Center for Family Development

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Notes on Attachment
Arthur Becker-Weidman, Ph.D.

A high percentage of the children that I see are foster or adopted children who have lived in one or more foster homes and have suffered from neglect and/or abuse. Often the children come with a diagnosis of Oppositional Defiant Disorder [ODD] or Conduct Disorder [CD]. Many have a secondary diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD). The child's symptoms could also be understood as a Post Traumatic Stress Disorder or depression stemming from a delayed grief reaction in response to one or more significant losses early in childhood. Whatever the diagnosis is, it is important that the developmental history receives the consideration required to provide the appropriate treatment.

Because attachment is developed in the first years of life, often times the trauma driving the child's pathology is preverbal. The child needs a solid educational component of treatment for the child to understand what force is driving the feelings and controlling the child's behavior. The parents also need the education and understanding that the child's behavior is not caused from their parenting, but from past traumas. From this base then, new parenting interventions can be designed from a cooperative relationship to fit a child with special needs.

Attachment is the base upon which emotional health, social relationships, and one's world view are built. The ability to trust and form reciprocal relationships will affect the emotional health, security and safety of the child, as well as the child's development and future interpersonal relationships. The attachment-disordered child does whatever she feels like, with no regard for others. She is unable to feel remorse for wrongdoing, mainly because she is unable to internalize right and wrong. This child may be savvy enough to speak knowledgeably about standards and values, but cannot truly understand or believe what she is saying. The child may tell you that something is wrong, but that will not stop her from doing it.

Children who are adopted after the age of 6 months or so are at risk for attachment problems. Normal attachment develops during the child's first two years of life. Problems with the parent-child relationship during that time, or breaks in the consistent caregiver-child relationship, prevent attachment from developing normally. There is a wide range of attachment problems that result in varying degrees of emotional disturbance in the child. The severity of attachment disorder seems to result from the number of breaks in the bonding cycle and the extent of the child's emotional vulnerability.

Emotional vulnerability can be affected by a variety of factors including: genetic factors; prenatal development including maternal drinking and drug abuse; pre-natal nutrition and stress; Fetal Alcohol Syndrome and Fetal Alcohol Effect; temperament; and birth parent history of mental illness (schizophrenia, manic depressive illness, etc.). One thing is certain: if an infant's needs are not met consistently in a loving, nurturing way, attachment will not occur normally.

So how can we tell the difference between a child who "looks" attached, and a child who really is making a healthy, secure attachment? This question becomes important for adoptive families, because some adopted children will form an almost immediate dependency bond to their adoptive parents. To mistake this as secure and healthy attachment can lead to many problems down the road. Just because a child calls someone "Mom" or "Dad," snuggles, cuddles, and says "I love you," does not mean that the child is attached, or even attaching. Saying, "I love you," and knowing what that really feels like can be two different things. Attachment is a process. It takes time. The key to its formation is trust, and trust becomes secure only after repeated testing.

Normal attachment takes a couple of years of cycling through mutually positive interactions. The child learns that he is loved, and can love in return. The parents give love, and learn that the child loves them. The child learns to trust that his needs will be met in a consistent and nurturing manner, and that the he "belongs" to his family, and they to him. Positive interaction. Trust. Claiming. Reciprocity (the mutual meeting of needs, give and take). These must be consistently present for an extended period of time for healthy, secure attachment to take place. It is through these elements that a child learns how to love and how to accept love.

Older adopted children need time to make adjustments to their new surroundings. They need to become familiar with their caregivers, friends, relatives, neighbors, teachers and others with whom they will have repeated contact. They need to learn the ins and outs of their new household routines and adapt to living in a new physical environment. Some children have cultural or language hurdles to overcome. Until most of these tasks have been accomplished, they may not be able to relax enough to allow the work of attachment to begin. In the meantime, behavioral problems related to insecurity and lack of attachment, as well as to other events in the child's past, may start to surface. Some start to get labels like, "manipulative," "superficial," or "sneaky." Sooner or later the family may decide that this kid is all "take" and no "give." The child "gives" only when it is to his own benefit. The child can seem to be very selfish and controlling. On the inside, she is filled with anxiety. She has not developed the self-esteem that comes with feeling she's a valued, contributing member of a family. The child cares little about pleasing others, since her relationship with them is quite superficial.

First Year of Life Cycle

The first year is a year of needs. When the infant has a need, it initiates attachment behavior in order to summon a nurturing response from the attachment figure. The need-gratifying response usually includes touch, eye contact, movement, smiles and lactose. When gratification occurs, trust is built. This cycle occurs hundreds of times a week and thousands of times in the first year. From this relationship, a synchronicity develops between parent and child. The caregiver develops a greater awareness of the child and learns just how to respond. The child develops good cause-and-effect thinking, feels powerful, trusts others, shows exploratory behavior and develops empathy and a conscience.

Parenting children with attachment difficulties is a job that requires a great deal of patience, understanding, courage, solid support systems and personal fortitude. Children with attachment difficulties rarely and only superficially return love. Therapists, teachers, child protective services and even spouses often do not understand the challenge and deception an attachment-disordered child displays toward an adoptive or foster parent in charge of primary care. Often times the child will project the greatest amount of pathology towards the mother figure in an attempt to make the world believe that if the mother was not so harsh and controlling, the child would be as lovable as he superficially displays.

Therapists often times are introduced to attachment disorder cases by witnessing a burned-out parent in their office who is angry, resentful and full of blame toward their child. The child, however, is engaging, full of energy, innocent and displaying confusion at the parent's anger. Unfortunately, the therapist reacts by thinking (and sometimes saying), "If this mom would just lighten up on this kid, she would not have so many problems." This can lead the therapist to scolding the parent much in the same way the parent scolds the child. Many well-intentioned but naive healthcare workers believe that, "All this kid needs is love," and end up creating an alliance with the child against the parents that further prevents the family getting the help they desperately need.

Treatment

The basic purpose of Dyadic Developmental Therapy is to help the child resolve a dysfunctional attachment. The goal is to help the child bond to the parents and to resolve the fear of loving and being loved.

A major dynamic in the treatment is the regressive work needed to heal the emotional wounds that drive these children's behavior. Treatment allows the child to access deep, genuine, and intense emotions needed to work through the feelings, not simply get over them. A corrective emotional experience is orchestrated when allowing the child to express these feelings, recognize and recall them, and identify the events and the people involved. In essence, the child going through this experience with their parents allows for resolution of old pathological emotions while simultaneously creating powerful new bonds.