceed through the same stages and processes of development, including using attachment behaviours to gain and maintain proximity to the primary caregiver, though children with disabilities develop at a slower rate. However, further examination suggests that the difference theory may also have some applicability in understanding the quality of the attachment behaviours and socio-emotional behaviours used by children with Down syndrome, in response to the primary caregiver. As with children without disabilities, the strange situation designed by Ainsworth and colleagues (Ainsworth, et al., 1978) is also useful for understanding the attachment between infants with a disability and their primary caregiver. However, not only has research been scarce in this area, but again it has focused primarily on the quality of the infant's responses to the caregiver and the impact of those responses on the attachment relationship rather than the quality of the attachment per se.

In one study, conducted by Thompson, Cicchetti, Lamb & Malkin (1985) that used a simulation of the strange situation to examine the quality of the responses of an infant with Down syndrome, the children were compared to children without any form of disability. This study involved children with Down syndrome aged 19 months and children without disabilities aged 12 ½ months to equate mental age and 19 ½ months to equate chronological age. Whilst the strange situation tool was designed for use with children aged 12 months, Thompson et al. (1985) argued that

the delayed development in infants with Down syndrome meant that 19 months was an appropriate age for measurement with the tool. The study examined the responses of children to the different stages of the strange situation tool as outlined in the introductory chapter. The study revealed that while infants with Down syndrome may follow a similar model of response to the strange situation, there was a marked difference compared to both the mental age and chronological age-matched normal group in the quality of the responses elicited from children with Down syndrome. Specifically children with Down syndrome demonstrated significantly less distress in response to separation from the mother, and recovered more quickly on return of the mother.

Thompson et al. (1985) proposed two possible theories for the observed difference in response between children with and without the Down syndrome disorder. The first theory proposes that cognitive differences, that is the capacity of infants with Down syndrome to interpret new situations may be impaired which restricts or slows their ability to process stimulus events, i.e., the departure of the mother. A second theory proposes that it is differences in the biochemical functioning of children with Down syndrome and more specifically deficiencies in the adrenal system that limit the organismic activation of the child in response to stress, fear or threat. Thompson et al. (1985) suggest that the findings of their study provide greater support for the second of these hypothesis, as infants with Down syndrome were not only limited in their arousal to the separation but also recovered quicker. However, they did not dismiss the role that cognitive factors can play.

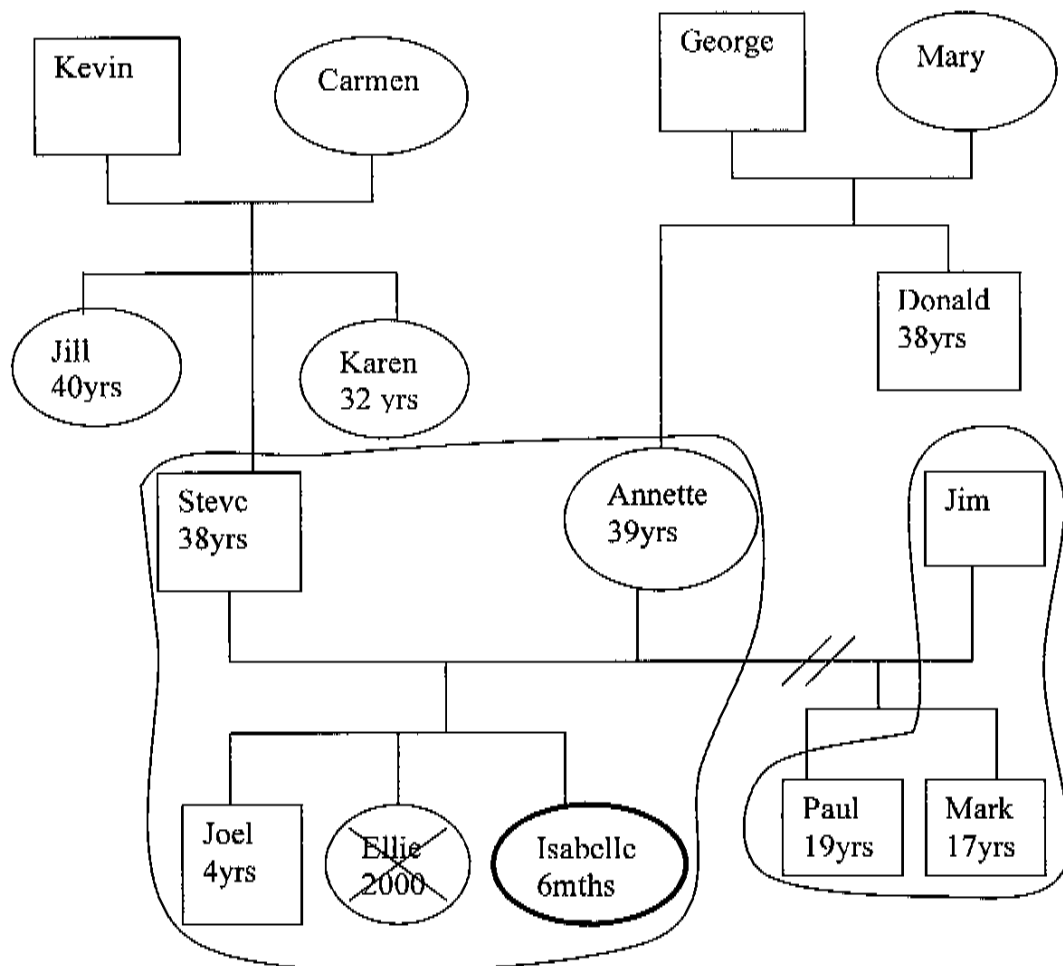
Whether the differences in the development of attachment behaviours in children with Down syndrome is attributed to a development or difference theory, undoubtedly this difference has an impact on the attachment between an infant with

Down syndrome and his mother. Not only are infants with Down syndrome shown to display more restricted emotions of fear or distress, such as in the strange situation, but they are also seen to show a diminished intensity of smiling, laughter and eye contact in comparison to children matched for mental age (Berger & Cunningham, 1981; Cicchetti & Sroufe, 1978). Further, research has shown that young children with Down syndrome may be more difficult and less gratifying as social partners. They take less initiative, respond and initiate interactions in a less contingent and predictable manner and give social and communicative signals that are less readable (Berger, 1990). This not only limits the ability of parents to understand and respond to their child's needs, but also indicates that parents are not receiving the same level of reinforcement when they do meet their child's needs. Further, less interaction on the part of the child may discourage mothers from initiating interaction (Landry & Chapieski, 1990).

The research involving children with Down syndrome has suggested that these children may be delayed in their ability to express emotions and needs. In response this may impact on the willingness and ability of parents to both respond to these children and develop a secure attachment with them. Following the case of Isabelle, a six-month old girl with Down syndrome, will be presented. This presentation examines the patterns of interaction between Isabelle and her mother, and will discuss the implications for development of both a secure attachment and Isabelle's subsequent social and emotional development.

THE CASE OF ISABELLE

Isabelle is a six-month-old baby girl who along with her mother, Annette, was referred to a mother-infant group. The maternal and child health nurse working with Annette and Isabelle initiated this referral when she became concerned about the quality of the relationship developing between Annette and Isabelle.



Family History

In an interview prior to the commencement of the mother/infant group, Annette provided information regarding both Isabelle's family and developmental history. Isabelle is six-month-old baby who was born with Down syndrome, a condition caused by a Trisomy of the 21st chromosome. This condition was diagnosed prior to Isabelle's birth and Annette informed that while she and her husband were given the option to abort the pregnancy they decided to proceed with the pregnancy.

Annette reported that she had been married once previously. She informed that her first marriage was very violent with her husband, the father of two eldest sons Paul and Mark, frequently physically abusing her. This domestic violence began not long after the marriage and continued through both her pregnancies. This relationship ended after a period of five years when Annette left. Annette informed, both of the boys remained with Jim following the separation due to her fear about what he would do to her or the children should she request custody. Annette was married for the second time to Steve six years ago. She has had three children with Steve, however, one of these children was stillborn. Annette informed that her two youngest children reside with her and Steve, and despite the violent relationship she had with her first husband, she is still in close contact with both Paul and Mark.

Annette informed that each of her children have suffered some form of disability from birth. Her eldest son, Paul was born with a cleft lip and palate, a separation of the body structure of the lip, the roof of the mouth (hard palate) and the soft tissue in the back of the mouth (soft palate). To correct this problem Paul required surgery at twelve months of age and follow-up surgery at three years of age. Whilst Paul, no longer suffers any effects of the cleft lip and palate, Annette

informed that prior to the surgery she had great difficulty in feeding him, due to the interference of the cleft palate. Both Annette's second son Mark and third son Joel were born with a congenital deformity of the skull, referred to as Craniosynostosis. This refers to impairment of the development of the skull as various skull bones have failed to fuse. Whilst this condition did not affect the boys' cognitive development, it did require surgery to alter the abnormal development of the skull. In both cases both boys' underwent surgery at around age two years.

Annette informed that her first daughter was born with Trisomy 18 Syndrome, or Edward's Syndrome. This is a chromosomal disorder, similar to Down syndrome, in which there is an extra chromosome 18. The incidence of this disorder is quite rare, with most infants dying in the embryonic or foetal stages of development. If born with this disorder, infants suffer severe facial deformities, organ malformation and intellectual disability. Annette and Steve's baby, Ellie died approximately one day before Annette was scheduled to be induced. Annette informed that she felt something was wrong with the baby on the day she died, however, the doctors failed to respond to her concerns. Annette informed that following the death of Ellie, she and Steve sought the advice of doctors about having another child. According to Annette, they were informed that the chances of having another child with a similar disorder (e.g., Down syndrome), were extremely rare. Annette became pregnant with Isabelle approximately four months after Ellie's death.

Developmental History

Annette described her pregnancy with Isabelle as uneventful, aside from the amniocentesis test, which identified the Down syndrome condition. She informed

that Isabelle was induced three weeks prematurely and due to difficulties breathing, was placed in a humidicrib for the first three days. One week after her birth, it was identified that the bones at the top of Isabelle's nose were fusing together, making it impossible for her to breathe through her nose. Rectifying this problem required the insertion of a stent (straw-like object) in each nostril that protruded on to her face. Annette informed that it was anticipated that these stents would be removed after twelve weeks. The stents would often fill with mucus, which required Annette to suction them on a regular basis. This occurred during the day and night and as a consequence Annette slept in Isabelle's room to ensure that she could hear when suctioning was required. The stents also restricted Isabelle's ability to feed and required a specialised bottle, which meant that Annette was unable to breastfeed her.

As with most infants with Down syndrome, Annette informed that Isabelle suffered from hypotonia, or poor muscle tone. This meant that her developmental milestones of raising her head, and other early movements were delayed and that physiotherapy was required to help build her muscle tone. Annette reported that she was required to learn the tasks recommended by the physiotherapist and spend time each day using these techniques to assist Isabelle to build her muscle tone. During the period that the mother-infant group ran a medical check up revealed that Isabelle had a hole in her heart which would require surgery around three years of age should it not heal itself before that time.

Current Concerns

Annette and Isabelle were referred to a mother/infant group by their maternal and child health nurse following concerns about the interaction and bonding between

Isabelle and Annette. In a referral letter the nurse reported that she had concerns regarding Annette's continuing feelings of grief and guilt over the death of her daughter Ellie as well as over Isabelle's Down syndrome condition.

Overview of Observation and Assessments

The group aimed to provide a therapeutic, educational and intervention role. This was done through providing the mother with the opportunity to first discuss and address her concerns regarding her infant and her role as a mother, second to learn about normal development, and third to provide assistance in identifying and understanding the infant's signals and to provide instruction and practice in utilising other forms of interaction with the infant. In the case of Isabelle, this also required providing some additional direction about the delays in Isabelle's development and how Annette can encourage Isabelle to use some attachment behaviours such as making eye contact.

General Impressions

Annette was observed to be very cheerful at the beginning of each of the group sessions, though often this cheerfulness appeared forced. While she would often become teary during the group when discussing the death of her daughter Ellie, Annette also generally left the session with a cheery disposition. Annette responded well to all of Isabelle's physical needs, competently suctioning her stents and feeding her with the specialised bottle. However, when she interacted with Isabelle, Annette was always very enthusiastic and at times over zealous. Despite making many comments to Isabelle such as 'who's my beautiful baby', Annette was observed to

often make these comments without looking directly at Isabelle. Further, often Annette initiated these interactions with Isabelle when she was preoccupied examining a new toy. In response to Annette's attempts to initiate interaction Isabelle would often continue to focus her gaze on the toy she was examining or her hands rather than at Annette. Further, Isabelle very rarely responded to Annette with smiles, laughter or vocalisations.

Observations and Assessments

A common theme of discussion raised by Annette during the sessions was the loss of her baby Ellie. Annette spoke regularly about both her grief over Ellie's death, as well as her guilt about Ellie's disorder and subsequent death. Annette also spoke of her guilt about Isabelle's Down syndrome. This guilt was directed not only towards Isabelle, but also towards her whole family. Annette informed that she had wanted to have a baby girl, which was a major factor in deciding to have another child after Ellie's death. Annette informed that she felt responsible for bringing grief and misery on her whole family both in the form of Ellie and Isabelle. Annette identified in herself some ambivalence and difficulty in loving Isabelle and that at times she would accidentally call Isabelle 'Ellie'.

As the sessions progressed Annette spoke less frequently of Ellie and spoke more of enjoying having Isabelle as her child. This enjoyment was observed in the increase of face-to-face interaction between Annette and Isabelle, with Annette making and maintaining eye contact with Isabelle for longer periods of time. Annette was also able to make some positive steps outside of the sessions. These included taking time out from caring for her children and spending time on something she wanted to do; visiting Ellie's grave and taking a plant to leave there; spending more

time with her husband and allowing him to have time out to grieve over the loss of Ellie as well as Isabelle's disorder.

Prior to the second last session Isabelle had her stents removed. Annette informed the group that she 'felt as if she had her baby back'. In the last session she spoke of how things had changed for the entire family. For example, Annette and Steve were able to sleep in the same bedroom again, and Isabelle, who had begun physiotherapy to improve her muscle tone, had made some progress and was able to hold her head up for short periods of time. Annette spoke about how the physiotherapy was something positive she felt she could do to assist Isabelle to develop.

Parental Stress Index

The PSI is a tool to measure both a parent's feelings about her capabilities as a parent, as well as her feelings about her child. This tool is divided into two domains, a parent and a child domain. The first examines the parent's perceptions of herself and the second her perceptions of her child. Within the manual of this tool, a profile guideline is provided for parents of children with Down syndrome. Within each of these domains are a number of separate areas, for example the mother's feelings of isolation, depression, and her impressions of her child as reinforcing, how acceptable the child's appearance is, and the demandingness of the child.

Annette was required to complete the PSI both prior to beginning the group and following completion of the group. In her first assessment using the PSI, it was found that Annette's profile followed a similar pattern to that of other parents of a child with Down syndrome. However, while the scores of other parents typically fell

into the normal range, Annette's scores were found to be elevated to the clinical range for all areas of the assessment. The lowest scores were found in the areas of 'mood' and 'distractibility/hyperactivity'. On the child domain, areas found to be particularly high were 'reinforces parent', 'acceptability' and 'demandingness'. Elevated scores in these areas indicates that Annette is not experiencing Isabelle as reinforcing of her parenting behaviour, that she may not look or be perceived as Annette had first expected and her demands on Annette are more than Annette initially expected or feels that she can cope with at present.

On the parent domain, particularly high scores were revealed for the areas of 'competence', 'isolation', 'health', 'attachment' and 'depression'. All of these scores were above the ninety-fifth percentile and reveal Annette's feelings of incompetence, that she has little support, that she is unable to connect with Isabelle, and that she feels that her health has suffered as a consequence of Isabelle's birth. The level of elevation and broad spread of areas that are elevated are particularly concerning when considering Annette's feeling of connection to her infant and ability to provide appropriate care for Isabelle and even her ability to cope with everyday life in general. Despite describing her husband as supportive, both Annette's high score in the 'isolated' and 'spouse' areas indicate that Annette is not feeling supported by either her husband or others around her. In addition to the stress that Annette is experiencing in the mother-child relationship, her results also indicate that she is experiencing above average levels of stress external to Isabelle.

In her second responses to the PSI, following the completion of the group, there were marked changes in Annette's responses. While some scores still fell into the clinical range, overall there was a reduction in her scores in all areas on the assessment. Annette still reported feeling that Isabelle was not 'reinforcing' her role

as mother and that Isabelle's 'demandingness' of her was more than she had anticipated, and at times more than she was able to cope with. Annette also reported a continued feeling of 'isolation' as a result of Isabelle's birth, however in response to the area of 'spouse' it was seen that Annette felt that he was more responsive, involved and supportive. Whilst there was also a noted reduction in Annette's reported feelings of stress external to Isabelle or her relationship with Isabelle, this reported level of stress still fell within the clinical range.

Formulation and Recommendations

Isabelle is the six-month-old daughter of Annette and Steven. She and her mother Annette were referred to a mother-infant group following concerns regarding the development of attachment between the pair. Annette reported a previous violent relationship. Further, Annette reported some form of trauma associated with the pregnancy, birth or early childhood of each of her children. Observations of the interaction between Isabelle and Annette revealed that Annette would interact in an over-zealous manner that often intruded on Isabelle's exploration. Alternatively Annette was observed to respond appropriately and promptly to all of Isabelle's physical needs. Isabelle was observed to have almost no interaction with Annette, and unlike other infants her age, rarely engaged Annette by eye gazing, smiling, laughing or vocalising. However, the delay in development of these behaviours or the lower frequency and intensity of these behaviours may be associated with the delayed development of infants with Down syndrome.

Annette is contending with a number of factors in attempting to develop an attachment with Isabelle. First she is contending with the reduced attachment behaviours displayed by her infant. Second, she is contending with the reduced

ability of her infant to signal her needs. Third, Isabelle is suffering a number of medical conditions. Her breathing condition requires time-consuming intervention, which is also physically intrusive. Her heart condition at present does not require intervention, however, this is a risk for the future. Finally, Annette reports experiencing guilt over the disability or impairments, however minor, suffered by each of her children. Particularly she is experiencing guilt over the disabilities suffered by Ellie and Isabelle and the impact this has had on her family as well as her daughters. Annette's guilt and inability to grieve over Ellie's disability and death is also interfering with her ability to first grieve the loss of a 'normal' child and second accept Isabelle. In accepting and allowing herself to form a bond with Isabelle, Annette may feel that she is rejecting and deserting Ellie.

With the assistance of the group as well as changes in her own life circumstances, including the removal of Isabelle's stents, the relationship between Annette and Isabelle has begun to take on a more real emotional connection. Isabelle was observed to make and maintain eye contact with Annette on a few occasions during the last two sessions of the group. While this is encouraging for the development of a secure attachment between Isabelle and Annette, the continued formation of this relationship is dependent of the continued stability of the emotional environment provided for Isabelle. In order to provide this stable environment for Isabelle it is necessary to allow Annette the space to grieve the loss of Ellie but also address her feelings of guilt around the rest of her family, particularly her children. As such it is recommended that individual therapy be provided for Annette to assist with examining these issues.

While Annette is appropriately responsive to Isabelle's physical needs her conflicting feelings of wanting to interact with her child but feeling ambivalent

towards her is resulting in inappropriate interactions, that is these interactions are inconsistent and often at times when Isabelle is not requesting them. This inability to read her child's signals may be partially attributed to Isabelle who's signals are unclear, however, it is also important to recognise Annette's anxiety, which causes her to interact at times that suit her rather than Isabelle. To assist Annette in reading Isabelle's signals more correctly, continuation in a mother-infant group or an early intervention group that caters specifically to the needs of parents of children with Down syndrome is recommended. These recommendations were discussed with Annette and referrals were made to both a psychologist who conducts individual grief work with parents as well as to an early intervention program for infants with Down syndrome.

Discussion

The development of attachment typically focuses on the role of the mother and her behaviour towards and interaction with her infant. However, with infants with a disability or disorder, the focus shifts towards the infant and their role in the development or impairment of a secure attachment. This case clearly demonstrated that there were a number of factors specifically associated with Isabelle and the disorder she suffers, which would impair the development of a secure attachment between herself and her mother. These factors include her delayed ability to utilise attachment behaviours as defined by Bowlby (1969) (See Chapter 1); her delayed ability to signal or communicate her needs; and the secondary conditions she suffers, such as her need for stents, her heart condition and her physical development. Not only do each of these factors require time consuming intervention, which leave little time for other forms of interaction between Isabelle and her mother, but they may

also impact upon Annette's ability or willingness to develop a close attachment to her child due to her fear that Isabelle may die.

In contrast, however, the above case also clearly demonstrated the role Annette is playing in hampering the development of a secure attachment. Annette's previous experiences with each of her children suffering some form of disability and the death of her first daughter Ellie have created a degree of ambivalence within her. Whilst she wanted and welcomes having a baby girl, Annette also rejects Isabelle. This is for a number of reasons. First Isabelle is not Ellie, who has taken on the guise of a perfect child, despite the fact that her disabilities would have been more severe than Isabelle's. Second, Isabelle consumes significant amounts of Annette's time, which interferes with her relationships with other members of her family. Third Annette experiences feelings of guilt that she has failed to protect her children, from either disability or in the case of her elder two sons from their violent father. Accepting Isabelle means Annette must also accept her failures. Due to her feelings of ambivalence, Annette is not available to Isabelle when Isabelle needs; she has little space for observing Isabelle's signals; and little time to teach and assist Isabelle to communicate her needs.

The behaviour demonstrated by Annette is similar to that observed in parents of children classified as insecure-ambivalent (Blehar, Lieberman & Ainsworth, 1977). These children learn that their parents are intermittently and unpredictably responsive, a pattern of response which encourages the child's use of attachment behaviours, despite being unable to trust the consistency of their parent's response (Cassidy & Berlin, 1994). Further, Annette's interactions often intruded on Isabelle's own exploration and play. Being only six months of age, Isabelle may not have yet internalised a template for interaction with her mother, however, if this pattern of

interaction continues, it is anticipated that the form of attachment to develop between Isabelle and Annette will be insecure-ambivalent. This highlights the need for intervention to assist Annette to understand and respond to the signals of her daughter. At this early stage it is anticipated that intervention will be highly successful in altering the pattern of interaction and therefore the quality of the attachment that develops between Isabelle and Annette.

This case has been useful in highlighting the role of the mother and maternal behaviours in the attachment that develops between an infant and his primary caregiver. However, it is still important to recognise that children with disabilities make different demands on their parents, and may be far more difficult for parents to interact with and understand their signals. Consequently, it is important that an intervention service dealing with attachment in children with disabilities, be not only aware of the special needs of Isabelle, but also able to educate Annette in how to cater to all of Isabelle's needs, including physical, social, emotional and cognitive. For example, due to Isabelle's delayed development, it is important that intervention services be highly skilled in identifying and interpreting the signals given by Isabelle and assisting Annette to also identify these signals.

Further, this case has highlighted the importance of not only dealing with the attachment relationship per se, but also issues within the mother. Annette's grief and guilt is interfering with her ability to be available to Isabelle, therefore, until these issues are resolved, teaching her to read, understand and respond to Isabelle's signals will be ineffective. While in many cases it may be sufficient for the mother and infant to seek intervention together as a unit, in this case it seems more appropriate to also provide Annette with an individual service. This will provide Annette with the opportunity to grieve over her many losses and also to understand her role in those

losses instead of taking on the blame and guilt for each of the negative experiences in her life. Finally, it will help to make her more available to Isabelle.

Conclusion

While typically the focus of research examining attachment between a caregiver and her infant focuses on the role of the mother, in the case of children with disabilities, the focus shifts to the role of the child. While this case supported the view that the special needs of a child with a disability can impact on the attachment that develops, it also clearly demonstrated that the role of the mother is still equally important, if not more so than with a child without a disability. The difficulty children with disabilities have in communicating their needs, means that the mother needs to be especially available to the child in order to recognise and respond to her child's signals.

CHAPTER 3 – INHIBITED SOCIAL INTERACTION AS A CONSEQUENCE OF DISTURBANCE WITHIN THE PRIMARY ATTACHMENT

Mary Ainsworth, her strange situation tool and research around this tool have provided empirical support for the impact of disturbances within the mother/infant primary attachment. Ainsworth and colleagues proposed that attachment between a mother and her infant can be classified under one of three forms of attachment, including secure attachment and two forms of insecure attachment, insecure-avoidant and insecure-ambivalent (Ainsworth et al., 1978). In addition, Main and Solomon added an extra form of insecure attachment during the 1980s labelling it insecure-disorganised (Main & Solomon, 1986). The categories derived by Ainsworth and colleagues through the use of the strange situation have proved useful for understanding the quality of mother/infant attachment. In addition the further research conducted by a variety of researchers using these labels has provided some understanding of the impact of that attachment on a child's future behaviour and relationships (See Chapter 1). However, these categories are not easily transferable to a clinical diagnosis of disordered attachment (Boris, Furey & Zeanah, 1997). That is, children who are classified as suffering an insecure attachment, be it an avoidant, ambivalent or disorganised insecure attachment, are not necessarily suffering from an attachment disorder under the criteria of classification tools such as the Diagnostic and Statistical Manual of the American Psychiatric Association (1994).

The DSM-IV recognises the impact of interference to the early attachment under a disorder labelled 'Reactive Attachment Disorder of Infancy or Early Childhood' (APA, 1994). This disorder was first introduced as a clinical condition

within an earlier version of the DSM, the DSM-III in 1980 (American Psychiatric Association, 1980). Reactive Attachment Disorder was added to the DSM-III as a reflection of the increasing awareness within the clinical, theoretical and empirical world that institutionalisation and deprivation of maternal care, as outlined in the Chapter 1 had a detrimental impact on an infant or young child's development (Richters & Volkmar, 1994). However, despite the observations and descriptions of children with disturbed attachment as 'superficially charming' by David Levy in 1937 or 'socially promiscuous' by Ainsworth in 1961 the late addition of this disorder to the DSM highlights that only recently has an understanding developed of the possible clinical implications of disturbed attachments (Hughes, 1999; Karen, 1994).

At the time of initial introduction, the disorder was generally equated with failure to thrive (Spitzer & Cantwell, 1980). Since that time substantial modifications have been made to provide a more appropriate definition of the disorder. These changes included alterations to the age of onset, a greater emphasis on the role of psychosocial factors (that is a requirement for evidence of pathogenic care was included), and finally the notion that with appropriate treatment, this condition could be reversed (Richters & Volkmar, 1994). Within the more current version of the DSM, the DSM-IV, the essential feature of this Reactive Attachment Disorder is the "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care... (This pathological care) may take the form of persistent disregard of the child's basic 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" (APA, 1994, p. 116).

Two patterns of Reactive Attachment Disorder have been described within the DSM-IV: inhibited and disinhibited. The inhibited subtype focuses on a pattern of behaviour identified as emotionally withdrawn, whereas the pattern of behaviour identified as the disinhibited subtype is described as indiscriminately social (Smyke, Dumitrescu & Zeanah, 2002). Children classified under the inhibited subtype are identified by their persistent failure to initiate and respond to most social interactions in a developmentally appropriate way. Identification and description of this inhibited subtype is said to have stemmed from investigations with children who have been maltreated (Zeanah, 1996). Alternatively, children classified under the disinhibited subtype are identified by their indiscriminate sociability or selectivity in choosing attachment figures (APA, 1994), with work with children raised in institutions providing evidence for this subtype (Zeanah, 1996). Of these two subtypes of Reactive Attachment Disorder, to date neither has been shown to be a more severe reaction to the attachment disturbance than the other (Hughes, 1999).

An essential element of attachment is the use of attachment behaviours identified by Bowlby (1969). Bowlby suggested that the purpose of these attachment behaviours, including crying, clinging and smiling is to gain and maintain proximity to the mother figure, as outlined in Chapter 1 (Ainsworth, 1973; Bowlby, 1969). Ainsworth and colleagues observed how children's different use of these attachment behaviours denoted a difference in the quality of their attachment to their primary caregiver. These differences are even more significant between children with a secure attachment and those who have been diagnosed with a clinically disordered attachment as defined by Reactive Attachment Disorder. Further, the manner in which the use of these behaviours differs is dependent on the form of attachment disorder the child has developed. In the inhibited subtype of Reactive Attachment

Disorder children are seen to have a distinct absence of the attachment behaviours. In contrast, within the disinhibited subtype, the attachment behaviours are present, however, they are indiscriminately directed (Zeanah, Smyke, & Dumitrescu, 2002).

The alternative development of attachment behaviours or the lack of attachment behaviours observed within the children with disordered attachment is thought to stem from the child's attempts to find ways to have his needs met. In children with an inhibited subtype Reactive Attachment Disorder these behaviours may represent the child's need to be increasingly self-reliant, learn to meet his own needs and reject all urges to be supported and comforted by a caregiver. This reflects the child's need to feel in control of his own environment in order to minimise his own feelings of vulnerability (Hughes, 1999). This is consistent with the basis from which this subtype has arisen, that is work with children who have been maltreated (Zeanah, 1996). Such children have learnt not to trust the caregiver, who may on occasions offer care and comfort, however, associated with that is physical and emotional pain and rejection. Alternatively, a child who has developed the disinhibited subtype of Reactive Attachment Disorder learns that by charming and manipulating others he can induce them to meet his needs at least in the short term (Hughes, 1999). In contrast to the inhibited subtype, this subtype is associated with children who have not had a consistent caregiver with whom to establish an attachment (Zeanah, 1996). As a result, these children do not associate care, protection or the meeting of their needs with a particular individual, towards whom they can direct their appeals for assistance. The experience of having a range of people reinforce some level of attachment behaviours, without any additional experience of physical pain or rejection from that caregiver, can encourage the continued use of attachment behaviours rather than the extinguishment of them.

Both the strange situation tool and the DSM-IV provide a means to understand the impact of a disturbed attachment on the quality of that attachment and the impact on a child's later development. A similarity of the two classification systems is that they both identify children who do not have a secure base from which to operate. However, while all children diagnosed with a clinically disordered attachment are classified with an insecure attachment under Ainsworth's classification system not all children with an insecure attachment have a disordered attachment. That is, Ainsworth's strange situation classifications encompasses a far broader range of attachment styles, which include children with only mildly disturbed attachment to those with major disturbances in attachment. In contrast Reactive Attachment Disorder includes only those children whose attachment is so disturbed as to be non-existent, and based on the existence of some form of pathogenic care (Crittenden & Ainsworth, 1989; Wilson, 2001; Zeanah, 1996; Zeanah et al., 2002).

The highly stringent classification system provided with the DSM-IV has arisen from a need to identify socially abnormal behaviour stemming from an attachment disorder as opposed to other forms of disorders including, pervasive developmental disorder, conduct disorder, oppositional-defiant disorder and attention deficit hyperactivity disorder (Reber, 1996; Zeanah, 1996). However a number of criticisms have arisen around the DSM-IV's criteria for diagnosis. First, it has been suggested that attachment should be viewed on a continuum of mild to severe disordered attachment, in order to ensure that the full spectrum of the disorder is addressed (DeAngelis, 1997; Wilson, 2001). Second, a criticism has been raised about the DSM-IV's requirement, that the child have suffered pathogenic care or repeated changes in caregiver (Wilson, 2001; Zeanah, 1996). The great difficulty in

assessing the type of care a child has experienced means that children deserving of such a diagnosis are not included due to an inability to gather a thorough history. Third, a criticism has arisen from the emphasis in the DSM-IV on the reactive nature of the disorder, rather than the child's behaviour or interaction with an attachment figure (Wilson, 2001; Zeanah, 1996). Fourth, criticism has been made of the DSM-IV's requirement that the socially inappropriate behaviour be present across different social contexts. Developmental research suggests that attachment may vary across relationships and as outlined in the introductory chapter, a second attachment, can actually mediate against the impact of a poor initial and primary attachment (Ainsworth & Marvin, 1995; Morelli & Tronick, 1991; Schaffer and Emerson, 1964; Zeanah, 1996). Fifth, there is criticism surrounding the lack of research supporting the DSM's classification system, as it brings into question the validity of the diagnostic criteria and the attachment classifications (Wilson, 2001; Zeanah, 1996). Finally, the DSM-IV criterion has been criticised for its focus on general social behaviour, rather than focusing on the specific attachment behaviours outlined by Bowlby as imperative to understanding the attachment relationship (Zeanah, 1996).

The diagnostic criteria used within the DSM-IV has caused Zeanah (1996) to question whether this disorder is in fact representative of a maltreatment syndrome, rather than an attachment disorder *per se*. However it is also suggested that the strange situation tool, whilst helpful for understanding the quality and nature of the attachment, is also not applicable for understanding disordered attachment (Zeanah, 1996). The strange situation examines attachment within a laboratory rather than a naturalistic setting (Zeanah & Emde, 1994), it examines only one aspect of attachment, that is separation and reunion (Graensbauer & Harmon, 1982) and rather than indicating psychopathology, it is tool to determine the risk for psychopathology

(Sroufe, 1988). As a result neither the strange situation nor the DSM-IV classification systems appear to be entirely appropriate in understanding disordered attachment and its impact on children's development. In order to bridge the gap between these two classification systems and encompass children ranging from those who have dysfunctional, yet stable attachments to those who have developed no attachment at all, Zeanah (1996) proposed an alternative system of classification. Under his classification system, Zeanah identified three main types of attachment disturbances including, non-attached, disordered and disrupted (Zeanah, 1996). This system differs from the DSM-IV criteria in two significant ways. First, rather than focus on pathogenic care, this classification system focuses on how the child's attachment allows him or restricts him in exploring his environment (Wilson, 2001). Second, this criterion specifically focuses on the child's attachment behaviours and attachment relationships, rather than social behaviour in all relationships (Zeanah, 1996).

According to Zeanah (1996), children who are classified as non-attached are those over ten months of age who show no evidence of a preferred attachment to anyone. Zeanah included two subtypes within this form of attachment that coincide with the classification subtypes used within the DSM-IV. These include non-attached, indiscriminately social subtype and non-attached, emotionally withdrawn, inhibited subtype. Disordered attachments focuses on the child's disordered use of their caregiver as a secure base. As discussed in the introductory chapter, Ainsworth noted that one of the primary functions of the attachment between an infant and his mother is to provide the infant with a secure base from which to explore the world, which is important for the development of the child's social skills and independence (Ainsworth, 1973; Bowlby, 1988). Of this type of attachment disturbance Zeanah

defined three subtypes, including (a) disordered with inhibition, which is marked by excessively clingy behaviour towards the caregiver and inhibited exploration of the child's world; (b) disordered with self-endangerment, a child who explores without using the caregiver as a secure base to check back on, even in times of danger; and (c) disordered with role reversal, a child who worries excessively about the emotional well being of the caregiver, thus taking on the parenting role. The final type of attachment disturbance identified by Zeanah is disrupted attachment. This final category addresses the disruption to attachment and the grief response of an infant upon the loss of his primary caregiver.

Whilst only minimal research has examined the use of either Zeanah's alternative classification system or the DSM-IV diagnostic criteria, one study conducted by Boris, Zeanah, Larrieu, Scheeringa, and Heller (1998) has compared the validity and reliability of these two classification systems. Boris et al. (1998) examined the ratings of four clinicians using both the DSM-IV criteria and Zeanah's criteria to determine which of the two was more stable across the raters. The clinicians were each required to rate 48 clinical case summaries using both diagnostic criteria. The findings of this study indicated that stability across the different clinician's rating was more consistent when using Zeanah's classification system as opposed to the DSM-IV's criteria.

In summary, three classifications systems have been offered for understanding the attachment between a mother and her infant and the impact of that attachment on the child's development. Following the case of Simon will be presented. Simon is a three-year-old boy who displays delays in his cognitive, social and emotional development. The case of Simon will be discussed with regards to the

possible ways of understanding Simon's attachment with his mother and the impact of this relationship on Simon's development.

Erin. Simon, does not currently, nor has he previously had contact with his father. Rachel informed that Simon was the result of an unplanned pregnancy and that she was only in a casual relationship with Simon's father. Erin was also the result of an unplanned pregnancy, and Rachel is unsure whether Erin's father is her current partner, Jeff or another man, with whom she was having a casual relationship. Currently Jeff has taken on some of the parenting responsibilities for Erin, however, he is not claiming paternity. Rachel informed that she had never wanted to have children, however, her religious beliefs prevented her from having an abortion with either pregnancy.

Rachel described her relationship with her parents as civil, however, she informed that she had moved out of home at seventeen years of age, due to her father's violent and aggressive behaviour towards her. Rachel reports having few friends, and informed that while her mother tried to be supportive, this was made difficult by the fact that she lived over an hour away from Rachel.

Rachel informed that she has a number of health conditions that have made the task of parenting difficult for her. These included depression, for which she has been treated over the past seven years; epilepsy, which was diagnosed six months previously; and repetitive strain injury (RSI) in both her wrists, which limits her ability to lift her children.

Developmental History

Rachel informed that her pregnancy with Simon was extremely difficult due to severe morning sickness, which continued throughout the entire pregnancy. In addition, Rachel informed that the labour was a traumatic and difficult experience,

with Simon's heart rate dropping seriously low, resulting in a need for a forceps delivery with induction. Rachel informed that the depression she has experienced over the past seven years was exacerbated following Simon's birth. Rachel attributed this to the stress resulting from Simon's behaviour, including the tendency to hold his breath and turn blue in the bath as well as the difficulty she experienced in feeding him. Further, Rachel reported Simon to be a grumpy, crying baby, who was difficult to settle.

Simon's childcare centre referred him to a speech therapist following concerns about his language development. The speech pathologist diagnosed Simon as having dyspraxia (an inability to control his facial muscles in order to produce speech). This has a severe impact on Simon's speech and Rachel informed that he is only able to say approximately ten words clearly. Rachel reported she often does not understand what Simon is trying to communicate and that when he wants something he will often whimper and repeat "mummy, mummy", and point indiscriminately. When she does not respond, Simon will stomp out of the room and find what he is wanting himself.

Rachel reported Simon's developmental milestones were all delayed, though she could not recall at what ages he first sat, crawled or walked. However, she recognises that her second child appears to be developing at a faster rate. Simon first began to say a few words around two years of age, though at present his vocabulary is still very limited. Simon is currently toilet trained during the day, but not during the night. Whilst suffering no major injuries during his life, Simon has previously had a number of ear infections that were treated with antibiotics. His hearing has been tested multiple times and is reported to be within the normal range.

Simon's mother reports he has no set bedtime, and will fall asleep where he is on the couch or floor, or put himself to bed. Simon is reported to like to watch videos, cartoons and play computer games. Rachel informed he will watch videos in the morning, whilst she cleans the house, often watching the same video over and over. Rachel informed that she often has difficulty controlling Simon's behaviour, that he will throw tantrums when she asks him to do something, and will hit her.

Simon attends childcare two days a week at the local childcare centre. Rachel informed that initially Simon would scream when she left him at childcare, however he has now settled. He is currently attending speech therapy where he is in a group treatment program, which involves his mother learning tactics to assist and encourage Simon. Rachel reports that she has difficulty providing the assistance that Simon needs or the money to provide him with the rewards encouraged by the speech pathologists. The strategies recommended therefore, have not been implemented.

Current Concerns

Simon's speech pathologist referred him for a cognitive assessment to clarify whether there were any underlying cognitive conditions contributing to his language deficits. However, Rachel reported that her main concerns surrounding Simon involve his behaviour problems. He ignores her when she asks him to do something. He will also throw tantrums, say 'no', kick doors, and say things like 'die mummy'. Rachel believes that Simon's behaviour is worse after he has been playing with the children next door. She has attempted a variety of different tactics to manage Simon's behaviour, including sending him to his room, using a time out chair in the corner, smacking him and threatening Simon with a cold shower. She finds that the only

approach that appears to work, and that is only on occasions, is the threat of a cold shower, which she has actually done on one occasion. Rachel reports that one of the main arguments with Simon revolves around the computer. Simon is reported to be very adept on the computer and Rachel reported that he knows things about the computer of which she has no knowledge, and he has never been taught or observed anyone else doing. Simon will spend much of the day playing on the computer, however, he refuses to turn it off when asked.

Overview of Observation and Assessments

Simon was seen for four sessions at the developmental assessment centre. A further session was spent observing Simon at his childcare centre and one at his home. A cognitive assessment was conducted using the Wechsler Preschool and Primary Scale of Intelligence (WPPSI-R; Wechsler, 1989) a standardised measure of general cognitive ability. The WPPSI-R provides an assessment of a wide range of both verbal (Verbal Component) and non-verbal (Performance Component) cognitive skills.

General Impressions

Simon presented as a shy, timid three-year-old, though he became progressively more relaxed as the session progressed. He was happy to attend the initial session with his mother. However, when on the second session he was invited to attend the assessment room on his own, he became extremely distressed, lying on the floor and whimpering. When his mother accompanied him to the room, he settled

and was compliant with her waiting for him in the waiting room. Whilst Simon demonstrated noticeable distress at each of his sessions at the centre, by the last session he was able to accompany the writer to the room without his mother. During his first visit with his mother, Simon was happy to sit beside his mother and play with jigsaw puzzles, however, when his mother left the room briefly to get a glass of water, he was observed to become distressed. He was also observed to whimper on a few occasions during the session. When asked what he wanted, he pointed indiscriminately at the toys. It was not until his mother questioned specifically about which toy he wanted that Simon attempted to make sounds indicating that he wanted a toy that was out of his reach.

Within the formal cognitive assessment Simon settled well to the required tasks and showed interest in all the subtests. His speech was very unclear during the assessment, and there were a number of times when the assessor was unable to determine what Simon was saying. Though happy to comply with the assessment, at one point during the formal assessment Simon began to look distressed and made a move to stand up. When the assessor inquired what Simon wanted, he indicated a tissue and settled down after being encouraged to get one. Simon responded well to praise within the assessment, and did not display any lack of attentiveness or distraction during the assessment.

Observation and Assessments

Simon's overall functioning as measured by the WPPSI-R fell into the Borderline range (Full Scale score = 78), with a significant difference between his scores on the Verbal and Performance components. On the Verbal component

Simon's performance fell within the Intellectually Deficient range (Verbal = 66), whereas Simon's abilities in the Performance component fell into the Average range for his age group (Performance = 95). The large discrepancy between Simon's Verbal and Performance components suggest that the overall score is not representative of the strengths and weaknesses in Simon's abilities. This discrepancy reflects Simon's difficulty in verbal communication and is supportive of the speech pathology assessment, that Simon is suffering from a specific language disorder.

Within the Verbal component, Simon demonstrated no specific areas of strength and weakness, with his scores on the subtests all consistently below the expected performance level for a three-year-old child. On the Performance component, Simon's score were varied with strengths in the areas of Mazes, indicating good visual-motor coordination and the ability to attend to directions and plan and execute actions. However, Simon displayed a weakness on the Performance subtest Picture Completion, which measures the child's ability to discriminate essential from non-essential details. Performing more poorly in this subtest may indicate that Simon can become preoccupied with irrelevant details or that anxiety induced by performing the task may have affected his concentration and attention.

Simon was also observed at his childcare centre, where they reported he is a pleasant, friendly boy who is never a problem. Simon's main carer at the childcare centre informed that she cannot remember the last time that she had to discipline Simon and the only problem she can remember having with him was in relation to rest time, where he wouldn't sleep, but has now learnt that he has to sit down and rest at that point and so will quietly read a book. Simon was observed to interact minimally with other children at childcare, generally playing by himself. However, when other children approached Simon he would interact with them or involve them

in his play. Simon was also observed to be very patient, to the extent of being almost passive in his interactions with other children. This was particularly noted at one point, when Simon was building a train track in the sandpit and other children would accidentally walk over it. The first few times this occurred, Simon patiently pointed out to the child that he was building, however eventually Simon became distressed. When distressed, Simon was observed to whimper to seek the attention of staff. However, he would never directly seek out a staff member to assist him. This reluctance was even noted when at one point Simon tripped over and hurt himself, but failed to seek comfort from staff.

An observation of Simon was also undertaken at home. Simon greeted the writer and was happy to show the writer his abilities on the computer, his new kitten, and his baby sister. As reported by Rachel, Simon was observed to refuse to comply, when she asked him to stop playing on the computer. The difficulties Simon had in communicating with his mother were demonstrated when he was attempting to request a drink, and it took several attempts before Rachel understood what he was wanting.

Formulation and Recommendations

Simon is a three-year-old boy who was observed both in individual sessions with the assessor, at his home and at his childcare centre. In all situations he was a pleasant little boy, though he demonstrated great distress when asked to separate from his mother. When unable to communicate, express his needs, or was unhappy with the situation, Simon was seen to use strategies such as whimpering, rather than directly asking for assistance. While Rachel reported Simon will use tantrums and

aggressive behaviour when he doesn't get his own way, this behaviour was not observed by the writer or reported by staff at Simon's childcare centre.

Simon's performance on the cognitive assessment indicated that there is a large discrepancy between his abilities on the verbal and performance components of the test, with age appropriate functioning in the performance component and large delays in his abilities on the verbal component. This performance is indicative of a specific learning disability of a verbal nature.

Simon's poor behaviour appears to reflect his difficulty in communicating. While he is able to clearly plan, organise and execute activities, both observations of his behaviour and interactions with others as well as his performance on the WPPSI-R demonstrates a child who has great difficulty communicating his needs. This situation is further exacerbated by Rachel's reported lack of patience and inability to comply with activities recommended by the speech pathologist to develop with his ability to communicate.

While the strategies Simon uses to communicate or gain attention appear to have developed from his experience that these are the only effective methods he can use to communicate, they in fact hamper his development of other interaction and communicative skills. In order to assist Simon communicate more easily and alter his strategies to communicate, he needs support not only from his childcare centre, but also from his mother. It is therefore recommended that staff at the childcare centre are made aware of more effective ways to assist Simon to communicate. At present Simon's language skills are so severely impaired that other forms of communication are recommended. Liaison with Simon's speech pathologist is encouraged, so that she can assist to develop alternative methods of communication.

At present, Rachel reports feeling isolated, with little support. As a result, she feels that she has little energy or ability to assist Simon develop his skills. In order to assist Rachel to implement these strategies, and to find more effective methods of interactive with her child and manage her children, a referral to a local family services unit is recommended.

Simon will be attending kindergarten in the following year and it is recommended that funding be applied for to provide some form of support or aide to assist Simon develop his communication and social skills. These recommendations have been discussed with Rachel and the childcare centre. Further, Simon's speech pathologist has been contacted regarding these recommendations and a referral has been made to the local community family services agency.

Discussion

The case of Simon illustrates a young boy with severe communication and social difficulties, which have been attributed to a specific language disability. While this disorder is the result of specific deficits in Simon's abilities, as can be seen from this case report his relationship and interaction with his mother is further hampering the development of his language, communication and social skills. Further the patterns of interaction observed both between Simon and his mother, Simon and his peers and Simon and other adults, shows a child severely inhibited in his ability to initiate interaction. While Simon's poor social interaction skills may be attributed in part to his poor language skills, the difficulties are evidentially exacerbated by the poor patterns of interaction observed between Simon and his mother.

Rachel described interaction with Simon as frustrating, due to his limited communication skills. Rachel informed that she will sometimes simply ignore him

when she can't understand what he is trying to communicate. Further problems in the relationship between Simon and his mother are indicated by her description of her feelings, including not wanting to have children, feeling depressed prior to and after his birth, having difficulties setting aside time and energy to assist with his speech development and feeling anxious about parenting him. However, in contrast, Rachel's pursuit of services for Simon and her demonstration of being proud of his abilities for example on the computer, indicate her desire to help Simon. Both Simon's responses to his mother and her expressed feelings towards him, indicate that the attachment that has developed between Simon and his mother may be disturbed in some form.

There are three ways in which to understand the relationship between Simon and his mother. The DSM-IV (APA, 1994) provides criteria for understanding the clinical impact of a disturbed attachment on Simon's development. Despite displays of inhibited behaviour, Simon would not meet the criteria for the DSM-IV's Reactive Attachment Disorder (APA, 1994). This is in part because the limitations within Simon's interaction skills are not sufficiently impairing his ability to function to be considered a clinical disorder. Further, the care Simon receives from his mother would not be considered grossly pathological in nature. Finally, Simon's poor interaction skills could possibly be attributed to the limitations in his language and communication skills. However, the lack of a clinical label does mistakenly suggest that Simon's attachment with his mother is not disturbed.

The second, alternative approach available to consider the attachment between Simon and his mother would be to use an age appropriate adaptation of Ainsworth's classification system. Under Ainsworth's system, Simon's behaviour is indicative of a child with an insecure-ambivalent attachment. While Simon was

happy to play when in the room, his exploration was quite restricted and he preferred to sit beside his mother. When his mother had left the room momentarily, Simon became quite distressed, even though he could still see her. In understanding the attachment between Simon and his mother under Ainsworth's framework, the quality of attachment is made clear, however, the implications of that attachment for Simon's social development are not clearly articulated.

The final alternative framework for understanding the attachment between Simon and his mother is through Zeanah's classification system (Zeanah, 1996). Under Zeanah's system the most appropriate form of disturbed attachment for understanding Simon's attachment with his mother is "Disorder Attachment with inhibition, which is marked by excessively clingy behaviour towards the caregiver and inhibited exploration of the child's world". This classification fits with Ainsworth's explanation of insecure-ambivalent attachment (Ainsworth et al., 1978). While Zeanah's classification system is not as well known, it does provide valuable information about not only the nature of the attachment between a child and his primary caregiver, but also the impact this attachment disturbance has on the child's development. In examining Simon's attachment to his mother under this framework, we see that Simon's ability to explore is hampered by his need to continue monitoring his mother. However, due to the little research provided around this classification system and the lack of a standardised method of applying the system, it is difficult to determine whether the appropriate label has been applied to Simon.

Neither of the three models available to understand the relationship between an infant and his caregiver are sufficiently appropriate to understand the nature of the attachment between Simon and his mother. This raises concerns about the role of intervention services who are more likely to focus on developing Simon's

communication skills. There is no doubt from this case study, that Simon is suffering a language disorder, however, without intervention to alter the patterns of interaction between Simon and his mother, the inhibition he displays in interacting with others is unlikely to alter.

Conclusion

Research has provided a number of guidelines for understanding the attachment between a child and his mother. However, only one of these frameworks, that of the DSM-IV is used within clinical work. This case demonstrates how without an appropriate frameworks for understanding attachment, clinicians can fail to understand or provide the necessary attention to the role of the mother/infant attachment in a child's development.

CHAPTER 4 – ATTACHMENT IN THE MIDST OF TRAUMA AND LOSS

A child will form an attachment to any caregiver who is present consistently enough in the child's life to allow the development of a relationship. However, the quality of that attachment is dependent on the quality of the care provided by the caregiver (Ainsworth & Marvin, 1995). In some cases the nature of the attachment or lack of an attachment results in the development of an attachment disorder within the child. Whatever the type of attachment that has developed, once formed, that attachment has been shown to be stable across childhood and even impact upon the relationships formed within adulthood (Cassidy & Berlin, 1994; Grossman & Grossman, 1991; Main & Cassidy, 1988). Although, it has been noted that the continued stability of the attachment is dependent on the continued stability of the child's caregiving environment (Belsky, Campbell, Cohn, & Moore, 1996; Lewis et al., 2000). One major and irreversible change that will alter the nature of the child's caregiving environment is the death of the primary attachment figure. In these cases, not only does the child have to adjust to the loss of the attachment figure, but is often required to then build new attachments with new people. When the child's primary attachment was not of a secure quality in the first place, this process may be further complicated.

The previous chapters have explored and discussed the different ways of understanding the attachment between an infant and his primary caregiver. Within Ainsworth's strange situation tool attachment is classified under one of four subtypes, including secure attachment or one of three forms of insecure attachment, insecure-avoidant, insecure-ambivalent and insecure-disorganised as outlined in the

introductory chapter (Ainsworth et al., 1978, Main & Solomon, 1986). When the infant/primary caregiver attachment goes awry the impact on the child may result in a clinical disorder, Reactive Attachment Disorder, of which there are two subtypes, inhibited and disinhibited (APA, 1994). It has been argued that neither of these classification systems provides a sufficiently comprehensive means for understanding the impact of a disturbed attachment on a infant or child (Wilson, 2001; Zeanah, 1996). Zeanah (1996) attempted to provide a more effective means for understanding the impact of disturbed attachments on an infant by suggesting that there were three main ways in which the attachment may be disturbed. These include non-attached, disordered attachment and disrupted attachment (See Chapter 3 for full descriptions of these subtypes) (Zeanah, 1996). Of all these different classification systems, only Zeanah (1996) provides a label to explore and understand the impact of the death of an attachment figure on a child. This final form of attachment, disrupted attachment, is specifically for children who have lost an attachment figure either through death or permanent separation and addresses the grief response experienced by the child at the unexpected loss of that attachment figure (Zeanah, 1996).

In his early work Bowlby identified a standard set of responses that a child develops in response to the departure of the primary caregiver (Bowlby, 1973). This pattern of responses consisted of three separate phases, beginning with acute distress at the departure of the caregiver that results in what is termed the 'protest' phase. During this phase the child tries all means possible to locate the primary caregiver. In response to being unable to locate the primary caregiver, the child then becomes miserable and withdrawn, moving to the 'despair' phase, where they believe that the caregiver may not return. Finally, given time, the child loses all hope that the

caregiver will return and consequently they move to the 'detachment' phase (Bowlby, 1973). In examining the impact of separation, Bowlby was typically discussing children who were placed in hospitals, institutions or out of the care of their primary caregiver as a result of an unavoidable circumstance where the mother was unable to continue providing care for the child. This situation was generally temporary and Bowlby found that should the separation be halted before too long, then the relationship could generally be repaired (Bowlby, 1973).

Children and adults have both been seen to display a similar pattern of response to the bereavement of a loved one, specifically a close attachment figure (Bowlby, 1988). This common pattern of response generally begins with feelings of numbness, centred around an inability to accept the loss of the attachment figure and further that the caregiver will not be returning. Once the numbness and shock of the loss has worn off, it is replaced by feelings of acute pain. Over time this pain gradually eases, with the distress becoming less and the despair experienced duller. However, with the lessening of the pain feelings of guilt and blame, for both the death of the loved one and for beginning to come to terms with the death, often develop. Further the bereaved child may experience feelings of anger at the attachment figure for dying and leaving them or anger at others for still being alive when the attachment figure has died (Marris, 1993).

Feelings of anger are often accompanied by aggressive behaviours targeted at either the attachment figure who has died, or at a third party (Bowlby, 1973). This anger and aggressive behaviour forms in the early stages of the grieving process when the child is unable to accept that the attachment figure is not returning. It is thought that these feelings are a continuation of the hope felt by the child that the lost caregiver will return. The child experiences these feelings because he continues to

hope that the lost person can be recovered and aim to reproach their attachment figure for deserting them when they return, in order to prevent them from leaving in the future (Bowlby, 1988). If a child is provided with the opportunity to express each of these feelings and experience each of the phases associated with grief then, these feelings can be resolved in a satisfactory manner. However, when the child is unable to express feelings of loss, anger, guilt and pain then this grief may manifest itself in other forms of psychopathology (Marris, 1993).

While the full cycle of a grief process is thought to extend at least six months (Bowlby, 1988), this process can be further complicated by the quality and type of attachment previously existing between the child and the lost attachment figure. Whilst other attachments can serve to mediate the impact of an insecure attachment, the loss of an attachment figure with whom the child has developed an insecure attachment, may serve only to remind the child of the potential insecurity of other attachments (Marris, 1993). After the loss of an attachment figure, it is not uncommon for children to avoid intimacy with others. Accompanied by intimacy is an emotional closeness which only serves to emphasise the child's feelings of vulnerability and their loss of control over both the individual, the situation and their environment. As a result that intimacy which is offered as a promise of safety and security, serves more as a threat for the child (James, 1994).

The manner in which an insecure or disordered attachment may impact on a child's grief process depends on the nature of that insecurity or disorder. Whatever the form of insecure attachment, these infants learn that they cannot trust their caregiver to remain available (Bolen, 2000; Cassidy & Berlin, 1994). However the methods and strategies by which the child deals with the unavailability of the attachment figure is dependent on the type of interaction experienced with the

attachment figure (James, 1994). In the same way the manner in which the child deals with the loss of that caregiver can also differ. A child with an insecure-ambivalent attachment, has learnt that his caregiver will respond inconsistently to his signals. However, this irregularity reinforces the hope in the child that the attachment figure will one day provide the secure base, care and protection he requires, a hope that continues beyond the death of the attachment figure, making death more difficult to accept (Cassidy & Berlin, 1994; Fonagy, et al., 1995). A child with an insecure-avoidant attachment has given up all hope that the caregiver will provide the secure base they require (Cassidy & Berlin, 1994). In response to the death of the primary caregiver, this child who still desperately wants the care of an attachment figure, has long ago accepted that that care is not going to be provided (Sroufe, 1983). In contrast the child with an insecure-disorganised attachment has no set strategy for dealing with the unavailability of the attachment figure, and therefore no cohesive strategy for dealing with the loss of that attachment figure (Main & Solomon, 1990). When the care experienced by the child is abusive in nature, then the child is torn between feelings of fear of the caregiver and desiring protection from that same person (James, 1994). This may further complicate their feelings of grief at the loss of the attachment figure, with conflicting feelings of relief at finally feeling safe from the abuse of the caregiver, but still mourning the loss of that person (James, 1994). Despite the type of attachment a child has developed, be it traumatic, chaotic or some form of insecure attachment, the loss of an attachment figure is still clearly traumatic for the child (James, 1994).

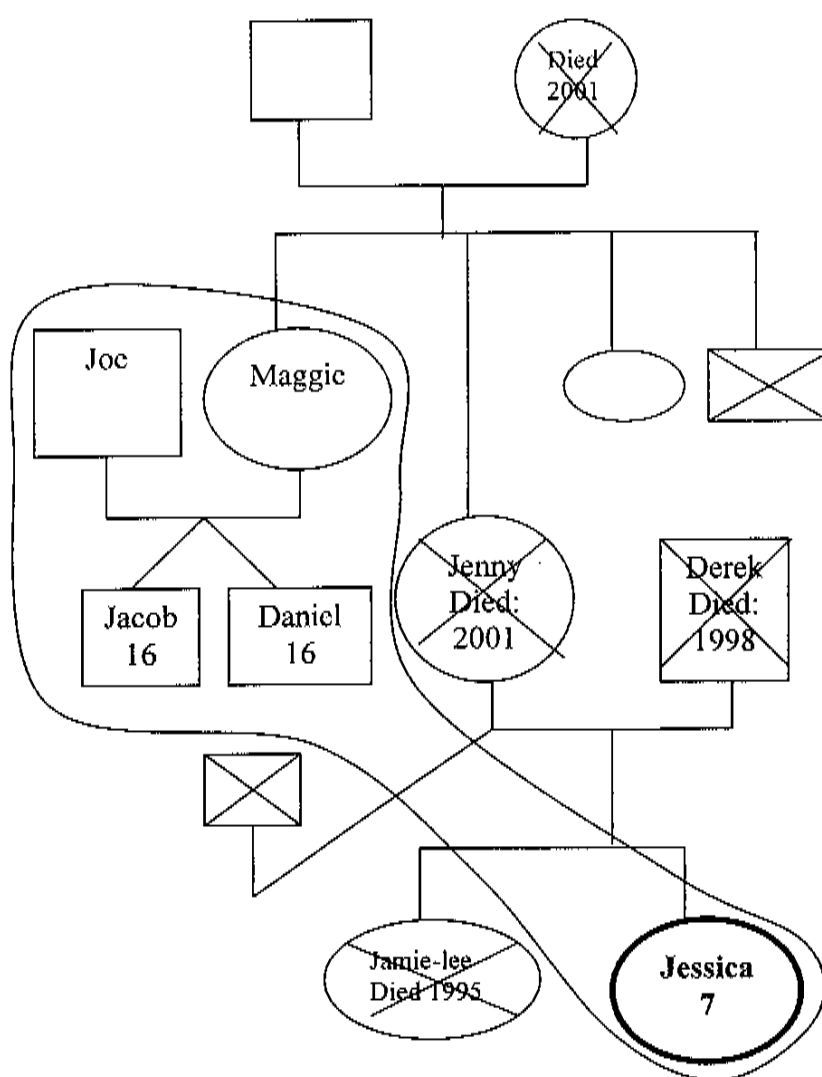
Whatever the nature of the child's attachment and their methods for dealing with the loss of the attachment figure, caution needs to be taken that the child does not jeopardise future attachments through his inability to resolve his loss over the

death of the attachment figure. One particular stage of the grieving process where the child may get stuck in his grief, is the denial phase. As part of this phase the child may continue the relationship with the missing attachment figure through idealization, magical thinking and various reunion fantasies (James, 1994). However, as long as the child remains in this phase surrounded by their fantasy, they will also resist the efforts of adults and new caregivers to assist them to deal with their loss, which will consequently begin to interfere with the child's ability to develop new attachments (James, 1994).

In understanding the impact of the loss of a primary attachment figure on a child and working to help resolve that loss, there are a number of factors that need to be addressed. Not only does work with these children need to focus on helping them to overcome their grief, but it is also necessary to help them form new and healthy attachments. Follow-up research with children who have had severely disturbed attachments has shown that through intervention these children can form secure attachments (Zeanah, Smyke, & Dumitrescu, 2002). However, when the child has experienced a significantly disturbed attachment, his ability to interact and trust other people is severely impaired (James, 1994). As a result the child needs to also be taught how to form a healthy attachment, how to relate in a healthy way and how to trust the new attachment figure. While attachment to a new caregiver can help to mediate the impact of the loss of an attachment figure, even one with whom the child developed a disturbed attachment, it needs to be remembered that for all children, however particularly children with disturbed attachments, there can remain long-lasting vulnerabilities related to the loss and abandonment previously experienced (James, 1994).

THE CASE OF JESSICA

Jessica is a seven-year-old girl who was referred by Jessica's teacher following concerns regarding some unusual behaviour. This behaviour included inappropriate sexual behaviour and inappropriate boundaries towards other people.



Family History

The following information was provided by Jessica's legal guardian and maternal aunt, Maggie. Jessica is a seven-year-old girl who lives with Maggie and her husband, Joe as well as their sixteen-year-old twin sons Jacob and Daniel. Jessica has been residing with the family for the past twelve months, following the death of her mother. She now refers to Maggie and Joe as mum and dad.

Maggie informed that Jessica has had quite a traumatic beginning to life. Maggie provided information regarding the history of both Jessica and her mother Jenny. According to Maggie, Jenny had a history of drug addiction, which continued throughout her life, despite drug-free periods and a number of attempts at rehabilitation. Maggie informed that Jenny had four significant relationships that she was aware of, including two marriages and an on/off relationship with a woman named Pam, that continued for over ten years up until her death, though was never acknowledged as a 'relationship'.

Following the suicide death of her first husband, Jenny married Derek, who was in his early seventies. Maggie reported that Derek helped to contain Jenny and she is thought to have remained drug free for most of their marriage. Derek and Jenny had a baby girl within a year of their marriage. Maggie reports that this baby, Jaymie-Lee, died of Sudden Infant Death Syndrome at age four months. Within eighteen months of Jaymie-Lee's death Jessica was born. Maggie believes that due to the trauma and loss experienced as a result of Jaymie-Lee's death, Jenny had difficulty forming a close attachment to Jessica. Not long after Jessica's birth, Derek was diagnosed with lung cancer. Despite treatment, by Jessica's first birthday this cancer had spread throughout Derek's body and he required full time care, which

Jenny provided. When Jessica was approximately eighteen months old Derek died. Maggie reported that following Derek's death, Jenny's behaviour changed. For example, whilst prior to Derek's death Jenny was very conscientious about ensuring that the house was tidy, this was a task she became complacent about following his death. Maggie believes that this may in part be attributed to Jenny resumption of drug use, in the last months of Derek's life. Maggie reported that while the family tried to support Jenny during this time, distance made this difficult.

Maggie reported that following Derek's death, Jenny's relationship with Pam resumed, however within a year of Derek's death, Jenny had formed a relationship and moved in with another man, Bob, whom Maggie described as an alcoholic, who was violent towards both Jenny and Jessica. Maggie informed that since residing with Maggie, Jessica has recalled incidents of Bob hitting her mother. Bob is reported to have a teenage son who resides with him, whom was described by Maggie as a "bit backward". Maggie informed that after ending this relationship, with the assistance of Pam, Jenny alleged that Bob was violent and had raped her.

Jenny and Jessica then resided with Jenny's parents, in their house, before moving to a separate residence with Pam. During this time, Jenny is reported to have been heavily using drugs. Maggie informed that she was unsure of whether Pam was abusive towards Jessica in anyway, but recalled that Jessica had informed her on one occasion that Pam had touched her on the bottom.

In 2000, Jenny died from a drug overdose. On the day of her mother's death, Jessica had attended school and was collected by Pam. Maggie reported that as of the next day she took custody of Jessica, who has been in her care since. Two weeks following the death of Jenny, Jessica's maternal grandmother died of a heart attack.

Developmental History

Maggie reported that she could provide little information about Jessica's developmental history, but that she believes that Jessica was delayed due to the lack of stimulation she received in her early years. Maggie noted that Jessica's fine motor skills were 'underdeveloped'. Jessica was reported to love school but have difficulty staying in her seat and concentrating. Further when Jessica commenced school initially she did not make friends with her peers; rather she would socialise with older children at the school. More recently, however, Jessica has begun to socialise with same age children.

Current Concerns

Jessica has been residing with her maternal aunt and family for the past twelve months. Maggie informed that when she first came to live with them Jessica displayed some signs of grief over the loss of her mother, though these did not extend beyond the first few weeks. Jessica still occasionally talks about her mother being in heaven, however Maggie informed there is no distress associated with this. Maggie informed that initially Jessica had little understanding of boundaries or personal space. For example, Maggie reported that Jessica would try to look under doors at people, would walk in on people in the shower and would stare at anybody she saw kissing. In addition, Maggie reported that Jessica also had poor boundaries in regards to strangers or visitors to the family, for example requesting to go home with strangers and hugging or kissing people indiscriminately. Maggie informed that while over the past twelve months many of these behaviours have declined and

Jessica appears to have a better understanding of appropriate boundaries, these behaviours are still sufficiently present to be of some concern to her.

According to Maggie, Jessica was experiencing between twenty and thirty nightmares a night when she first came to reside with them. Maggie believes, based on Jessica's recall of the dreams, that they were generally about people hurting her. More recently these nightmares appear to have reduced and currently Jessica has only two or three distressing dreams per night. The content of these nightmares has shifted, and is now centred on death, specifically the death of people in Maggie's immediate family. According to Maggie, Jessica expresses great concern over people getting hurt and constantly worries about her family.

Maggie informed that she was quite concerned about Jessica's behaviour towards her dolls. She had observed Jessica on occasion rip the clothes off her dolls, and then simulate sexual activity with them. Jessica was also observed to act out her dolls hitting each other. Maggie informed that when she questioned Jessica about this behaviour, Jessica would say that Bob used to do it to Mummy and Pam to her, but would refuse to discuss the matter further. More recently this behaviour has diminished.

Overview of Observation and Assessments

The assessment of Jessica consisted of observation and engagement in play with her, conversations with her aunt and teacher as well as administration of the Child Behaviour Checklist (Achenbach, 1993) and Child Sexual Behaviour Inventory (Friedrich, 1996), both of which were completed by Maggie, as well as the Touch Survey (Hewitt, 1999), which was completed with Jessica.

General Impressions

Jessica presented as a bright, talkative girl, though extremely friendly in her manner towards the writer. She separated easily from Maggie, though she was always eager to see her at the end of sessions. Walking to the therapy room, Jessica would hold the writer's hand.

Jessica generally wanted to initiate the activities undertaken in the session. She would engage the writer in these activities, and was very directive, instructing on what to do. While Jessica would listen to the writer when the writer initiated activities, she often refused to participate in these activities. If Jessica did participate in activities initiated by the writer, her interest waned after a short period of time.

At the conclusion of each session, when the writer announced that it was time to pack up Jessica would instantly stop what she was doing, drop what she was playing with and leave the room, without saying goodbye to the writer and not waiting to walk with the writer.

Observation and Engagement in Play

It was evident during the assessment that there were certain tasks that Jessica found difficult to participate in. Tasks that required Jessica to talk about her feelings, dreams, things she did or didn't like, all appeared to be difficult for Jessica. When the writer initiated activities or conversations around these topics Jessica would move onto another activity, or would instruct the interviewer to stop questioning her.

There were a number of different themes that emerged from the sessions with Jessica. In particular, Jessica often focused on death, dying and sickness. The theme of death was also apparent in Jessica's expressed fear of having nowhere to live if

Maggie died. Another theme that commonly arose in Jessica's play was of a violent man, generally the father. When playing with the cooking set, Jessica would often warn the writer to be careful as this man was going to hit her, however, she would then offer to protect the writer.

Touch Survey

The Touch Survey was conducted with Jessica. In the Touch Survey, children are asked questions about a variety of different forms of touch (eg. kissing, hugging, hitting). The questions include, 'does anyone kiss you?' 'who kisses you?', 'where do they kiss you?' 'do you like it?'. Whilst Jessica was happy to respond to the first two forms of touch, hugging and tickling, she refused to discuss other forms of touch. With regards to the survey's question about private parts, Jessica informed that she couldn't talk about it because it was mean and she would get in trouble. On further prompting Jessica informed that it was bad people who did it, but could not clarify what or whom she meant.

Report From Teacher

Jessica's teacher, Sian, reported that Jessica had become far more settled during the school year. According to Sian, initially Jessica could not concentrate for even short periods of time on tasks, would not make eye contact and would distract or seek attention from other children. In addition, Jessica would often get up during class, wander around and sing and dance. Sian also reported that she often had difficulty with Jessica taking things from the classroom, including pencils, textas, a calculator and plastic buttons off a clock. While Sian informed that all of these

behaviours had eased as the year progressed, Jessica still had difficulty sitting still and concentrating, and would often seek to gain the attention of other children.

Child Behaviour Checklist

Maggie completed the Child Behaviour Checklist with regards to Jessica. The CBCL is a general measure of children's behaviour across a number of domains including 'Withdrawn', 'Somatic Complaints', 'Anxious/Depressed', 'Social Problems', 'Thought Problems', 'Attention Problems', 'Delinquent Behaviour' and 'Aggressive Behaviour'. In the assessment, Maggie described Jessica as caring, helpful and loving. However, she also noted that she was concerned about Jessica's difficulty in sustaining attention on a task, and lack of understanding of appropriate behaviour and boundaries.

The assessment indicated that Jessica is quite a social and interactive child, who helps with chores at home and participates in a number of extra-curricular activities including ballet, netball and piano lessons. The assessment suggested that Jessica displays some concerning social, thought and attention problems as well as delinquent and aggressive behaviour. For these behaviours, Jessica scored in the clinical range, indicating that the difficulties experienced by Jessica in each area may be impacting upon her every day functioning.

Child Sexual Behaviour Inventory

The CSBI is a measure of children's sexualised behaviour, administered in an attempt to understand the primary caregiver's observations of the child's behaviour. Maggie noted, when completing this assessment, that while currently many of the

behaviours have settled to a large degree, they were far worse when Jessica first came to live with her. This assessment was conducted based on Jessica's current behaviours. Jessica's score on this assessment tool indicated that she is functioning within the clinically significant range. This means that behaviour displayed by Jessica, is overly sexualised for what is expected of her age group.

Formulation and Recommendations

Jessica is a six-year-old girl whose early childhood has been marked by significant trauma and loss. This includes the death of her parents, her mother's drug history and the allegedly violent relationships her mother was involved in. It is thought that during the time Jessica resided with her mother, she received very little stimulation and may have been subjected to physical and sexual abuse.

The type of behaviour that Jessica displayed is indicative of a child who has had difficulty forming a secure attachment to her early primary caregivers. Such difficulty is not unusual amongst children with a history of trauma and loss, as Jessica has experienced. Both Jessica's play and reports from her aunt reflect a child who is overwhelmed by the fear that the people close to her will die and leave her alone. As a result she seeks security from anyone available, whether an appropriate source or not, in order to protect herself. However, to avoid the pain of rejection and abandonment, which appear to be her primary fears, Jessica may reject others first.

Jessica was seen to worry about her family and those close to her getting hurt. It appears that these worries of being left alone, and abandonment are consuming a significant amount of Jessica's time and energy. As such she may be finding it difficult to put any energy into concentrating on other activities, such as her class

work, or thinking about her past or what she wants for the future. In addition, Jessica's difficulty concentrating may also reflect her experience of witnessing violence, which may have led her to be vigilant about who is around her and what they are doing.

Maggie's descriptions of the behaviour displayed by Jessica, along with the results of the CSBI, indicate that Jessica is displaying some concerning sexualised, behaviours. Often when children engage in sexualised behaviour such as these, there has been some history of sexual abuse, physical abuse or poor boundary experiences. Exposure to violence has also been linked to such behaviour. Further, children with these experiences may use such behaviour as a means of making contact with others. Again this is consistent with the possibility that much of Jessica's behaviour reflects her anxiety about rejection and abandonment.

Jessica has shown great improvement in her behaviour over the time she has resided with Maggie and her family. The more appropriate boundaries have been effective in teaching her appropriate behaviour and she has also begun to make advances in her ability to sit and concentrate at school. Further, the continuation of this consistent care and support provided by Maggie, will help in making Jessica feel more secure. However, Jessica is also in need of an opportunity to discuss and release some of the overwhelming worry that appears to consume much of her time and energy. At present it appears that Jessica has had little opportunity to discuss her feelings of grief and worry over the death of her mother as well as other members of her family. Before she can discuss other important issues in her life, Jessica needs the opportunity to resolve these overwhelming emotions. As such, presently a referral to a centre dealing with bereavement would be appropriate for Jessica. This recommendation has been discussed with Maggie and a referral has been made.

Discussion

The loss of an attachment figure is a traumatic experience for any child (James, 1994). However, when the quality of attachment between the child and adult is poor in the first place, this further complicates the child's ability to cope with the loss of their attachment figure and form new attachments. The case of Jessica demonstrates the difficulty in understanding and catering to the needs of a child who has suffered multiple traumas and has experienced a disturbed attachment with her primary attachment figure. Jessica is a child with an extremely complicated history. Not only has she suffered the loss of many loved ones, but she has lost her primary attachment figure. This experience of loss would be sufficient to cause significant trauma and grief on her behalf. However, other concerning behaviours displayed by Jessica, including sexualised behaviour and a degree of indiscriminate sociability, suggest that there have been other incidents in Jessica's life which are exacerbating the grief and trauma she is experiencing over the loss of her mother and impacting on her ability to attach to her new carer. The multiple traumas experienced by Jessica as well as the disturbed attachment between herself and her mother have created a complicated case, and in providing an adequate therapeutic approach to cater to Jessica's needs, it is important that all components be addressed.

The most clear of these components is the grief that Jessica has experienced at the loss of her mother. A set pattern of grief is typically seen after the loss of an important person. This includes a protest stage in which the child cannot and does not believe that the attachment figure has gone, a time that may be associated with numbness and the child attempting to search for the caregiver (Bowlby, 1969; Marris, 1993). The next phase, despair is where the child experiences acute pain

while beginning to accept the loss of the attachment figure, who they now believe won't return (Bowlby, 1973; Marris, 1993). Finally the child moves to the detachment phase where all hope of the caregiver returning is lost (Bowlby, 1969). It is at this point that most children proceed to accept the caregiver's death and begins to build other relationships (Marris, 1993). However, in the case of Jessica, the quality of attachment experienced with her mother may be interfering with her ability to move through or even experience this grief process.

The true quality of the attachment between Jessica and her mother is unclear, as is the type of care Jessica received from her mother. While Jessica's maternal aunt, Maggie has implied that the care provided to Jessica has not been optimal; she was unable to provide specific information about Jessica's experiences as an infant. What is known about Jessica's mother, Jenny, is that she was extremely distressed over the death of her first child, she was a prolific drug user across her life and she was responsible for the care of her husband at a time when Jessica was very young. All these factors would indicate a mother who was not available to her daughter's needs. Though Jessica's disinhibited social interaction may indicate a subtype of Reactive Attachment Disorder, the lack of specific information about the care that Jessica received means that such a diagnosis cannot be applied, as the information is not clearly indicative of a child who has suffered grossly pathological care.

While a diagnosis of Reactive Attachment Disorder is not essential for treating Jessica's obvious grief and social interaction difficulties, understanding the quality of the attachment between Jessica and her mother is important for understanding the impact this may have on Jessica's ability to form an attachment with Maggie. What can be hypothesised from the information provided about Jessica is that the pattern of interaction she experienced with Jenny was one in which

she was unable to trust Jenny to be available or meet her needs. As a result, Jessica began seeking others to meet those needs (i.e., her disinhibited social interaction). The loss of her mother served only to confirm to Jessica that she was unable to trust others to meet her needs or provide safety and protection for her. In order to find a balance between maintaining protection and explore her environment, Jessica's disinhibited social interaction, or seeking out care wherever it is available has only been exacerbated.

Maggie has shown good insight in attempting to provide a safe environment for Jessica. Further, she is setting boundaries to help Jessica understand appropriate and inappropriate behaviours. However, without having a framework to understand why Jessica is indiscriminately friendly, she may easily become impatient with Jessica's behaviour, and more importantly feel rejected or unrewarded for the care she is trying to offer Jessica (James, 1994). Further without understanding how this insecurity and lack of trust of adults is impacting on Jessica's social and emotional development, the expectation of both Maggie and other family members may be for Jessica to deal with and get over her grief, rather than understanding that this process is made difficult by her difficulty in trusting other adults.

Questions have been raised about the stability of early attachments. The generally held belief is that the attachment remains stable only so long as the child's caregiving environment remains stable (Belsky, Campbell, Cohn, & Moore, 1996). It is evident in the case of Jessica, that her caregiving environment has encountered dramatic changes, rather than remaining stable. This is encouraging for Jessica's ability to form a new secure attachment with her new caregiver, Maggie. However, overcoming the level of loss that Jessica has experienced will require time, effort, patience and encouragement. It can be seen already that Jessica is far more settled in

response to the change in her caregiving environment, a change that is permeating through both her behaviour at home as well as at school.

Conclusion

The loss of a primary attachment figure has major implications for a child's continuing development. The grief involved with that loss requires time and patience to be processed. Further the child requires a loving and safe environment to feel free to form new attachments. When a child's loss is exacerbated by a poor attachment in the first place, his ability to form new attachments or even process the loss of the primary attachment is made more difficult. In understanding the impact of grief on a child, it is important to also understand the nature of the relationship the child experienced with the lost caregiver.

CHAPTER 5 – ATTENTION DEFICIT HYPERACTIVITY DISORDER AND ITS RELATIONSHIP TO ATTACHMENT

Beginning with the work of Bowlby researchers have tried to understand the link between early childhood attachment and the development of psychopathology (Bowlby, 1969). Bowlby's interest in attachment was sparked by his observation of two boys whose displays of maladjusted behaviour were thought to be linked to the massive disruptions in their relationships with their mothers (Bretherton, 1991; Fonagy, 2001). As noted in Chapter 3 the main psychopathological disorder associated with a disturbed primary attachment is Reactive Attachment Disorder. The essential features of this disorder include the "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care" (APA, 1994, p. 16). Reactive Attachment Disorder is considered to be one of the most severe forms of infant psychopathology and is also one of the only ones to be directly linked to the form of care provided in early childhood (Wilson, 2001). However, more recently literature has noted some of the commonalities between behaviours resulting from disturbed attachments and those resulting from other disorders, including conduct disorder, oppositional-defiant disorder, attention deficit hyperactivity disorder (ADHD) and pervasive developmental disorder (Reber, 1996; Zcanah, 1996). Further it is suggested that in some cases, disorders of attachment are misdiagnosed as one of these alternative disorders (Wilson, 2001). As with Reactive Attachment Disorder these disorders can continue over the lifespan, affecting the future relationships developed by these children. However, there are also some fundamental differences

in both the causes and symptomatology of each of these disorders. The remainder of the introduction to this chapter will explore one of these alternative diagnoses, ADHD, and the manner in which the symptoms of this disorder may be confused with those present in an attachment disturbance. A case study will follow that provides an example of the difficulty in differentiating between the potential causes of symptomatology displayed in children.

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most prominent disorders of childhood, with reports that diagnoses of ADHD account for at least half of the referrals to child mental health agencies (Daw, 1996). ADHD has become increasingly popular diagnosis during the past twenty years, however the first description of ADHD was over 100 years ago and medication to treat the symptoms of this disorder have been well known for at least the second half of the 20th century (Green & Chee, 1997). ADHD is a biological condition caused by an imbalance in the neurotransmitter chemicals, noradrenaline and dopamine. The imbalance of these chemicals has been shown to occur mainly in the frontal lobe areas of the brain, the area responsible for self-monitoring and inhibiting behaviour (Green & Chee, 1997). As a result these chemicals prevent the child from having full inhibitory control over their behaviour. The essential feature of ADHD “is a persistent pattern of inattention and/or hyperactivity-impulsivity” (APA, 1994, p. 78).

To gain a diagnosis of ADHD under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994) a child is required to meet five separate criteria. In the first, a child must display six out of a possible nine symptoms of either inattention or hyperactivity-impulsivity over a period of six months or longer and to a degree that is maladaptive and inconsistent with the child’s developmental level.

The other four criteria require that at least some of the symptoms were evident prior to seven years of age; impairment from the symptoms is displayed in at least two separate settings; that there is clear evidence of clinically significant impairment in social, academic or occupational functioning as a consequence of the symptoms; and finally that the symptoms are not better accounted for by another mental disorder.

Whilst the DSM-IV requires that the symptoms of ADHD are present prior only to age seven years, these symptoms have been reported in children as young as two years of age, with some parents reporting that they knew from birth that their child was different (DuPaul, McGoccy, Eckert, Vanbrakle, 2001; Green & Chee, 1997). Within early childhood these symptoms present as restless impulsive behaviours including impatience, difficulty in delaying or inhibiting responses, difficulty in waiting one's turn and frequently interrupting or intruding on others (APA, 1994; Green & Chee, 1997). However with increasing age, there is generally a shift in the symptoms with a move towards symptoms of inattention, inability to sustain work output, deficient short-term memory and frustration with learning (Green & Chee, 1997).

With the high and increasing level of ADHD diagnoses reported, there has been an increase in the amount of research conducted examining ADHD. This research has been primarily reported within educational and child psychology journals, reflecting the tone of the research, that is, focusing on the child with the disorder (Erdman, 1998). This is despite the fact that ADHD is recognised as having a significant impact on not only the individual but the whole family system (DuPaul, McGoccy, Eckert & Vanbrakle, 2001; Erdman, 1998; Green & Chee, 1997). Possible reasons for the almost singular focus within the research on the child rather than the family as whole is that first, in providing this diagnosis parents and teachers may be

relieved of further responsibility for managing or altering a child's difficult behaviour (Erdman, 1998). Second, as with any disorder it is generally easier, for both the family itself and those attempting to assist intervention and change to deal with and try and effect change in the individual rather than the entire family system (Green & Chee, 1997).

Despite the focus of the research, the family and intervention services on the individual sufferer of ADHD, it is important to recognise and remember that ADHD sufferers do develop within a family unit and their behaviour not only impacts on the family, but is also affected and influenced by the family itself. In understanding and focusing on the role of the family, this is not to suggest that the development of ADHD is caused by some factor within the family, nor query the existence of ADHD (Erdman, 1998; Green & Chee, 1997). However, in questioning the role of the family, questions have been raised in the current literature, with professionals now suggesting that amongst the high rates of children being diagnosed with ADHD, there are children who are actually being misdiagnosed. This thinking follows the line of argument that rather than attributing the symptoms of ADHD purely to the individual and chemical imbalances within the brain of that individual, there may actually be other symptoms similar those reported in ADHD, that are actually a result of other causes. Therefore in understanding the behaviour of children, it is especially important to consider all possible sources of causation, intervention, support and change. Rather than focusing primarily on the child an alternative way to view these problematic behaviours is within the contextual framework of family dynamics and interactions (Bretherton, 1992).

With the increasing understanding of the impact of early attachment on a child's normal and healthy development it is important to also focus on how

maladaptive or disturbed attachments impacts on a child's development. As the introductory chapter outlined, most children form an attachment of some description. The only requirement for the development of that attachment is continuity of the primary caregiver (Ainsworth & Marvin). However, the quality of the attachment between an infant and his primary caregiver depends on the quality of care provided to the infant. As outlined by Ainsworth and those who have furthered her work, the quality of the mother/infant attachment can be classified into four separate categories, only one of which is a secure attachment category (Ainsworth et al., 1978; Main & Solomon, 1986). In order for a child to develop a secure attachment they require a 'secure base'. This secure base allows the child to go and explore his world (Ainsworth, 1967). When the attachment between a child involves pathological care and the disturbance to the child's development impacts severely on his everyday functioning then this may be considered an attachment disorder (APA, 1994). Whether the nature of the attachment is so severe to cause a disorder in the child, or impacts on the child more moderately, both levels of disturbance have been seen to present with symptomatology similar to ADHD type behaviours.

Disturbed attachments develop as a consequence of the attachment figure's inappropriate, inconsistent or in some cases nonexistent responses to the child's signals and needs. In response to the caregiver's inappropriate behaviours and thus the development of a disturbed attachment the child has no secure base from which to explore and as a result attempts at exploration are either completely discouraged or become extremely distressing and stressful for the child (Erdman, 1998). As noted in the introductory chapter there is support for the view that the type of typical interaction an infant experiences with his primary caregiver forms a prototype for future interactions and relationships (Ainsworth, 1983; Bolen, 2000; Sroufe, 1983).

Further, when the relationship is disturbed and the child is lacking a secure base, then his ability and freedom to explore his environment is severely impaired (James, 1994). As a result, the child or infant is required to find an alternative means to balance his desire to both explore his environment and maintain his own protection (James, 1994). It is these modified behaviours, which children develop to protect themselves, that may reflect behaviours also associated with ADHD (Crittenden, 1992).

Crittenden (1992) explored the types of behaviours and strategies that children with a disturbed attachment may develop in an attempt to find some way to feel sufficiently safe to explore their environment despite their caregiver's unavailability. One method children may use to alert their caregiver to situations, which induce fear in the child, is anger and aggressive behaviours. This serves to give the child a sense of power despite their helpless and powerless position. However, rather than invoke protective responses in the caregiver, this anger actually encourages the negative involvement from the caregiver, who is responding to the child's anger (Crittenden, 1992). As a result this only increases the child's feelings of anxiety and vulnerability and continues the cycle of negative interactions between the child and his caregiver (Erdman, 1998). This strategy of using anger follows a pattern of coercive behaviour, typically used by these children to gain the caregiver's attention. This pattern of behaviour includes using a façade of vulnerability to lure the caregiver into providing attention and then aggression to force the caregiver to meet the child's needs. However, in response to this behaviour parents begin to respond to only the most extreme of these behaviours, thus requiring the child to increase the intensity and extremeness of their behaviour to gain the caregiver's attention (Moretti, et al., 1994). The aggressive, coercive and intrusive behaviours

used by these children have been shown to closely reflect the patterns of behaviour demonstrated in children diagnosed with ADHD (Erdman, 1998).

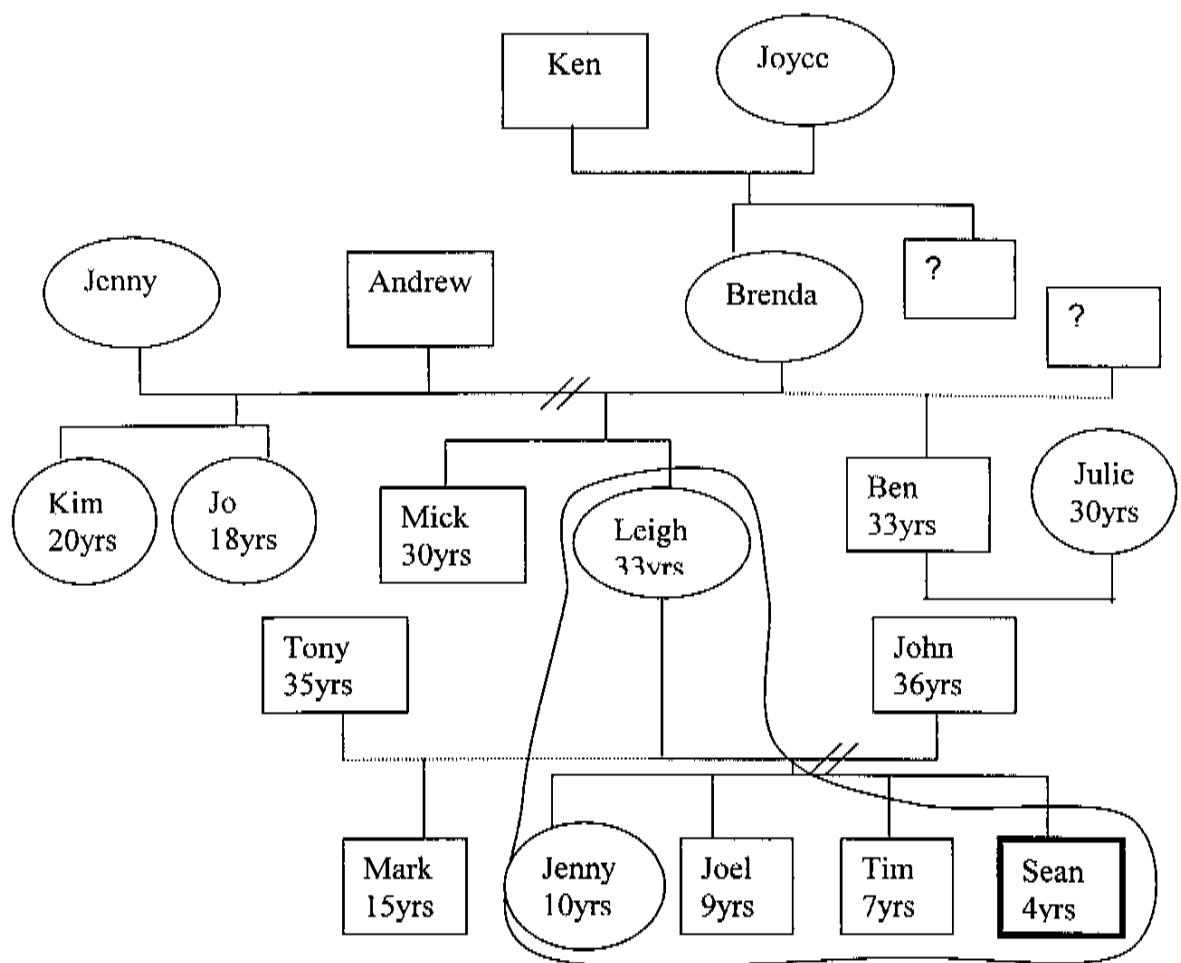
Not only has the interactions observed between an infant with a disturbed attachment and his attachment figure been seen to simulate, to an extent, the types of interactions observed with children diagnosed with ADHD, but similarities in the types of social, emotional, and cognitive development have also been noted. In comparison to children without ADHD, who have developed a secure attachment, these children have been observed to have greater difficulties in planning and organisation of tasks and their environment; poor social skills and inappropriate social interactions; limited ability to persist at problem solving; less purposeful interactions with other; less purposeful investigations of their environment; and poorer self esteem (APA; 1994; Erickson, 1991; Green & Chee, 1997; Landry & Chapickski, 1990; Maslin-Cole & Spieker, 1990; Pastor, 1981; Sroufe, 1985; Waters, Wippman, & Sroufe, 1979).

Whilst there are evident similarities between the two disorders, there are also some major differences, including the etiology of the symptoms within each of the disorders. While attachment disturbances or disorders result from a disturbance within the primary attachment, ADHD, stems from a chemical imbalance. Children with ADHD are unable to sustain attention, have difficulties in their social relationships, are aggressive and unable to inhibit these behaviours due to this chemical imbalance (Green & Chee, 1997). Similar symptoms in a child with an attachment disturbance have stemmed from the child's experience of interaction with his primary caregiver, in which the child is required to form alternative means of communicating his needs; of ensuring his safety and protection; and of developing a means to explore his environment (Cassidy & Berlin, 1994; James, 1994). Further

the approach to intervening in a family or with an individual displaying these types of behaviours also differs markedly. While medication may be used to treat ADHD (Green & Chee, 1997), similar symptoms in attachment disturbance require alteration of the child's experience of his primary caregiver and the patterns of interaction between the two parties within the relationship (van IJzendoorn, Juffer, & Duyvesteyn, 1995). Following the case of Scan will be presented. Scan is a four-year-old boy referred for an assessment regarding ADHD, however, whose history indicates disruption to the primary attachment.

THE CASE OF SEAN

Sean is four-year-old boy who was referred by his Paediatrician to a developmental assessment centre for zero to six year olds after there was some query as to whether he was suffering Attention Deficit Hyperactive Disorder (ADHD).



Family History

Sean's mother Leigh provided the following information. Sean is the youngest son of Leigh, aged thirty-three years. He has three brothers aged fifteen, nine and seven and a sister aged ten years. Leigh informed that Sean has no contact with his father who was jailed for sexually abusing the three eldest of Sean's siblings. Sean's eldest brother no longer resides at home, though the other four children do. According to Leigh, the abuse of Sean's siblings came to light just prior to Leigh discovering that she was pregnant with Sean. Leigh informed that this was an extremely traumatic time for the whole family, however, particularly herself and that she was smoking, consuming alcohol and antidepressants during and after the pregnancy to cope with the stress. Leigh informed that she decided to stop using alcohol and medication when Sean was approximately six months old. In order to assist, Leigh attended a rehabilitation centre. She informed that it was another six months before she completely stopped using any form of medication or alcohol.

For the first two of years of Sean's life, his great grandmother resided in a granny flat in the backyard of Sean's home. While Leigh was seeking treatment for her alcohol issues, Sean's great grandmother would take care of the children. She is now in residential care due to a stroke and dementia. Sean's maternal grandmother also resided with the family for twelve months, approximately one year ago, however after a falling out with Sean's mother she no longer has any contact with the family.

Approximately two years ago Sean's nine-year-old brother Joel was found inappropriately touching his seven-year-old brother Tim. Tim is not believed to have suffered abuse from his father. Intervention was sought following the incident, of which similar types of incidents are thought to have occurred over a period of time.

While Leigh reported that firm boundaries have now been established at home, she noted that this again was particularly stressful time, with a notification made to the Department of Human Services (DHS), and a subsequent investigation. Leigh informed that she was particularly worried about the impact the previous abuse was having on her children and how this was going to manifest and affect her two younger children. Leigh informed that at that time the family had been seeking therapeutic intervention at the local CASA (Centre Against Sexual Assault), however the agency recommended the removal of Joel from the family for the treatment to continue. Leigh informed she disagreed with this suggestion and consequently terminated treatment at that centre. Since that time the whole family have received counselling from a counsellor who was contracted through the Victims Referral Service.

Sean's brothers Mark and Tim have both been given diagnoses of ADHD. Leigh informed that in both cases the boys were diagnosed at age six years. Both boys are prescribed medication to assist with controlling the symptoms of the disorder, however, Leigh reported that she believes the medication has no impact on the boys' behaviour.

Developmental History

Leigh discovered that she was pregnant after four months gestation, however, despite the traumatic circumstances surrounding the time of his gestation and birth, Leigh reported no difficulties during the pregnancy and birth. Sean was born via a planned caesarean due to large birth size. While the birth was not physically traumatic, Leigh described it as an ordeal due to her own feelings of not wanting to

be pregnant. Leigh informed that she had considered aborting the pregnancy, however, was unable to due to the how late the pregnancy was discovered. Following the birth, Leigh and Sean spent three days in hospital. Leigh informed that for the first six months of his life she had difficulty cuddling Sean as she associated him with the abuse of her other children. She never breastfeed him and while she would meet his physical needs, she relied on her other children to keep him entertained. Leigh informed that during the second six months of Sean's life she began to make steps to interact further with him, however, this process was hampered by her rehabilitation attempts.

Leigh informed that she believes all Sean's motor developmental milestones were met at age appropriate times. She believes he first crawled around eight to nine months and first walked at fourteen months. Sean's verbal milestones were reported to be slightly delayed. He had little vocalisation prior to age two years, however, his verbal communication skills are now reported to be at an age appropriate level. Leigh reported a slight delay in toilet training, Sean was toilet trained during the day by three years and at night by four years.

Leigh reported that she often has difficulties with Sean at bedtime and that he has always been a bad sleeper. Up until three months ago, Sean would climb into his mother's bed in the middle of the night, however, Leigh has an agreement with Sean which has proven to be successful in keeping Sean in his own bed. Sean currently goes to bed around eight-thirty on a weekday, though his mother reported that he doesn't go to sleep until around nine-thirty. On weekends, Sean will go to bed later, however Leigh informed that he is then often irritable the next day.

Sean has been attending childcare three days a week for the past six months. He is reported to love attending and will remain there next year for extended days, instead of attending kindergarten.

Current Concerns

Leigh reported that Sean's behaviour at home is often unmanageable and intolerable. She reported that he will throw tantrums when he doesn't get his own way, that he destroys toys, that he will sometimes climb on the roof and on fences and that it is very difficult to find an activity that will hold his attention for a substantial period of time. The one exception to this is the Nintendo (a computerised game), which Sean will play for hours at a time on a regular basis. To try and manage Sean's behaviour, Leigh reports that she tries to ensure that all doors are locked and that she keeps a close eye on him. She uses Sean's room for time out when he is misbehaving, and he will stay there for five to ten minutes until he has calmed down.

There has also been some concern in regards to Sean's behaviour at his childcare centre. According to Leigh Sean was reported to have engaged in sexualised behaviour with another child at the childcare centre. This allegedly included mutual touching of each other's genitals. Workers at the childcare centre made a notification to DHS regarding this behaviour. According to Leigh, workers from DHS have investigated both the reported behaviour at the childcare centre as well as the children's behaviour at home. According to Leigh, DHS reported that they did not find any evidence that sexualised behaviour was occurring at home between the siblings and feel that there is not enough evidence to suggest that the behaviours at the childcare centre are concerning. Both Leigh and workers at the

childcare centre informed that DHS made recommendations of appropriate boundaries that should be put in place both at home and at the childcare centre.

Overview of Observations and Assessments

Observations were conducted of Sean both during a structured and unstructured individual play session at the developmental assessment centre. Further Sean was observed in at his childcare centre during group time, and free play both inside and outside at the centre.

General Impressions

Sean presented as a friendly boy of average height and weight. He was seen on three occasions by the writer, one of which was at his childcare centre. During the first session he was happy to attend the session alone, leaving his mother in the waiting room. During this session Sean was asked to participate in a number of activities including playing with trucks, playing in the sand pit and assembling jigsaw puzzles. During the second session he attended Sean again separated easily from his mother with no distress. During this play session Sean was allowed to choose which activities he wished to participate in. He initiated a number of different activities, including playing with playdoh, playing in the sand pit and building with blocks. Sean did not include the writer in his any of these activities and was happy to explore the room independently.

In the observation of Sean at his childcare centre, he was observed to generally play independently, though he would seek out staff members assistance

should he require it and was noted to observe what other children were doing. However the means by which Sean sought the attention of staff was generally to yell loudly, to bang the equipment he was using or to cause a disturbance. Sean participated in a variety of different activities, including activities inside and activities outside the childcare centre. Sean moved well between the various activities and was generally able to follow the instructions of the workers. During the observation Sean was also required to participate in a group musical activity. During this time he became quite excited, and would bump into other children in the group. When reprimanded for these behaviours, Sean typically responded by settling down.

Observations and Assessments

Observation of Sean in both structured unstructured session indicated that Sean was able to engage in a range of activities for appropriate amounts of time for his age. Sean was seen to have some difficulties in engaging with other children and staff members at the childcare centre and he was seen to be disruptive in his approach to seeking interaction or assistance from others. During the individual sessions Sean was happy to talk about his family and in particular he spoke about his brothers and playing with them at home. In drawing his family, Sean included his mother, his brothers and his grandmother and great-grandmother. Sean noted that his father did not live with his family rather he lived in jail. There was no evidence of sexualised play during the individual assessment or the observation at the childcare centre.

Staff at Sean's childcare centre report that he was a child often difficult to engage. He would play independently and his methods of seeking attention when he

required it were often disruptive to the group. They noted that his interactions with his peers was limited, however, he did on occasions make attempts to interact with others when they were performing an activity in which he wished to engage. Staff reported that while Sean could be disruptive, when they attempted to discipline he was generally responsive and could settle down.

Formulation and Recommendations

Sean is a four-year-old boy whose family have experienced an extremely traumatic time beginning prior to his birth, the ramifications of which continue to today. Sean was referred under a query of ADHD, a disorder with which two of his elder brothers have been previously diagnosed. Sean was observed on three separate occasions, twice individually and once at his childcare centre.

While Sean's mother reports extreme behaviour problems at home, which she has been unable to control, these behaviours were not demonstrated to the same extent within either the individual assessment sessions or at his childcare centre. Further, while staff at the childcare centre noted some difficult and unusual behaviour in Sean, they did not report uncontrollable behaviour or an inability to focus or concentrate on tasks. When Sean's behaviour was viewed as inappropriate he typically respond acceptably to the boundaries set by staff at the centre.

Sean was observed to seek little assistance from others, in both the group childcare setting and the individual assessment sessions. When Sean did seek assistance, his approaches typically included causing a disturbance, by either yelling out, banging objects, or other disruptive behaviour with objects. Sean was noted to have difficulty interacting with other children and the forms of interaction used were

often inappropriate, with one reported incident of sexualised behaviour and reports of banging into other children.

Based on the information gathered from the individual sessions and observations and reports from the childcare centre, Sean does not meet the criteria for a diagnosis of ADHD. He is seen as able to focus attention, respond to boundaries and the behaviours reported at home are not observed in any other setting. While Sean's behaviour is evidently more difficult to manage in the home environment, other possible contributors should be considered. Sean's early developmental years have been particularly marked by disruption to the family, which has resulted in the unavailability of his mother at certain times in his life. Leigh reported the difficulty she had in forming an emotional connection to Sean early in his infancy. Further, Sean has two older brothers demonstrating symptoms and behaviours of ADHD on which to model his own behaviour.

Sean's disruptive behaviour at home is indicative of an independent child who has difficulty appropriately seeking assistance. As a result, Sean uses other disruptive ways to seek attention and interact with others. Leigh's difficulty in allowing herself to be available to Sean in his infancy, may mean that the template for interaction he has developed is of a caregiver who not available. While Leigh may desire a closer relationship with Sean now, the additional demands on her time, including two sons with ADHD and three children coping with the impact of sexual abuse, may still be limiting her availability to Sean. As a result it is recommended that an intervention program that helps to alter the patterns of interaction between Sean and Leigh been put in place. A referral to a local a mother-child attachment intervention centre was discussed with Leigh and made by the writer. Further, while there were no clear indicators of ADHD, Sean's behaviour should be monitored and

should concerns persist once he has commenced primary school then a review is recommended.

Discussion

Within certain disorders of childhood, there are similarities between the types of symptoms with which children present. In particular similarities have been reported between Reactive Attachment Disorder, AD/HD, Conduct Disorder and Oppositional Defiant Disorder. However, while some of the symptoms may be similar and cause confusion when diagnosing children, the causes of these symptoms are distinctly different. The case of Sean illustrated how a child may present with symptoms of AD/HD, however, when examining the child's family and developmental history, it is clear that there may be factors other than a chemical imbalance in the brain contributing to these symptoms.

Sean was referred for an assessment under a query of AD/HD. This was following his mother's reports that he was having difficulty concentrating for periods of time on a task, was performing risky behaviour and was not responsive to discipline or boundaries. While this particular behaviour was not observed in other settings, it was noted in both individual sessions with Sean and at his childcare centre, that he had difficulty interacting with and seeking assistance from others. While Sean did not meet the criteria for AD/HD, his behaviour was sufficiently disturbed in the home and there were some indicators at the childcare centre that may have been symptoms of AD/HD. Therefore whilst the behaviour displayed did not interfere with his development at a clinical level, there were obvious disturbances in his behaviour.

Rather than focus purely on Sean's behaviour as many researchers examining ADHD have done, this writer also considered the role of Sean's family environment and gathered a full family and developmental history. What this information revealed was that Sean was born at a time of great trauma, where consequently his mother was unavailable to be responsive to his needs for at least the first year of his life. If consideration had not been given to Sean's family and personal history, the events around his birth and the impact this has had on his family, but particularly his mother, then questions may not have been raised about the attachment between Sean and his mother. While Sean's behaviour would still not be considered in the clinical range and not fit with a diagnosis of Reactive Attachment Disorder, there were clear indications of possible disturbances within this relationship. While no measure was taken of the quality of attachment between Sean and his mother, both Sean's independence from his mother, even within a strange and new situation with a strange person as well as his inappropriate forms of seeking assistance from adults, is indicative of an insecure attachment, specifically an insecure-avoidant attachment.

This case has helped to illustrate the need for considering all possible diagnoses and other relevant factors involved when considering the cause of the symptoms a child is displaying. As can be seen while the symptoms for each type of disorder are not identical, there is some overlap between the behaviours linked to ADHD and those linked to a disturbed attachment. If all information is not considered, then children may be treated for a disorder they are not suffering. More importantly, in the case of a child with a disturbed attachment, the patterns of interaction within the family or between the child and attachment figure may not be altered. This can also have detrimental effects for the child's development, impacting on the child's social, emotional and even cognitive development.

Conclusion

Diagnosing disorders in childhood can be particularly difficult. The symptoms may manifest in a variety of ways, and often symptoms from different disorders can overlap. In understanding the causes of a child's behaviour it is important to consider all contributing factors and possible aetiologies to ensure that the true cause is not overlooked. When all possible causes and factors are not examined, children may not receive the appropriate intervention to cater to their specific disorder.

CHAPTER 6 – SUMMARY AND CONCLUSIONS

The relationship between an infant and his primary caregiver (typically his biological mother) has long been held to be a special relationship. However, it was only during the 20th Century that true recognition was given to the importance of this relationship (Ainsworth & Marvin, 1995; Bowlby, 1969; Fonagy, 2001; Karen, 1994). The relationship between an infant and his primary caregiver came to be known as an attachment, a title given to this relationship by John Bowlby, when in 1958 he wrote a paper entitled “The Nature of a Child’s Tie to His Mother” (Ainsworth et al., 1978). The primary purpose or function of a child’s attachment to his primary caregiver is to maximise his chances for survival, a purpose that is based on a biological drive within the child (Bowlby, 1969; Fonagy, 2001; Karen, 1994; Slade, 1998). The means by which a child uses attachment to ensure his survival is to gain and maintain proximity to the primary caregiver (Bowlby, 1969). Further the means by which a child gains and maintains proximity is through a specific set of attachment behaviours, including signalling, orientating and active physical contact behaviours (Ainsworth, 1973; Bowlby, 1969).

The child’s use of attachment behaviours is dependent on the patterns of interaction that develop between the mother and the child. That is, the way in which the mother responds to the child’s use of attachment behaviours (Fonagy, Steele, Leigh, Kennedy, Mattoon, & Target, 1995). This emphasises the role of the mother’s response to her child in the development of attachment. However, other research has emphasised that attachment is a dyadic relationship in which the child also contributes to the type of patterns of interaction which develop (Raval, et al., 2001). Ainsworth and colleagues helped to provide empirical support for the theories that Bowlby formulated to understand attachment. One of the primary advances in the

understanding of attachment that Ainsworth has been credited with is the development of a tool to understand the quality of attachment between an infant and his mother. This tool, titled the 'strange situation' used the patterns of interaction between a mother and infant to understand the attachment (Ainsworth, et al., 1978).

Understanding the quality of the attachment between an infant and his primary caregiver has become more important with increasing knowledge about the importance of attachment to a child's development. While the purpose or function of attachment is to maximise the infant's chances for survival, attachment between an infant and his primary caregiver is also considered imperative to the child's healthy social, emotional, cognitive and physical development (Bowlby, 1969; Field, 1991; Grossman & Grossman, 1991; Sroufe, 1985; Waters, Wippman & Sroufe, 1979). The manner in which attachment can impact on a child's development is through the way the child views the attachment-figure's ability to provide them with a secure base (the notion of the parent as a secure base formed from the work of Ainsworth, see Chapter 1). For a child to be able to explore their world, they need to ensure that they have a safe place to return for protection. However, when an infant has learnt that he cannot trust his mother to be that secure base and provide protection, then he must develop a way to balance the conflicting desires to both explore, whilst still maintaining his own protection and safety (James, 1994). It is in maintaining this balance that children are often forced to compromise other areas of development.

The purpose of this portfolio has been to present some of the issues associated with understanding the impact of attachment on a child's development. The cases presented have illustrated some of the issues which may arise when considering the impact of attachment on a child's development. The first case, Isabella, discusses attachment in light of a disability. Typically research examining children with disabilities has focused primarily on the role of the child in the quality of attachment

that developments. However, the case of Isabella helps to demonstrate the importance of understanding the mother's history and the impact of the disability on her interactions towards her child. Isabella's mother faced not only issues regarding Isabella's disability but also trauma with regards to her other children, which were interfering with her ability to engage with and respond to Isabella. On the other hand, this case also supports the work of research investigating the role of the child in the development of attachment. Though Isabella was only six months old, it was evident that it was far more difficult for her mother to understand her signals or even make attempts to engage in interaction with her. This case supports the view of attachment as a dyadic relationship in which the abilities of both parties to interact need to be considered.

The second case examined the role of attachment in the development of inhibited social interaction within a child. In order to understand the impact of poor attachment on a child, it was necessary to move beyond Ainsworth's classification system. An alternative method for understanding the impact of a poor attachment on a child was examined. The DSM-IV (APA, 1994) provides a classification system, Reactive Attachment Disorder, for children with clinically disordered behaviour that developed in response to grossly pathological care from the attachment figure. While the behaviour of Simon indicated a child with severely impaired social interaction skills, a diagnosis of Reactive Attachment Disorder was not applicable. This was because the type of care Simon experienced from his mother could not be classified as grossly pathological. Further, Simon's language impairment may also be contributing to his social inhibition. An alternative and less known method for examining attachment was also explored. This classification system, devised by Zeanah, provides a broader system of categorisation to understand the attachment between a mother and her infant. However, as with Ainsworth's strange situation tool, this method of

classification provided little understanding of the impact on the child. Through examining the applicability of varying classification systems to understanding the attachment between Simon and his mother, it was clear that when a child has not suffered pathological care, or has other forms of impairments, there is no real means for understanding the impact of the attachment on his development. Consequently, the attachment between a child and his mother is often overlooked.

The third case illustrated the impact on a child of the loss of an attachment figure. This case also highlighted the further complication of understanding the child's grief process when the attachment itself was not of a secure nature. Again this case demonstrated the difficulty of understanding the quality of the attachment between the primary caregiver and child. While in Jessica's case understanding of the attachment between her and her mother was further complicated by the lack of information available, the behaviour demonstrated by Jessica was clearly indicative of disturbances within the attachment. However, despite the clearly disinhibited and disturbed nature of Jessica's social interactions, the only category applicable was one that focused on the loss of the attachment figure, that is, 'disrupted attachment' provided by Zeanah. It appears, under the classification systems available, that no system considers the impact of both a disturbed attachment and the loss of that attachment.

The final case raised the issue of differentiating between numerous possible diagnoses. The case of Sean, presented a child referred for and reportedly demonstrating some behaviours symptomatic of ADHD. However, in gathering more specific information about Sean's family and personal history, it is noted that the limited availability of Sean's mother during his infancy and early childhood years may actually have played a far larger role in Sean's current behaviour. This case illustrates the importance, when considering any diagnosis, of gathering a complete

history. It also raises concerns about the narrow focus applied in research examining the development of disorders such as ADHD. That is, a focus that examines primarily the role of the child and symptoms of the child, rather than the role of, and interaction between, members of family (DuPaul, McGoey, Eckert & Vanbrakle, 2001; Erdman, 1998; Green & Chcc, 1997).

This series of case studies has helped to demonstrate the role of attachment in a child's development. However, more importantly it has helped to highlight the difficulties faced by researchers and clinicians trying to apply the current classification systems. This portfolio has discussed some of the issues with the current classification systems for understanding first, the quality of attachment and second, the impact of that attachment on a child's development. While the DSM-IV has been criticised for being too narrow in its criteria for diagnosis (Crittenden & Ainsworth, 1989; Wilson, 2001; Zeanah, 1996; Zeanah et al., 2002), other systems of classification emphasis the role of the mother, rather than the impact, both in the short and long term, of the attachment relationship on a child's development (Boris, Fucyo & Zeanah, 1997).

Researchers and clinicians alike do not dispute the importance of attachment for a child's development. Research has helped not only to validate the importance of attachment, but also provide a better understanding of the relationship between an infant and his mother. However, what has been demonstrated throughout this portfolio is that individually each of the current classification systems is insufficient for fully understanding the impact of attachment across a broad range of children. While it is still important to be able to distinguish between clinically and non-clinically disturbed attachment, this does not diminish the need for understanding both types of disturbed attachment. In cases where children are presenting with symptoms of disturbed attachment in association with other disorders, the need to understand the patterns of

interaction between the mother and her infant should be highlighted rather than focusing purely on the other disorder. As noted previously when children do not have a sufficiently secure base from which to explore, they are forced to find a careful balance between maintaining their safety and protection while still complying with the inclination to explore. Unless intervention also considers the need to provide a child with a secure base, then the child's ability to feel sufficiently safe to engage in intervention is severely compromised. While current knowledge about attachment is helpful for understanding the manner in which it can impact on a child's development, there remains a need for a broader classification system to allow clinicians and researchers to understand the full impact of disturbed attachment on a child's development.

References

- Achenbach, T.M. (1993). Manual for the Child Behaviour Checklist. Burlington VT: Author.
- Ainsworth, M.D. (1963). The development of infant-mother interaction among the Ganda. In B.M. Foss (Ed.), Determinants of Infant Behaviour (vol. 2). London: Methuen.
- Ainsworth, M.D.S. (1967). Infancy in Uganda: Infant care and the growth of attachment. Baltimore: Johns Hopkins University Press.
- Ainsworth, M.D.S. (1973). The development of infant-mother attachment. In B.M. Caldwell & H.N. Ricciutti (Eds.), Review of Child Development Research, Vol. 3 (p. 1-94). Chicago: University of Chicago Press.
- Ainsworth, M.D.S. (1983). Patterns of infant-mother attachment as related to maternal care: Their early history and their contribution to continuity. In D. Magnusson & V.L. Allen (Eds.), Human Development: An interactional perspective, (p. 35-57). New York: Academic Press.
- Ainsworth, M.D.S. (1989). Attachments beyond infancy. American Psychologist, 44, 709-716.
- Ainsworth, M.D.S., Bell, S.M., & Stayton, D.J. (1971). Individual differences

in strange situation behaviour of one-year-olds. In H.R. Schaffer (Ed.), The Origins of Human Social Relations, (p. 17-57). London: Academic Press

Ainsworth, M.D., Blehar, M.C., Waters, E., & Wall, S. (1978). Patterns of Attachment: Assessed in the Strange Situation and at Home. Hillsdale, NJ: Lawrence Erlbaum.

Ainsworth, M.D.S., & Marvin, R.S. (1995). On the shaping of attachment theory and research: An interview with Mary D.S. Ainsworth. Monographs of the Society for Research in Child Development, 60, (2-3, Serial No. 244).

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington D.C.: American Psychiatric Association.

Bacon, H., & Richardson, S. (2001). Attachment theory and child abuse: An overview of the literature for practitioners. Child Abuse Review, 10, 377-397.

Belsky, J., Campbell, S.B., Cohn, J.F., & Moore, G. (1996). Instability of infant-parent attachment security. Developmental Psychology, 32, 5, 921-924.

Berger, J. (1990). Interactions between parents and their infants with Down syndrome. In D. Cicchetti & M. Beeghly (Eds.), Children With Down Syndrome: A Developmental Perspective (pp. 101-146). Cambridge: Cambridge University Press.

- Berger, J., & Cunningham, C.C. (1981). The development of eye contact between mothers and normal versus Down's syndrome infants. Developmental Psychology, 17, 5, 678-689.
- Blehar, M.C., Lieberman, A.F., & Ainsworth, M.D.S. (1977). Early face-to-face interaction and its relations to later infant-mother attachment. Child Development, 48, 182-194.
- Bolen, R.M. (2000). Validity of attachment theory. Trauma, Violence & Abuse, 1, 2, 128-153.
- Boris, N.W., Fucyo, M., & Zeanah, C.H. (1997). The clinical assessment of attachment in children under five. Journal of the American Academy of Child and Adolescent Psychiatry, 36, 2, 291-310.
- Boris, N.W., Zeanah, C.H., Larrieu, J.A., Scheeringa, M.S., & Heller, S.S. (1998). Attachment disorders in infancy and early childhood: A preliminary investigation of the diagnostic criteria. American Journal of Psychiatry, 155, 2, 295-297.
- Bowlby, J. (1969). Attachment, vol. 1 of Attachment and Loss. London: Hogarth Press.
- Bowlby, J. (1973). Separation: Anxiety and Anger, vol. 2 of Attachment and Loss. London: Hogarth.

Bowlby, J. (1988). A Secure Base: Clinical Applications of Attachment Theory.

London: Tavistock/Routledge.

Bretherton, I. (1991). The roots and growing points of attachment theory. In C.M.

Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), Attachment Across the Life Cycle, London: Tavistock/Routledge.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary

Ainsworth. Developmental Psychology, 28, 759-755.

Bretherton, J., & Waters, E. (1985). Growing points of attachment theory and

research. Monographs of the Society for Research in Child Development, 50, (S1-2, Serial No. 209).

Byng-Hall, J. (1991). The application of attachment theory to understanding and

treatment in family therapy. In C.M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), Attachment Across the Life Cycle, (p. 199-215) Routledge: London.

Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989).

Disorganised/disorientated attachment relationships in maltreated infants.

Developmental Psychology, 25, 4, 525-531.

Cassidy, J. (1990). Theoretical and methodological considerations in the study

of attachment and the self in young children. In M.T. Greenberg, D. Cicchetti, & E.M. Cummings, Attachment in the Preschool Years: Theory, Research and Intervention (p. 87-120). Chicago: The University of Chicago Press.

- Cassidy, J. & Berlin, L.J. (1994). The insecure/ambivalent patterns of attachment: Theory and research. Child Development, 65, 971-991.
- Cicchetti, D., & Serafica, F.C. (1981). The interplay among behavioural systems: Illustration from the study of attachment, affiliation, and wariness in young Down's syndrome children. Developmental Psychology, 17, 36-49.
- Cicchetti, D., & Sroufe, L.A. (1978). An organizational view of affect: Illustration from the study of Down's syndrome infants. In M. Lewis & L.A. Rosenblum (Eds.), The Development of Affect (p. 309-350). New York: Plenum.
- Clarke-Stewart, K.A. (1973). Interactions between mothers and their young children: Characteristics and consequences. Monographs of the Society for Research in Child Development, 38, (5-6 Serial No. 153), 1-108.
- Coggins, T.E., & Morrison, J.A. (1981). Spontaneous imitations of Down's syndrome children: A lexical analysis. Journal of Speech and Hearing Research, 24, 2, 303-308.
- Crittenden, P.M. (1992). Quality of attachment in the preschool years. Development and Psychopathology, 3, 175-190.
- Crittenden, P.M. & Ainsworth, M.D. (1989). Child maltreatment and attachment theory. In D. Cicchetti (Ed.), Handbook of Child Maltreatment Theory and Research: A Life-Span Developmental Perspective.

- Davies, P.T., & Cummings, E.M. (1994). Marital conflict and child adjustment: An emotional security hypothesis. Psychological Bulletin, 116, 387-411.
- Daw, J. (1996). Family Therapy and ADHD. Family Therapy News, 14.
- DeAngelis, T. (1997). Psychologists are providing a controversial treatment for reactive attachment disorder. APA Monitor [On-line].
www.apa.org/monitor/jun97/disorder.html.
- De Wolff, M.S. & van IJzendoorn, M.H. (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment. Child Development, 68, 571-591.
- Down Syndrome Association Victoria, (2000) www.dsav.asn.au.
- DuPaul, G.J., McGoe, K.E., Eckert, T.L., Vanbrakle, J. (2001). Preschool Children with Attention Deficit/Hyperactivity Disorder: Impairments in behavioural, social and school functioning. Journal of the American Academy of Child and Adolescent Psychiatry, 40, 5, 508-521.
- Encarta (1999). Down syndrome. Microsoft Corporation 1993-1998.
- Erdman, P. (1998). Conceptualizing ADHD as a contextual response to parental attachment. American Journal of Family Therapy, 26, 2, 177-186.

- Erickson, M.F. (1991). The importance of attachment in children's development. Early Report, 18, 2, 6-18.
- Farran, D.C. (1990) Effects of intervention with disadvantaged and disabled children: A decade review. In S.J. Meisels & J.P. Shonkoff (Eds.), Handbook of Early Intervention, (pp 501-539). Cambridge: Cambridge University Press.
- Feeney, J.A., Hohaus, L. Noller, P. & Alexander, R.P. (2001). Becoming Parents: Exploring the Bonds between Mothers, Fathers, and Their Infants. NY: Cambridge University Press.
- Field, T. (1991). Attachment and early separations from parents and peers. In J.L. Gewirtz & W.M. Kurtines (Eds.), Intersections with Attachment, (p. 165-179). Hillsdale: NJ: Lawrence Erlbaum and Associates.
- Fonagy, P. (2001). Attachment Theory and Psychoanalysis. New York: Other Press.
- Fonagy, P., Steele, H., Leigh, T., Kennedy, R., Mattoon, G., Target, M. (1995). Attachment, the reflective self, and borderline states: The predictive specificity of the Adult Attachment Interview and pathological development. In S. Goldberg, R. Muir, J. Kerr (Eds.), Attachment Theory, Social, Developmental and Clinical Perspectives. London: Analytic Press.
- Friedrich, W.N. (1996). Child Sexual Behaviour Inventory. Psychological Assessment Resources.

- Fyffe, C. (1996). The contribution of intentional and automatic processes to the recognition memory of people with an intellectual disability. Unpublished PhD thesis, Monash University, Melbourne, Australia.
- Gibson, D., & Harris, A. (1988). Aggregated early intervention effects for Down's syndrome persons: Patterning and longevity of benefits. Journal of Mental Deficiency Research, 32, 1-17.
- Goldsmith, H.H., & Alansky, J.A. (1987). Maternal and infant temperamental predictors of attachment: A meta-analytic review. Journal of Consulting and Clinical Psychology, 55, 805-816.
- Graensbauer, T.J., & Harmon, R.J. (1982). Attachment in abused, neglected and premature infants. In R.N. Emde & R.J. Hamon (Eds.), The Development of Attachment and Affiliative Systems (p. 263-280). New York: Plenum Press.
- Green, C. & Chee, K. (1997). Understanding ADHD (Attention Deficit Hyperactivity Disorder). Sydney: Doubleday.
- Greenberg, M.T., Cicchetti, D., & Cummings, E.M. (1990). Introduction: History of a collaboration in the study of attachment. In M.T. Greenberg, D. Cicchetti, & E.M. Cummings, Attachment in the Preschool Years: Theory, Research and Intervention (p. xiii - xix). Chicago: The University of Chicago Press.
- Grossman, K.E., & Grossman, K. (1991). Attachment quality as an organizer of

- emotional and behavioural responses in a longitudinal perspective. In C.M. Parkes, J. Stevenson-Hinde, & P. Marrie (Eds.), Attachment Across the Lifecycle (p. 93-114). London: Tavistock/ Routledge.
- Hess, E.H., & Petrovich, S.B. (1991). Ethology and attachment: A historical perspective. In J.L. Gewirtz & W.M. Kurtines (Eds.), Intersections with Attachment, (p. 55-68). Hillsdale: NJ: Lawrence Erlbaum and Associates.
- Hewitt, S. (1999). Touch Survey.
- Hughes, D.A. (1999). Adopting children with attachment problems. Child Welfare, 78, 5, 541-560.
- Isabella, R. (1993). Origins of attachment: Maternal interactive behaviour across the first year. Child Development, 64, 605-621.
- James, B. (1994). Handbook for Treatment of Attachment-Trauma Problems in Children. New York: The Free Press.
- Karen, R. (1994). Becoming Attached: First Relationships and How They Shape Our Capacity to Love. New York: Oxford University Press
- Lamb, M.E., Thompson, R.A., Garnder, W., & Charnov, E.L. (1985). Infant-mother attachment: Origins and developmental significance of individual differences in strange situation behaviour. Hillsdale, NJ: Lawrence Erlbaum.

- Landry, S.H., & Chapieski, M.L. (1990). Joint attention of six-month-old Down syndrome and preterm infants: Attention to toys and mother. American Journal on Mental Retardation, 94, 5, 488-498.
- Lewis, M., & Feiring, C. (1989). Attachment as personal characteristic or a measure of environment. In J.L. Gewirtz & W.M. Kurtines (Eds.), Intersections with Attachment (p. 1-21). Hillsdale NJ: Erlbaum.
- Lewis, M., Feiring, C., & Rosenthal, S. (2000). Attachment over time. Child Development, 71, 3, 707-720.
- Lieberman, A.F., & Pawl, J.H. (1990). Disorders of attachment and secure base behaviour in the second year of life: Conceptual issues and clinical intervention. In M.T. Greenberg, D. Cicchetti, & E.M. Cummings, Attachment in the Preschool Years: Theory, Research and Intervention (p. 375-398). Chicago: The University of Chicago Press.
- Main, M., & Cassidy, J. (1988). Categories of response with the parent at age six: Predicted from infant attachment classifications and stable over a one month period. Developmental Psychology, 24, 415-426.
- Main, M., & Goldwyn, R. (1991). 'Interview-based adult attachment classifications: related to infant-mother and infant-father attachment', Developmental Psychology. Cited in C.M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), Attachment Across the Life Cycle. London: Tavistock/Routledge.

- Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganised attachment status: Is frightened and/or frightening parental behaviour the linking mechanism? In M.T. Greenberg, D. Cicchetti, & E.M. Cummings, Attachment in the Preschool Years: Theory, Research and Intervention (p. 161-182). Chicago: The University of Chicago Press.
- Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), Monographs of the Society for Research in Child Development Serial 209, (p. 66-104). Chicago: University of Chicago Press.
- Main, M., & Solomon, J. (1986). Discovery of a new, insecure-disorganised/disorientated attachment pattern. In T.B. Brazelton & M. Yogman (Eds.), In Support of Families. Norwood, NJ: Ablex.
- Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganised/disorientated during the Ainsworth strange situation. In M.T. Greenberg, D. Cicchetti, & E.M. Cummings, Attachment in the Preschool Years: Theory, Research and Intervention (p. 121-160). Chicago: The University of Chicago Press.
- Marris, P. (1993). Loss and Change. London & New York: Routledge.
- Marvin, R. Cooper, G., Hoffman, K., & Powell, B. (2002). The circle of security

project: Attachment-based intervention with caregiver-pre-school child dyads.
Attachment & Human Development, 4, 1, 107-124.

Maslin-Cole, C. & Spieker, S.J. (1990). Attachment as a basis for
 independent motivation: A view from risk and nonrisk samples. In M.T.
 Greenberg, D. Cicchetti, & E.M. Cummings, Attachment in the Preschool
 Years: Theory, Research and Intervention (p. 245-272). Chicago: The
 University of Chicago Press.

Matteoli, L. (1999). Frederick II Hohenstaufen: a “modern” medieval Emperor.
www.matteoli.iinet.net.au/html/Articles/FrederickII-Eng.html

Milgrim, N.A. (1973). Cognition and language in mental retardation: Distinctions and
 implications. In D.K. Routh (Ed.). The Experimental Psychology of Mental
 Retardation (pp 157-230). Chicago: Aldine.

Mitchell, S.A. (2000). Relationality: From Attachment to Intersubjectivity. Hillsdale
 NJ: The Analytic Press.

Morelli, G.A., & Tronick, E.Z. (1991). Efe multiple caretaking and attachment. In J.L.
 Gewirtz & W.M. Kurtines (Eds.), Intersections with Attachment, (p. 41-51).
 Hillsdale: NJ: Lawrence Erlbaum and Associates.

Pastor, D.L. (1981). The quality of mother-infant attachment and its relationship to
 toddler's initial sociability with peers. Developmental Psychology, 17, 326-
 335.

- Rcber, K.(1996). Children at risk for reactive attachment disorder: Assessment, diagnosis and treatment. Progress: Family Systems Research and Therapy.
- Raval, V., Goldberg, S., Atkinson, L., Benoit, D., Myhal, N., Poulton, L., & Zwiers, M. (2001). Maternal attachment, maternal responsiveness and infant attachment. Infant Behaviour & Development, 24, 281-304.
- Richters, M..M., & Volkmar, F.R. (1994). Reactive attachment disorder of infancy or early childhood. Journal of the American Academy of Child and Adolescent Psychiatry, 35, 3, 328-332.
- Rutter, M. (1971). Parent-child separation: Psychological effects on the children. Journal of Child Psychology and Psychiatry, 12, 223-260.
- Saenz, R.B. (1999). Primary care of infants and young children with Down syndrome. American Family Physician, January, 1-12.
- Schaffer, H.R., & Emerson, P.E. (1964). The development of social attachments in infancy. Monographs of the Society for Research in Child Development, 29, (3, Serial No. 94).
- Slade, A. (1998). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. Shaver (Eds.), The Handbook of Attachment Theory and Research. New York: Guilford Press.

- Smyke, A.T., Dumitrescu A., & Zcanah, C.H. (2002). Attachment disturbances in young children. I: The continuum of caretaking casualty. Journal of the American Academy of Child and Adolescent Psychiatry, 41, 8, 972-983.
- Spitzer, R., & Cantwell, D., (1980). The DSM-III classification of the psychiatric disorder of infancy, childhood and adolescence. Journal of the American Academy of Child and Adolescent Psychiatry, 19, 256-370.
- Sroufe, L.A. (1983). Infant-caregiver attachment and patterns of adaptation in preschool: The roots of maladaptation and competence. In M. Perlmutter (Ed.), Development and Policy Concerning Children with Special Needs: The Minnesota Symposia on Child Psychology (vol 16, p. 41-83). Hillsdale: Erlbaum.
- Sroufe, L.A. (1985). Attachment classification from the perspective of infant-caregiver relationships and infant temperament. Child Development, 56, 1-14.
- Sroufe, L.A. (1988). The role of infant-caregiver attachment in development. In J. Belsky & T. Nezworski (Eds.), Clinical Implications of Attachment (p. 18-40). Hillsdale: Erlbaum.
- Sroufe, L.A., & Waters, F. (1977). Attachment as an organizational construct. Child Development, 48, 1184-1199.
- Stratford, B. & Gunn, P. (1996). New Approaches to Down Syndrome. London:

Cassell.

Thompson, R.A. (1997). Sensitivity and security: New questions to ponder. Child Development, 68, 4, 595-597.

Thompson, R.A., Cicchetti, D., Lamb, M.E., & Malkin, C. (1985). Emotional responses of Down syndrome and normal infants in the strange situation: The organization of affective behaviour in infants. Developmental Psychology, 21, 5, 828-841.

Trumble, S. (1993). How to treat people with Down syndrome: Some tips for family physicians. <http://www.nas.com/downsyn/trumble.html>.

Urban, J., Carlson, E., Egeland, B., & Sroufe L.A. (1991). Patterns of individual adaptation across childhood. Development and Psychopathology, 3, 445-460.

van den Boom, D.C. (1997). Sensitivity and attachment: Next steps for developmentalists. Child Development, 64, 4, 592-594.

van IJzendoorn, M.H. (1995). Adult attachment representations in mothers, fathers, adolescents, and clinical groups: A meta-analysis on the predictive validity of the Adult Attachment Interview. Psychology Bulletin, 117, 387-403.

van IJzendoorn, M.H., Juffer, F., & Duyvesteyn, M.G.C. (1995). Breaking the

intergenerational cycle of insecure attachment: A review of the effects of attachment-based interventions on maternal sensitivity and infant security. Journal of Child Psychology and Psychiatry, 36, 225-248.

Vaughn, B.E., Egeland, B., Sroufe, L.A., & Waters, E. (1979). Individual differences in infant-mother attachment at 12 and 18 months: Stability and change in families under stress. Child Development, 50, 971-975.

Waters, E., Wippman, J., & Sroufe, L.A. (1979). Attachment, positive affect and competence in the peer group: Two studies in construct validity. Child Development, 50, 821-829.

Wechsler, D. (1989). Wechsler Preschool and Primary Scale of Intelligence. San Antonio: The Psychological Corporation.

Weiss, B., Weisz, J.R., & Bromfield, R. (1986). Performance of retarded and non-retarded persons on information-processing tasks: Further tests of the similar structure hypothesis. Psychological Bulletin, 100, 157-175.

Weisz, J.R., Yeates, K.O., & Ziegler, E. (1982). Piagetian evidence and the developmental-difference controversy. In E. Zigler & D. Balla (Eds.). Mental Retardation: The Developmental-Difference Controversy, (pp 213-276). New Jersey: Lawrence Erlbaum Associates.

Wilson, S.L. (2001). Attachment disorders: Review and current status. The Journal of Psychology, 135, 1, 37-52.

- Zeanah, C.H. (1996). Beyond insecurity: A reconceptualisation of attachment disorders in infancy. Journal of Consulting and Clinical Psychology, 64, 1, 42-52.
- Zeanah, C.H., & Emde, R.N. (1994). Attachment disorders in infancy. In M. Rutter, L. Hersov, & E. Taylor (Eds.), Child and Adolescent Psychiatry: Modern Approaches (p. 490-504). Oxford: Blackwell.
- Zeanah, C.H., Smyke, A.T., & Dumitrescu, A. (2002). Attachment disturbances in young children. II: Indiscriminate behaviour and institutional care. Journal of the American Academy of Child and Adolescent Psychiatry, 41, 8, 983-990.
- Zigler, E. (1982). Developmental versus difference theories of mental retardation and the problem of motivation. In E. Zigler & D. Balla (Eds.), Mental Retardation: The Developmental-Difference Controversy, (pp 163-211). New Jersey: Lawrence Erlbaum Associates.
- Zimmerman, P., Fremmer-Bombik, E., Spangler, G., & Grossman, K.E. (1997). Attachment in adolescence: A longitudinal perspective. In W. Koops, J.B. Hoeksema, & D.C. van den Boom (Eds.), Development of interaction and attachment: Traditional and non-traditional approaches, (p. 281-291). Amsterdam: North-Holland.