Understanding and Treating Attachment Problems in Children: What Went Wrong, and How Can Problems Be Fixed

Dave Ziegler, Ph.D.
Executive Director

Jasper Mountain
37875 Jasper-Lowell Road
Jasper, Oregon

Abstract

Developmental psychology, child development and clinical application with trauma have all placed important roles in a new understanding of attachment and bonding problems in early childhood. This article is broken into two parts. Part I discusses the important role that attachment plays in the future social success of children. It explains the tenants of traditional attachment theory and how trauma affects healthy attachment. This discussion continues with revisions to attachment theory that respond to its historical weak points. A new theoretical view of attachment is proposed identifying the causes of attachment behavior. Part II turns to clinical aspects of the treatment of attachment problems. Problems caused by trauma are identified and the many therapeutic complexities are outlined. A model for treating attachment disturbances is proposed that discusses the clinical process in three distinct areas: disrupted attachment, anxious attachment, and no attachment. The article ends with a discussion of the prognosis for a successful outcome and projects time requirements for attachment disorder therapy.

Understanding and Treating Attachment Problems in Children: What Went Wrong and How Can Problems Be Fixed

Introduction

The study of Psychology over the last hundred years can be compared to reading a novel starting late into the book and reading progressively backwards to the beginning. Our understanding of the complex mind and psychological make-up of Homo Sapiens has begun with adults, moved to young adults, teens, adolescents, toddlers and finally we are beginning to read with great interest the first chapters of life. As we have done this over the last thirty years, there have been continuous professional awakenings occurring as the antecedents of social, mental, and moral distress begin to tell their stories in very young children. The purpose of this article is to collect the blinding flashes of insight as well as the mundane aspects of research in order to begin to tell the story of how the patterns and organization of a human personality are established in how an infant enters the stage and what happens early in the first act. The theme of a person's story and, to a large extent, the fundamental success or failure of their entire life, is established in their early attachment and bonding with their environment.

We are just learning to understand very early childhood and the pre cursors to social and interpersonal success or failure. This is assisting us in beginning to see clearly how patterns of dysfunction in adulthood can be casually linked to the quality of very early attachment.

Part I Attachment Problems—What Went Wrong

How important is a secure attachment in setting the stage for personality traits and patterns of interpersonal and social success? The following quote by Mary Slater Ainsworth sums it up well:

> Securely attached [infants] are later more cooperative with and affectively more positive as well as less aggressive and/or avoidant toward their mothers and other less familiar adults. Later on, they emerge as more competent and more sympathetic in interaction with peers. In free-play situations they have longer bouts of exploration and display more intense exploratory interest, and in problem solving situations they are more enthusiastic, more persistent, and better able to elicit and accept their mothers' help. They are more curious, more self-directed, more ego-resilient – and they usually tend to achieve better scores on both developmental tests and measures of language development (Ainsworth 1979).

Some of the most severe attachment disorders are found with abused and neglected children. The trauma of abuse produces formidable hurdles for these children to

overcome. Neither the children nor society can afford for them to also have serious attachment deficits.

Attachment is defined by James as "a reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver" (James, 1994). Research with primates has shown the more advanced the species, the longer it takes to mature (Bowlby, 1982). The evolutionary message encoded in this phenomenon is that Homo Sapiens not only do better in a social network, but survival itself requires sophisticated levels of social interaction for many years following birth. The natural selective process has made humankind the most dependent of creatures on one another. The social survival network that is first and foremost in importance is the attachment bond with one or more primary care providers. To facilitate this, humans have instinctual patterns leading to survival that involve social mechanisms. Bowlby describes the role of instinct in the process of attachment as "a complex weave of survival and adaptability combined with fixed action patterns in a feedback loop with the environment" (Bowlby, 1982). Without attachment, survival is very much in doubt for one of nature's most helpless of creatures at birth.

Since Bowlby's early work on attachment starting in the fifties, it has been believed that attachment and bonding may well be one of the essential keys to explaining the most fundamental psychological and social problems. We now have significant research to confirm this global belief that a person's basic psychological disposition can be established very early in life. The way a child begins to understand their surroundings, what Bowlby called "inner working models," has been found to influence a child's perceptions from early childhood on into adulthood (Sroufe, 1988). An abused child may develop a working model of distrusting all relationships, a topic that will be explained further in Part II. Ainsworth's research on child abuse shows an effect abuse has on the development of a child far into the future (Ainsworth, 1978). Studies have shown that infants whose relationships with their mothers are more secure are more competent as toddlers, preschoolers and public school students (Belsky, 1988). The belief that attachment may have a generational dimension was given credence in a study that found that the history of nurturance the mother experienced in her own childhood predicted the quality of the attachment she developed with her own infant (Lewis, 1984). Abusive mothers have been shown to be more emotionally sensitive to their infants than neglectful mothers, but less sensitive than non-abusive mothers (Crittenden, 1981). It has also been found that socially withdrawn children are more likely to come from insensitive mothers, and social withdrawal from peers predicts future social problems (Rubin, 1988). Although the Rubin study focused on mothers who were insensitive due to a lack of awareness, there is a perhaps greater risk for children of mothers who are aware of what the child needs and wants but do not respond. Research has shown a link between attachment insecurity and later behavioral problems (Erickson, 1985). Foundations of social success were found in a study showing secure attachments predicted: more competence with peer

relationships, a more positive disposition, higher levels of empathy, and having more friends as the child matured (Lewis, 1984). In yet another study, securely attached infants at eighteen months were more enthusiastic, persistent, cooperative and more effective (Matos, Arend, and Sroufe, 1978). The nature and quality of primary attachments have predicted socially meaningful characteristics in later life (Bates, 1988). The above are just a few samples of the significant research findings over the last twenty years in this area.

More specific to trauma and abuse, research has also shown that abused and neglected children are more likely to show avoidance of their mothers and resistance to the mother after even a brief separation (Belsky and Nezworski, 1988). Abused children have also been found to be more difficult to raise, while neglected children are more passive, and children in supportive environments are more cooperative (Crittenden, 1981). And finally, a study resulted in the ominous conclusion that anti-social children become adults with disproportionately high rates of alcoholism, accidents, chronic unemployment, divorce, physical and psychiatric illnesses and welfare involvement—some of the definitional characteristics of societal casualties (Caspi, 1987).

In Psychology, as in medicine, we are much quicker to identify a problem than the causes or the solutions to the problem. It is clear that our society has many dysfunctional members. There are well over one million men and women in our jails and prisons. The majority of men and women in our correctional institutions were abused children and many have lived a life of anti-social behavior beginning in childhood. Our drug and alcohol programs are full with waiting lists, domestic violence, divorce and broken homes are at the highest level in our history. Poverty, unemployment and hopelessness exit in abundance in modern America. Although causative cultural phenomena can be identified, failure in our society is experienced one person at a time and one life at a time. How do some people beat the odds while others have the odds beat them? Some of the most exciting answers to this question are coming from the study of early dispositional patterns developed in childhood, or what can be called secure and insecure attachment. Bowlby addresses the importance of attachment in the following statement:

> A young child's experience of an encouraging, supportive and co-operative mother, and a little later father, gives him a sense of worth, a belief in the helpfulness of others, and a favorable model on which to build future relationships. Furthermore, by enabling him to explore his environment with confidence and to deal with it effectively, such experience also promotes his sense of competence. Thenceforward, provided family relationships continue favorably, not only do these early patterns of thought, feelings and behavior persist, but the personality becomes increasingly structured to operate in moderately controlled and resilient ways, and increasingly capable of continuing so despite adverse circumstances. Other types of early childhood and later experience have

> effects of other kinds, leading usually to personality structures of lowered resilience and defective control, vulnerable structures which also are apt to persist. Thereafter on how someone's personality has come to be structured turns his way of responding to subsequent adverse events, among which rejections, separations and losses are some of the most important (Bowlby, 1982).

Attachment Theory

It must be said from the outset that the following is an extremely brief treatment of traditional attachment theory and can only touch on some of the major areas of a very complex topic.

What is being called traditional attachment theory was first advanced by an English psychiatrist who was initially trained as a Freudian psychoanalyst. This psychiatrist, John Bowlby, had an initial goal in 1956 to explain the loss behavior of very young children in Freudian terms. From this beginning, research and clinical practice has steadily grown and in some ways is just now hitting its stride, forty years after its beginnings.

Initially Bowlby, as well as other clinicians, had noticed in young children's response to loss that there was a somewhat predictable sequence of behaviors: first, the child protested with anger and rage; second, the child became depressed and showed despair; and finally, the child became detached from people and the environment (Bowlby, 1982).

One of the first methods to understand this behavior was research with primates. Researchers found that young primates gravitated to stimuli of low, familiar, limited range of magnitude and avoided stimuli of a high, irregular, extensive range of magnitude. This indicated an organismic preference for the predictable and calming over chaos. When these animals were raised in extremely restricted environments they would respond with two equally unproductive reactions-either approach all stimuli or avoid all stimuli. It was consistently found that when primates were raised in an environment where its evolutionary adaptedness did not fit the environment, it would develop bizarre and, at times, non-survival behaviors (Bowlby, 1982).

Primate research was subsequently replicated with humans with the same results. It was found that humans' attachment had a lot to do with the infant experiencing its needs being met and also how these needs were met. For example being given a bottle to feed is qualitatively different than the touch, warmth and comfort of breast feeding with the mother (Bowlby, 1982).
As Bowlby's discovery work on attachment proceeded, he found no simple explanations for human attachment but a complex succession of increasingly

sophisticated systems mediating attachment behavior. These included the following systems: instinct, physical, emotional and social systems.

Instinct

A major influence upon attachment is instinct. For Bowlby, attachment is as instinctual as sexual behavior and parenting behavior. The first instincts of primary importance are the instincts to survive, to be social, and to be adaptable to the environment. How these three instincts interact is as important as each are individually.

Instincts are not restricted to infants, they also affect the mother. Although an infant appears to be predisposed or "wired" to the voice, smell and face of the mother, in a similar manner the mother is instinctively predisposed to respond in a protective and nurturing manner. Mother's are wired to develop an ideal level of proximity to the infant. Studies with mothers have indicated that the young age of a mother and a low educational level signal risk factors in providing a nurturing environment (Sroufe, 1986). One specific example of the mother/child instinctive reciprocity is smiling, which in infants is reserved initially for a human face and voice. Smiling is one of the first vehicles of communication (Bowlby, 1982).

Despite the importance of instincts on attachment, these mechanisms are not tamper proof. Deviations in evolutionary adaptedness, as Bowlby describes instinctive behaviors that don't achieve the desired results, can produce maladaptive behavior patterns. These patterns can include being at odds with the child's own best interests or even working against survival itself. Bowlby believes that instinctive behaviors can be thwarted, which could make them revert back to more primitive behavioral levels or become cross wired with their inherent purpose to promote reciprocal social bonding (Bowlby, 1982). When this occurs, a negative cycle develops with the child slipping further and further away from the instinctive goal of connection.

Physical, Emotional and Social Factors

The three important components of attachment theory are physical, emotion and social dimensions.

Physical factors influencing attachment involve aspects of human physiology including hormones and the central nervous system. The slow development of the pre-frontal lobes of the brain may have infants acting primarily on the pleasure principle enhancing attachment with the mother (Bowlby, 1982). The importance of physical touch and other senses have already been mentioned.

Emotional bonds are developed (or not developed) rapidly in infants and once established they are long lasting. The apparent role of emotions in the attachment process appears to assist in appraisal of both the infant's internal organismic states also of the external environment. Bowlby calls this affective appraisal intuition.

Social reciprocity is the purpose of attachment. To facilitate social behavior, early responses to stimuli become more discriminating with age—for example, an infant may initially respond to a picture of a face, then to a real face, then to a particular real face. Physical sensations combine with the infant's emotional/intuitive appraisal, producing behavior that is social or anti-social. Only if the child can accurately assess the affective state of another person can they productively participate in a social interchange (Bowlby, 1982).

Attachment Theory Behaviorally Defined

Attachment theory that has come from Bowlby's work has been primarily defined in behavioral terms and can be summarized in eight important steps: 1) Social responses are first elicited by a wide array of stimuli, then this gradually narrows and after several months becomes confined to one or more individuals, 2) A bias develops to respond more to certain kinds of stimuli than to others, 3) The more experiences of positive social interaction with a person, the stronger the attachment becomes, 4) Exposure to human faces produces discrimination in the attachment figure, 5) The timing of attachment is critical and needs to develop during the sensitive period within the first year, 6) The sensitive phase begins sometime after six weeks (this position has subsequently been criticized), 7) At the end of the sensitive period, the infant responds to non-attachment figures with a fear response, making it difficult to attach after one year, and finally 8) Once a child becomes strongly attached, they prefer this person over all others despite separation (Bowlby, 1982).

Efficacious and Problematic Behaviors

Bowlby breaks attachment behaviors into minute details. He addresses the important roles of crying, smiling, clinging, feeding, signaling, approaching, greeting and maintaining proximity. All these can be used to observe a developing bond.

There are also disruptive behavior patterns that can develop which are contrary to the attachment process. The very early affective or intuitive appraisal of the environment develops standards or "set points" by which situations are measured. When set points are maladapted due to early disruptions, parental bonding behaviors may be met with anxiety, alarm, and anger (Bowlby, 1982).

A variety of other behavior patterns can develop problems. Early negative experiences with hunger, illness, unhappiness and pain can produce disrupted bonding. If an infant's signaling is not responded to in either, sufficient quantity or quality, withdrawal can occur. Children have egocentrism, which means that after twelve months of age, they often construct their own internal world, and can ignore exterior information that contradicts this internal world (Bowlby, 1982).

Infants have predictable responses to separation of the attachment figure. When separations are short, the reconnection is usually rapid. However, longer separations can produce anything from distress, to the child rejecting the attachment figure (Bowlby, 1982).

When the focus turns to abused children, studies have found several important outcomes: abused children show significantly more frequent assaultive, harassing and threatening behaviors, they can respond to friendly overtures either by avoiding interaction or by mixed avoidance and approach, and they alienate and avoid adults who might help them, which can develop a self-perpetuating cycle (George and Main, 1979).

A New View of Attachment Theory Based on Trauma

Bowlby's theoretical treatment of attachment remains the most complete and influential viewpoint twenty-six years after it was first published. Few theories hold up over time without moderate to substantial modification and alteration. Bowlby's theory is somewhat of an exception, although it is not without flaws. Perhaps the biggest flaw in traditional attachment theory is its exclusive emphasis on behavior. Attachment behavior was later to be recognized as the outgrowth of attachment and not the attachment itself. Bowlby himself acknowledged this by pointing out his initial "failure in the first edition to make clear the distinction to be drawn between an attachment and attachment behavior" (Bowlby, 1982). Ainsworth goes a step farther to point out that no behavior in and of itself can be called attachment behavior. Ainsworth has also offered three classifications of attachment behavior to more clearly define behavioral traits. These three classifications have received significant research attention: A) insecure avoidant, B) secure, and C) insecure resistant (Ainsworth, 1978). Crittenden later added two new classifications which are avoidant ambivalent and compulsive compliant (Crittenden, 1981). Research with these many classifications have stemmed around the use of a procedure developed by Ainsworth called the "strange situation" (Ainsworth, Blehar, Waters, & Wall, 1978). This involves putting the child in a controlled situation without the mother, then introducing a stranger and assessing the behavior. Although this procedure has been a research standard for many years, its value in clinical application is not without controversy (Greenspan and Lieberman).

Traditional attachment theory initially confused the dependence of human infants and how long they take to mature, with their ability to attach. It was believed that humans took longer to form attachments than less advanced primates. Bowlby originally stated that the period of time may be many months to one or two years before the infant can be said to have attached (Bowlby, 1982). Developmental psychology research has now shown that attachment usually begins at birth (Lieberman & Pawl, 1988) and some, including the author, would argue even before birth.

It is not surprising that attachment theory has needed revision. What is surprising is the degree to which it has been supported by research in much the same version as originally presented. With the intensive focus on child trauma over the last two decades and its influence on attachment, it is possible to take attachment theory a step farther.

Throughout Bowlby's descriptions of behavioral systems of attachment and bonding, there are hints of other important aspects of human attachment other than behavior. Restricting the discussion of attachment to behavior does not assist in identifying the causes of the behavior and is of limited value in treating and rehabilitating attachment disorders. Recent work on the origins of attachment has developed a need to find an explanation that is not limited to behavioral factors and incorporates and weaves together instinct, intuition, learning and the experiences the child has with their environment. In studying the processes and responses of children abused early in life, it appears that attachment can be redefined into four principal areas: Spiritual, Inter-personal, Physical, and Affective. These are the four ways a child can experience attachment. All of these areas have behavioral manifestation, but go much deeper than behavior and, in fact, can be said to cause the observable attachment behavior so clearly identified by Bowlby.

> ***Spiritual*** – this can be described as the experience of oneness. In infants this begins as a state of being one with the mother, then having experiences with the mother and others, progressing to an internal world that includes developing beliefs and eventually developing values. This core experience of feeling connected or belonging to an ever expanding network of "I Thou" relationships can be called the individual's primary orientation to a social world. If the spiritual attachment process is halted at any stage, the result in the individual is permanently arrested development of their social orientation unless there are specific and effective interventions, which will be discussed in Part II.
>
> ***Inter-personal*** – from before birth, infants are wired to receive pleasure from the attachment figure. In fact, initially there are no barriers between the self and the other person. As the experience gradually develops of where the infant stops and the attachment figure and rest of the world starts, the infant experiences all interaction as inter-personal. At this level, instincts are in sync with the positive experiences of being inter-

related with the other person. This produces a social disposition that can continue for life or it can produce a life long anti-social orientation.

Physical – the infant first operates on the pleasure/pain principle. What provides pleasure is pursued and what produces pain is avoided. Either the child's many needs are met or they are not. The child learns very quickly that to be social is pleasurable or painful. A series of negative physical experiences, regardless of the cause, may produce disrupted set points that endure long after the pain is gone (i.e., child abuse).

Affective – the child's intuitive appraisal of the environment combines all of the above into an emotional response to their world. Fundamentally, it feels good and pleasurable to be attached or it feels anxious, frustrating, and bad. The affective response stems from the first three areas and determines the strength of the behavior.

Understanding these four ways that children experience attachment, as well as, the behavioral manifestations of each, begins to give a blueprint of how healthy attachment or attachment disorders develop. How these four components of attachment can be used to understand and to rehabilitate attachment and bonding, particularly in traumatized children, is the topic of Part II.

Part II Attachment Problems – How Can Problems Be Fixed

Recreating Attachment

In Part I, the process of attachment has been considered in traditional behavioral terms as well as adding affective, physical, inter-personal and spiritual states of connectedness. The goal thus far has been to describe how, when, and why attachment occurs. In Part II, the purpose turns to the clinical question of what we can do about attachments that have become disturbed or that have never developed in any form. Part II begins with a discussion of assessment and moves to a brief treatment of multiple issues that will be encountered in therapy with attachment problems. The remainder of Part II presents a detailed model for treating attachment disturbances that the author has developed and used with good success in a residential treatment program that treats serious attachment problems in young children.

In Part I, attachment theory was explained to form the foundation for clinical attachment interventions. For all its strengths, the question that remains not fully answered in traditional attachment theory is what can be done about attachment problems. This is not to downplay the contribution attachment theory makes to clinical work, but it provides few, if any, prescriptions. It also falls short of answering whether attachment can be developed later in life when none exists in the first months. The volume of cases where attachment problems are primary concerns has required the

therapy world to ask these and many other important questions. Finding the answers has required clinicians to forge new ground.

The use of the term disorder comes from the diagnosis Reactive Attachment Disorder in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994). The term disorder requires an explanation. The presence of a Reactivate Attachment Disorder in a child in most cases indicates dysfunction in the parent, not the child. The behaviors associated with this diagnosis are inherently adaptive and functional in the child's initial situation. The clinical focus of all attachment work must principally be on the total environment, not solely on the child.

James has identified the roots of attachment in fundamental interactions such as: crying/responding, proximity seeking, attention getting and distress/comfort. She goes on to set out the progressive mission of attachment—first, protection of the child, second, providing for the many needs of the child, and third, guiding the child in understanding and maneuvering in social interaction (James, 1994). A number of factors can disrupt each of these social transmissions, but few as massively as the trauma resulting from child abuse. One of the most damaging dimensions of abuse is the frequency that the abuser is a primary care provider. Statistically the most frequent source of abuse when all types of abuse are considered is the child's mother. The mission of attachment can be immediately thwarted in these cases when the child experiences neither protection or being provided with basic needs, much less the final step of guidance. It may not take long before the child's proximity seeking and signaling of distress, becomes the avoidance and manipulative control so often seen in children with trauma caused attachment disorders.

Assessing the Extent of Attachment Disorders

Before the focus turns to clinical solutions, it is important to determine the nature and extent of the attachment problem. A variety of methods have been used to assess attachment disorders including the often used "strange situation" described in Part I. Observational indices have been used by clinicians to examine the mother/child bond, including: 1) intensity of conflict, 2) duration of disturbance, 3) generalizability of dysfunction, 4) level of dysfunction in learning capacity, 5) existence of oppositional behavior, 6) negativism in response to requests, 7) passivity in interaction, 8) overly compliant behavior, and 9) ineffectiveness and lack of persistence in problem-solving behavior (James, 1994). James goes on to say the following:

> The evaluator must assess the quality and nature of the child's trauma-related interaction patterns in order to adequately and accurately assess the quality and nature of a traumatized child's attachment behavior patterns…a partial set of questions that reflect these subtle but important distinctions include at least the following: Under what conditions is the child compliant? Who regulates the intensity of feelings in the interaction

> between adult and child? Does the adult help the child function more independently or dependently? How does the adult achieve this support? To what extent are the boundaries between adult behavior and child behavior maintained or blurred? How are these boundaries established? Under what condition does the child engage in exploration? Does the child use the adult to enhance her ability to explore? Does the adult take over and dictate what the child should do? To what extent does the adult coach the child regarding possible solutions to problems? If the child has a high activity level, under what observable conditions does this activity level change? Does the child's behavior regress during interactions with the adult? If so, in what ways is this regression observable? Is the regression appropriate to the situation? Does the child show anxiety when the adult must leave the room? If so, how? What is the child's response to the adult's return? (James, 1994).

A variety of instruments and clinical methods have been developed to assist in the assessment of attachment disturbance, including this author's "Attachment Disorder Assessment Scale" (Ziegler, 1990). Some methods use observations of the child and mother and some rely on information provided by someone who knows the child well, perhaps in addition to other clinical assessment instruments.

A brief comment must be made at this point concerning a topic that is complex and needs more discussion than can be provided here—the trauma bond. Some behaviors that appear to be signs of attachment in children are actually seriously confused interactions which reverse the purpose of healthy attachment. These behaviors have been called trauma bonds and have as their purpose the protection of the abuser by the child. These displays of loyalty are bred upon fear and perhaps even concern for survival on the part of the child. It is clinically essential to distinguish between healthy attachment and a trauma bond.

What Must Be Fixed

To identify clinical solutions, we must first identify specific problems that develop from disrupted attachment. The following quote from Herman effectively starts this discussion:

> The child trapped in an abusive environment is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness. Unable to care for or protect herself, she must compensate for the failures of adult care and protection with the only means at her disposal, an immature system of psychological defenses (Herman, 1992).

One important point mentioned in the above is the adaptation of the child. To a large extent, most attachment disorders are adaptations to initially unresponsive, painful, or in some way unsuccessful attempts to attach. A serious clinical challenge arises when the child's adaptations become psychologically ingrained. When this occurs, the child is neither aware that they have made the adaptation, nor do they remember why they are acting the way they are. Nearly all attachment adaptations are pre-cognitive because they cannot be recalled due to the age of onset and they are pre-verbal as well. For this reason, the deepest levels of attachment issues are not available to insight or cognitive interventions.

James has identified a number of other therapeutic objects of remediating attachment and bonding:

- When a child adapts by playing a role for the parent, the child loses themselves in the role and has no sense of self.
- Actual or perceived trauma overwhelms the child's ability to cope with life.
- Regressed or even infantile behavior is common.
- Other issues include hypervigilance, heightened startle response, irritability, anxiety, hyperactivity and dissociation.
- Numbing and avoidance of affect are frequent.
- The alarm/numbing response produces arousal in the form of anxiety from the trauma and then numbing when the anxiety gets extreme.
- Understanding risks and the ability to problem solve are often poorly developed skills.
- The exploring and learning process is halted and the focus turns to safety, as well as needs and wants.
- Attachment problems may incorrectly be viewed as hyperactivity, low IQ, oppositional defiance, or conduct disordered (James, 1994).

There is evidence that physiological systems of the child are being negatively influenced by the disruption of attachment. The child's brain may learn to organize around a stress response at a very early age (James, 1994). The trauma arousal may even be neurologically addictive by activating production of endogenous opiods, which alleviate stress and may then intensify the trauma bond (van der Kolk, 1989). The unhealthy trauma bond becomes reinforced neurologically and the child's loyalty to the abuser becomes stronger as they view their survival in the hands of the abusive parent. In this topsy-turvy world, the child may learn to survive by developing a trauma bond with the abusive parent, but they also learn that intimacy is to be avoided at all costs. The unavoidable results are degrees of symptoms such as: ego deficiency, handicapped emotional relationships, connections with others based on needs, lack of emotional claim to a care provider, impaired intellectual functioning, deficiency to regulate aggressive impulses as well as frustration and displeasure (Bates and Bayles, 1988).

Several other factors deserve at least brief mention. Parenting style requires clinical attention in cases where attachment is an issue. In a study of discipline, abused children had more problem behaviors and more oppositional responses to parents. Abusive parents were more punitive in discipline, more angry when disciplining and punishment was not altered to fit the situation (Trickett and Kuczynski, 1985). Social support for single parent mothers may be another important intervention. In a study of neglectful mothers, they reported less social support and people in their environment viewed them as deviant and not wanting support (Polansky and Gaudin, 1985). The role of the parent was pivotal in a study of one-year-olds who showed more positive and less negative affect with happy signaling from the parent (Hershberg and Svejda, 1990).

The last three important areas where attachment must be remediated are: 1) the importance of developing a social rather than anti-social personality, 2) the regaining of childhood, and 3) the development of a conscience. Much of what has been discussed refers to a social or anti-social orientation. The process of survival, pleasing the parent, and constantly adapting to a harsh and unsafe environment will rob the child of their childhood. Successful clinical intervention requires giving the child a chance to once again have childhood experiences and to return to them their child likeness. An attachment disordered child will often have a poorly developed conscience. To develop a conscience, the child must experience connectedness to others which gives an ability to read other's emotions and react with distress to the distress of others. The child then learns to attune first with the parent and then to others, thus planting the seeds of a conscience (Kochonska, 1993). The parent plays an important role in conscience development, including discipline without an emphasis on power thus appealing to a child's internal sense of wrongdoing. This results in more internalization and a developing conscience (Kochonska, 1991). Whether developing a social orientation comes first or a conscience comes first is less relevant than the essential need for both to develop.

Factors That Influence Reattachment

There is not one scenario that the majority of attachment problems fit into, but several, which will be discussed in the next section. Regardless of the situation, the goal in clinical attachment work is to facilitate the reciprocal, enduring affiliation between parent and child if this is possible. However, there are factors to be considered that may stand in the way of attachment. This does not mean that attachment therapy should not be initiated, but it does mean that we must recognize the stress factors and inhibitors in the child's life that are potentially working against the clinical goal.

The first factor is the attachment history of the child. In most cases, there are understandable and often logical reasons why attachment problems initially develop. In general, attachment problems are adaptations on the part of the child for survival

and self-protection. It means little to the child who has distancing and avoidance behaviors that the threat, the abuse, and the pain of their past are long gone. To children who remember, it is like it happened yesterday. To children too young to remember, their bodies, through neurological processes that store trauma memories independently, do the remembering for them (van der Kolk, 1989). The child may be fortunate to start fresh in a loving and supportive environment, but traumatized children can never start totally fresh, their past is always with them. Without understanding their past, the clinician or parent cannot hope to understand the child's present. Because of the child's past experiences, expectancies develop that fit their working models of themselves and others. Until the clinician knows this, they cannot know the child.

Trauma bonds have been briefly discussed. One of the best diagnostic indicators of a trauma bond is an intense loyalty to the abusive or neglectful parent. It appears at times that the strength of the loyalty is in direct proportion to the seriousness of the abuse. Loyalty is also one of the outgrowths of loss, which is a significant and complex topic in itself. To many children, loss of the primary parent, regardless of the reason, is the loss of love, safety and protection (James, 1994). Where loyalty comes into play very directly, is when the child perceives that any attachment, particularly if it is positive, will be a direct betrayal of the loyalty they feel for the abuser. Understanding why they feel loyal often needs no more justification to the child than because it is their "real mother" or "real father". Unless the child has never experienced any form of attachment, which is rare, loyalty will necessarily be a part of attachment therapy.

Other potentially influencing factors in a mother/child attachment are physical and/or psychiatric conditions with either the child or parent. A child cannot be accurately diagnosed with an attachment disorder if they are currently being abused. This must be one of the first investigative inquiries. Various psychiatric conditions with either the parent or child, can substantially affect attachment. Issues such as addiction of the parent, dissociation, schizophrenia, mood disorders and parental developmental delays or, at times, a low intelligence level, can create barriers and make the parent physically or emotionally unavailable. The same result can come from the presence of these same psychiatric factors in the child. If the child perceives, correctly or incorrectly, that they are likely to lose the parent to illness, they may opt to withdraw and protect themselves. This can be a major unspoken factor with children who have lost a primary attachment due to illness, suicide or even death by accidental means.

A Model For Treating Attachment Disturbances

The clinical complexity of attachment work can seem overwhelming. Already in Part II of this article, over four dozen important treatment issues have been mentioned. It is now time to outline a treatment process for attachment disorder therapy.

James makes several general points that are useful when considering the treatment process: 1) individual therapy is inadequate to treat attachment problems, 2) a treatment milieu must be developed, 3) only after a relationship has been developed can treatment for trauma and loss be effective, 4) children should not be forced to explore their trauma or loss, 5) young children should not be asked to say good-bye to a loss without having something to take its place, 6) provide support, hope and guidance, 7) follow the child's pace with accepting a loss and 8) provide a nurturing environment where a relationship of safety, consistency and emotional closeness is possible (James, 1994).

James' above points are excellent and her clinical handbook on attachment problems is highly recommended. She identifies five steps in the treatment of attachment disorders: a) teaching, b) self-identity work, c) affect modulation, d) relationship building, and e) mastering behavior (James, 1994). While each of the above are clearly important to treating attachment disorders, it is equally important in what order the process occurs. This author has developed a suggested treatment process called the building blocks of treating attachment disorders (figure 1). The building blocks can be viewed as a therapeutic staircase that begins with the bottom step and progressively moves upward. The important aspect of the staircase analogy is that to be stable, stairs must be firmly established on the foundation of the step below. Thus, without *safety*, there is no attachment, no relationship, and no successful therapy that can occur. The stairs progress to *security* which is provided by consistent and predictable structure. This progression continues upward to *acceptance* on the part of the environment to who the child actually is, not just what their potential may be. The child must experience a *belonging* to the source of a potential attachment, although they will seldom acknowledge this feeling. *Trust* can only come after these preceding steps, and only then can a true *relationship* be available. It is in relation to another that we learn *self-awareness* and only with self-awareness can *personal worth* blossom. Personal worth is definitely a higher order state, but it is important for attachment as an adult. For even when a person has learned to attach and to love, if they do not feel they are worthy of the love and attention of the beloved, they may push the beloved away because they believe the other person deserves better.

These building blocks have been found to be an invaluable framework in the clinical practice of the author's work over the last decade. It can be used to determine how far the treatment has progressed and what the next step should be. It can also be an important diagnostic tool to consider on what step a child enters treatment and how far up the stairs they have been able to go. It is important to mention that a child may be on a different step with a variety of people. They may be on the trust step with one parent and on the security step with the other parent. It is also important to point out the most common inexperienced attachment therapist's misconception—believing they have a relationship with a child long before the essential steps have been climbed.

Building Blocks of Treating Emotional Disturbance

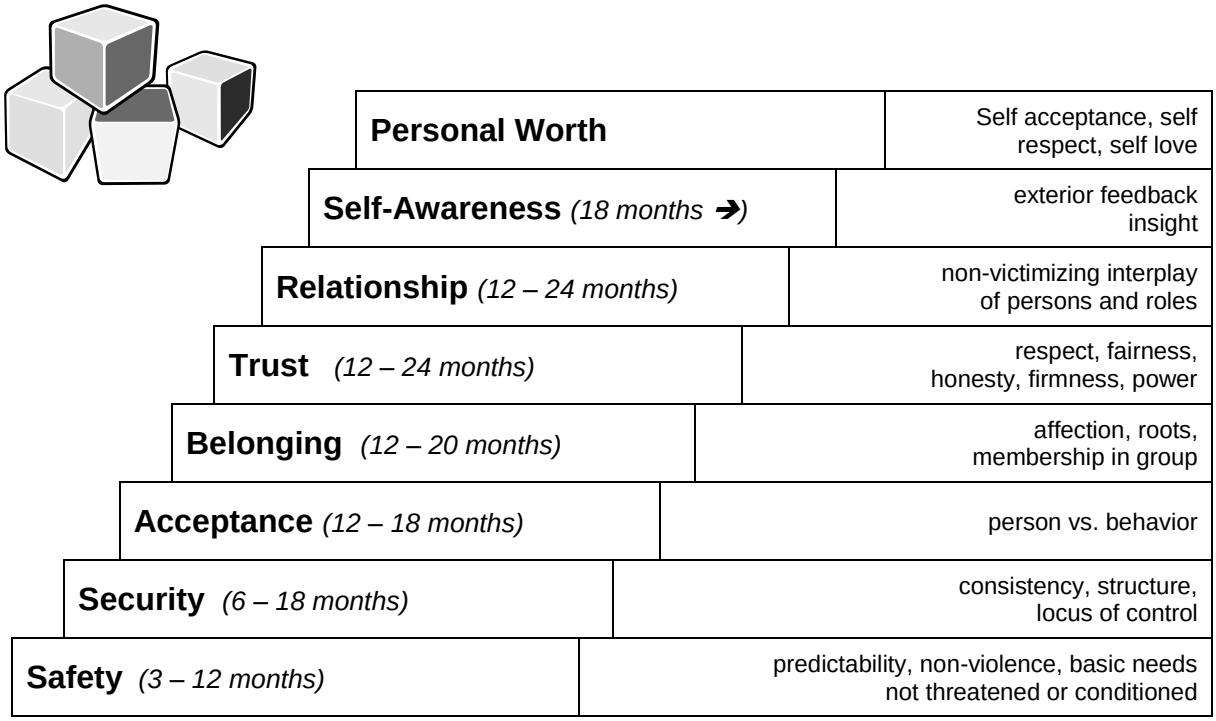

Figure 1

What appears early on to be a working relationship, inevitably turns out to be hollow mimicking or manipulation and control by the child of the therapist. If a child does not know that you are safe, that you accept them, that you can be trusted, then you may fool yourself into believing that you have a relationship with the child, but it is not yet the genuine article. Most of these children have become very good at pretense, what they need from a therapist is to spot this dynamic and help them experience a real relationship.

These building blocks do not take the complexity out of attachment therapy, but they can help immeasurably as a map to know where you are and the most direct route to your clinical destination.

Three Scenarios of Attachment Disorders

Attachment disorders fall into three categories: 1) disrupted attachment, 2) anxious attachment, and 3) no attachment (Lieberman and Pawl, 1988). A disrupted attachment is when a child experiences a significant attachment and then loses it due to illness, death, separation, abuse or some other reason. An anxious attachment is one that was not sound in the beginning and remains unsound. No attachment is when a child has

developed an attachment block due to the fact that no significant attachment has ever been achieved. Clinical interventions with these three scenarios are somewhat different in emphasis and in process.

Disrupted Attachment—The essential element of this scenario is that a successful attachment was developed when the child was very young and therefore the instinctive, neurological and pre-cognitive disposition still moves toward attachment. However, the child is not acting like they want to bond or to get close to others. As with each of the three scenarios, there is good reason for the child's behavior which in each case goes back to trauma. In a disrupted attachment, the bond initially worked as the child's natural dispositions intended and then something in the attachment process was disrupted. What went wrong will assist the clinician to determine how to get attachment back on track. Figure 2 is a representation of what happens in disrupted attachment. The four ways that humans experience attachment, which were discussed at the end of Part I, are shown in the figure—spiritual, inter-personal, physical and affective. With all sound attachments the process proceeds in this order. The child first experiences spiritual attachment or oneness with the mother in the womb, and then in the close proximity of touch—cuddling, breast feeding, and warm skin-to-skin contact. It is not clear to the infant that they are separate from the mother. Then the child experiences some sense of separateness but all contact with the world is inter-personal in nature. They pursue all experiences, explore all possibilities with no regard for protection. To a child, all experiences are inter-personal. They offer themselves without reservation and explore the other person with no sense of boundaries that separate. Since the child must interact with their world to survive, very quickly the task becomes letting their environment know when they are hungry, tired, needing touch or are feeling pain. The interaction with their world becomes more and more a series of physical encounters where their needs are or are not met. Depending on the success of these interactions, the final bond is developed—the affective or emotional bond. Feelings are produced with all three of the previous experiences of attachment. This is the primary vehicle for the appraisal of the environment or intuitive process that Bowlby describes as "being experienced by the child as a feeling or being felt" (Bowlby, 1982). To develop a successful attachment, all four areas must be experienced as positive by the child and parent, indicated by the pluses on the left side of Figure 2. The disruption in this scenario only comes after a successful attachment. The child first experiences a disruption when the interaction of affective experiences and physical experiences results in a negative appraisal (intuition) of the environment. It is a chicken and egg issue whether the affect follows physical needs not being met, or if the children experience physical needs not being met because they feel unsafe, insecure or other experiences producing the arousal of the alarm/numbing response (James, 1994). If this pattern continues to produce anxiety arousal in the child, the inter-personal nature of their disposition must change due to instinctive survival needs. The more intense the arousal becomes, due to affective and physical appraisals by the child, the more serious

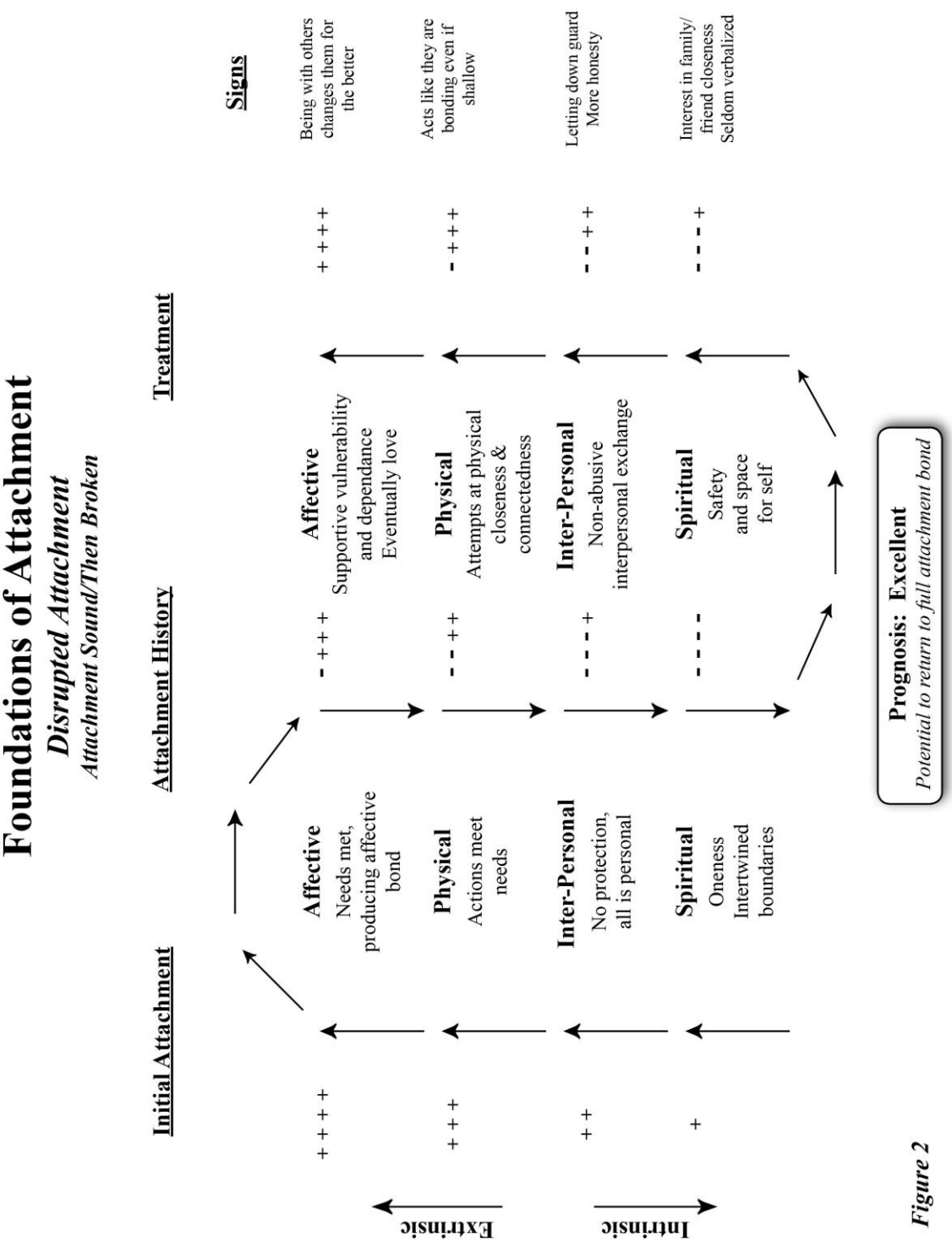
Foundations of Attachment
Disrupted Attachment
Attachment Sound/Then Broken
Initial Attachment
Attachment History
Treatment
Signs
Extrinsic
Intrinsic
+ + + +
+ + +
+ +
+
Affective
Needs met, producing affective bond
Physical
Actions meet needs
Inter-Personal
No protection, all is personal
Spiritual
Oneness Intertwined boundaries
- + + +
- - + +
- - - +
- - - -
Affective
Supportive vulnerability and dependance Eventually love
Physical
Attempts at physical closeness & connectedness
Inter-Personal
Non-abusive interpersonal exchange
Spiritual
Safety and space for self
+ + + +
- + + +
- - + +
- - - +
Being with others changes them for the better
Acts like they are bonding even if shallow
Letting down guard More honesty
Interest in family/ friend closeness Seldom verbalized
Prognosis: Excellent
Potential to return to full attachment bond

Figure 2

the inter-personal disruption becomes. The level of damage to the inter-personal experience determines the disruption to the spiritual bond or the deepest core of the attachment experience. In Figure 2 the arrows indicate the flow of the disrupted process.

Disrupted attachment intervention—In extreme cases of disrupted attachment, the rehabilitative route begins with core experiences--spiritual and inter-personal. If the attachment has been completely disrupted, the child will need to experience a spiritual or core safety as well as an intuitive experience of there being space in the environment for who they are. This is neither a cognitive nor verbal experience. This is why it means nothing to a traumatized child to tell them they are safe, you will take care of them, or in the case of an adoption, that you will be their family from now on. Words mean less than nothing to a child with no spiritual experience of attachment. What must happen is a day-to-day experience of safety. This not only means an environment free from external danger, but also one where they are loved for who they are. This points out the complexity of the beginning levels of the rehabilitative attachment process. The child by this time may be acting in extremely negative ways to drive everyone away (stealing, lying, cheating, etc.), but they must experience that who they are is accepted and wanted (step three on the building blocks). These children have learned very effective ways to keep everyone at a distance. The closer someone comes, the more negative they will become. A typical personality trait of a child with an attachment problem is control. The child will go to great lengths to put every possible aspect of the environment in their control. They experience control as comfort and security, when the parent is in control, they initially experience anxiety and fear. However, unless they can hand over the control to a trusted parent, they cannot regain their childhood, which is a major clinical objective. As any parent of an attachment disordered child knows, it is easier said than done to accept a child who is trying to get you to reject them, and it can take a very long time. The time required for a child to re-experience a spiritual bond is one of the reasons that techniques such as rage reduction, coercive holding, marathon flooding or other so called rapid therapies have no real chance of lasting success. Another serious flaw in any quick physically or emotionally coercive approach is the likelihood of developing or reinforcing a trauma bond rather than a healthy attachment, and thus leaving the child in worse shape than they started.

The process of rehabilitation of a disrupted attachment moves from the spiritual to inter-personal (non-abusive inter-personal interchange) to a physical closeness and connection because of the experience of physical needs being met, and finally beginning to feel supported, safe, cared for, and willing to risk dependence and vulnerability once again to another person. Depending on the level of disrupted attachment, this process can take from a year or two (notice the number of months listed on the steps in Figure 1), to as much as five to seven years, which is a length of treatment more consistent with scenario two and three.

***Anxious Attachment*—**This second scenario comes from an initially disrupted attachment where only a partially successful bond has been experienced by the child. They may have initially experienced the connectedness and oneness at birth, but very early in infancy came the alarm/numbing response when environmental appraisals produced anxiety for their safety and security. This is first experienced in moving from a spiritual bond to having no self-protection in an inter-personal situation, only to have painful or negative results. This immediately signals internal and even instinctive mechanisms of adaptation for survival, and results in an unsound attachment out of necessity. The process is reinforced each time physical needs are not met, such as crying and not being comforted or hungry and not being fed. The result of the unsuccessful inter-personal and physical bonding is a withdrawal and distancing affect that will become an ingrained automatic disposition for life without external intervention. It is not difficult to identify adults with this affective pattern which constantly works against their meeting a very basic human need of being attachment close to a significant other.

The anxious attachment process can get worse with time, and a negative spiral can result. This includes the infant withdrawing from the insecure parent who gets anxious and frustrated because the child rejects them. Thus the cycle spirals in a negative direction until whatever initial spiritual bond that had been established is no longer apparent in the child.

***Anxious attachment intervention*—**The process of rehabilitation for anxious attachments moves in the same fashion as disrupted attachment (see Figure 3). This is because there was an initial bond, although it was limited. The child must again experience safety and a predictable environment that makes room for them as they experience themselves. This highlights another complexity of the treatment process, the family must enable the child to experience acceptance at the same time that negative adaptive behaviors such as violence, withdrawal, and other behaviors designed to distance, are confronted as unacceptable. The answer to this problem most often rests in the teamwork between the knowledgeable and experienced therapist coaching the open and aware family in how to accomplish this challenging step. There is little doubt that essentially all rehabilitative attachment therapy occurs in a family, it does not occur in the clinician's office. An analogy may be drawn that the plays may come from the coach on the sidelines, but the game is played, as well as won or lost on the field. Again, the process is for the child to then move to experiencing success over time in inter-personal contact. This means learning to respond to an environment that predictably and unconditionally meets their basic needs. Slowly the child may be persuaded to accept human touch and even move to pursuing touch. At the top of Figure 3, is the rehabilitated affective experience. In the case of anxious attachment, it may be the best that can be hoped for during childhood that children share honest feelings. This usually means there will be much more negative than positive affect.

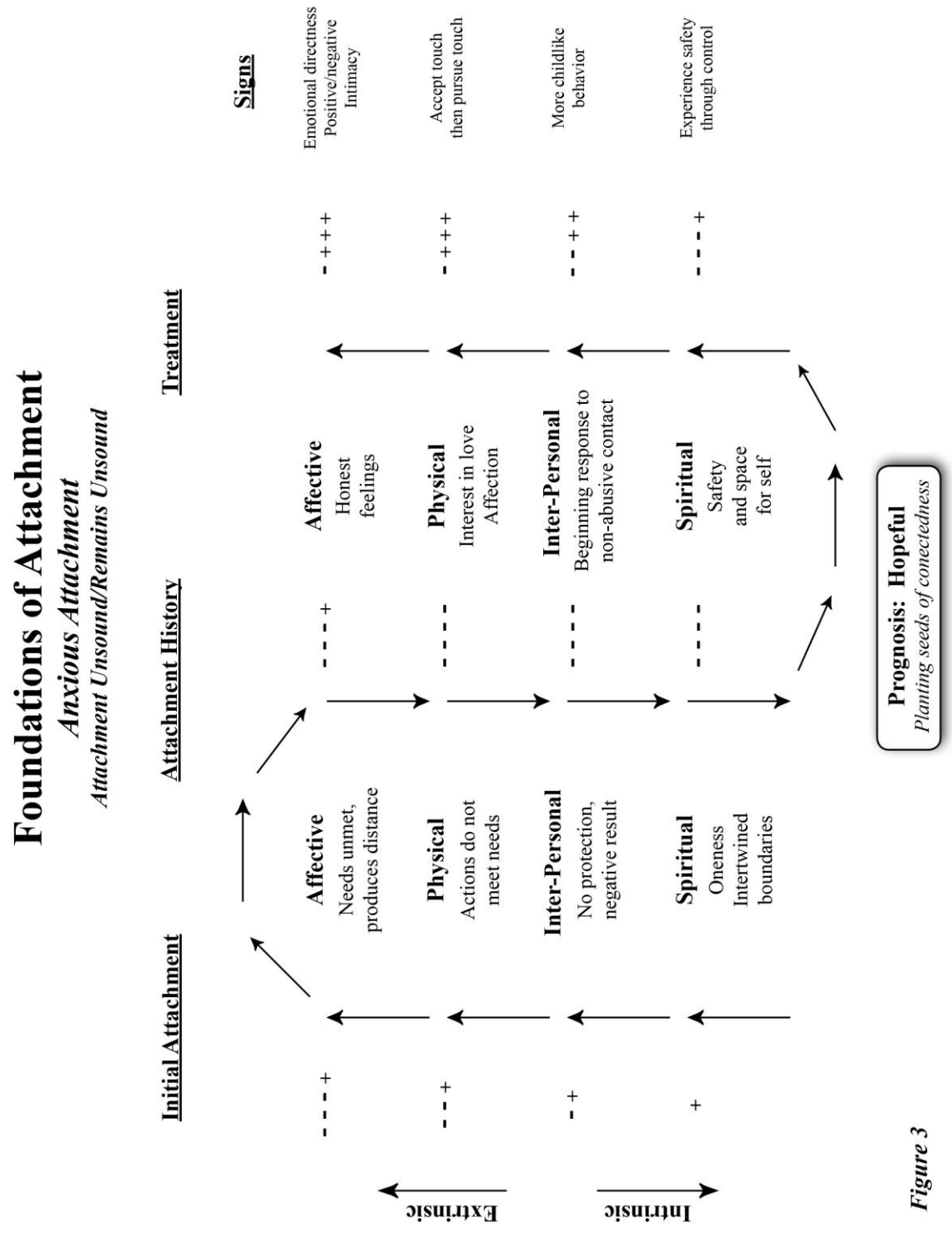
Foundations of Attachment
Anxious Attachment
Attachment Unsound/Remains Unsound
Initial Attachment
Attachment History
Treatment
Signs
Extrinsic
Intrinsic
- - - +
- - +
- +
+
Affective
Needs unmet, produces distance
Physical
Actions do not meet needs
Inter-Personal
No protection, negative result
Spiritual
Oneness
Intertwined boundaries
- - - +
- - - -
- - - -
- - - -
Affective
Honest feelings
Physical
Interest in love
Affection
Inter-Personal
Beginning response to non-abusive contact
Spiritual
Safety
and space for self
- + + +
- + + +
- - + +
- - - +
Emotional directness
Positive/negative
Intimacy
Accept touch
then pursue touch
More childlike behavior
Experience safety
through control
Prognosis: Hopeful
Planting seeds of conectedness

Figure 3

It is critical for parents to realize that honest negative affect is intimacy coming from these children. This can be hard to accept when you are on the receiving end day after day of anger or hostility. However, a child with an anxious attachment disorder could not express honest feelings in an unsafe home, so negative intimacy is an important step forward. Some of these children will not develop an affective attachment as children. It may take the combination of the experience of wanting a partner, combined with some capacity of personal self-awareness and personal insight to complete the affective attachment. It is also possible that many of the children with an anxious attachment may become adults who never reach a full range of affective attachment.

No attachment—Certainly the most difficult of the three scenarios is the lack of any level of attachment in the early years of the child. This is the true attachment disorder, as opposed to traumatized attachment, attachment problems, or attachment issues of most of the children who receive an attachment diagnosis. Fortunately, the child with no attachment is rare. The process of the developing problem (see Figure 4) is identical to disrupted and anxious attachments. However, with no attachment the process is immediately derailed either very soon after birth or even prenatally. In Part I a reference was made to attachment beginning before birth. The child has feelings and sensations that are either physically pleasant or unpleasant in the womb. The proliferating use of alcohol and illegal drugs during pregnancy is the main source of prenatal causes of no spiritual connection. In this case, the baby may be on the drug roller coaster in the womb each time the mother ingests the drug. In many cases, the unborn child has negative sensations and a negative experience of life before they are born. This may continue with their first task after birth of detoxing from heroine, cocaine, alcohol or other such drugs, an experience that can bring an adult to their knees.

A variety of other causes can produce no attachment. The child may lose their mother to death or abandonment at childbirth and not find a substitute primary attachment figure. Whatever the cause, the steps are the same—no spiritual connection leads to unsuccessful development of the necessary building blocks in Figure 1 from inter-personal experiences. This results in routine failure to communicate needs to the environment and therefore not having physical needs met. The failure of developing a spiritual, inter-personal and physical bond is concretized in no level of affective bond with anyone.

No attachment intervention—Due to the fact that there is essentially nothing to build upon in this scenario, the process cannot be called rehabilitation because the child was never habilitated with an attachment in the first place. This requires the process to proceed in the reverse direction from the first two scenarios (see Figure 4). One reason for this is that the child has never experienced any real level of spiritual attachment to anyone. Without an initial spiritual bond, it is problematic whether a spiritual attachment can ever be developed in childhood. The initial experience of oneness is

critical for the child in the first chapter of life. If the seeds of spiritual attachment are not planted in time, there can be no harvest in childhood, this does not rule out adulthood, which will be discussed in the next section.

The route to having a child experience sufficient attachment and to produce the many essential steps to social success as a human being outlined in Part I, is to go in the reverse order of the other two interventions. The process starts with affect. The child with no attachment has no real sense of self or self-understanding, due in part to the inability to climb the stairs of Figure 1. Even as teens or adults, they cannot tell the therapist why they do what they do or what it gets them. They cannot explain what they themselves do not understand. They are functioning on auto pilot, which is wired to avoid social risk and vulnerability, at times, more intensely than avoiding risk of danger and harm, which these children and adults do not necessarily avoid. They may not be able to tell you why they do what they do, but they can generally tell you what they want. True attachment disordered children want a great deal, mostly having to do with gratification (money, food, toys, sex, power, or control). They are actually rather easily motivated by gratification, although they will often tell you "there is nothing you have that I want and you can do anything to me but you can't hurt me." This is seldom the truth, although it is standard verbage from these children. Although they can often be easily motivated by physical gratification, they don't care what the cost of them getting what they want is to you or others. Insight, conscience, or social awareness are simply not capacities they have, and each of these will need to be taught. What they can do is to express themselves. This expression is almost entirely negative, but it is expression, and expression is the start of communicating and social interaction. It is better that a child scream "I hate you" than to ignore you, although over time, parents may wonder if it isn't less painful to be ignored. The child must be encouraged to express what they feel inside.

The second step is to focus on their gratification system and their physical experience of attachment which is accomplished by inter-personal dynamics. The gratification system is usually strong because these children usually have highly developed survival systems that are built upon gratification. The interplay here is the child wants something and so does the parent. The child wants gratification from things, and the parent wants connection with the child. Stated briefly, the strategy for the parent becomes—you get some of what you want, when I get some of what I want. This requires sophistication on the part of the parent. They can't say "give me a hug and tell me you love me or you don't get dinner." But it may look like, "If you will take a ten minute walk with dad, you can have ten minutes of Nintendo before dinner."

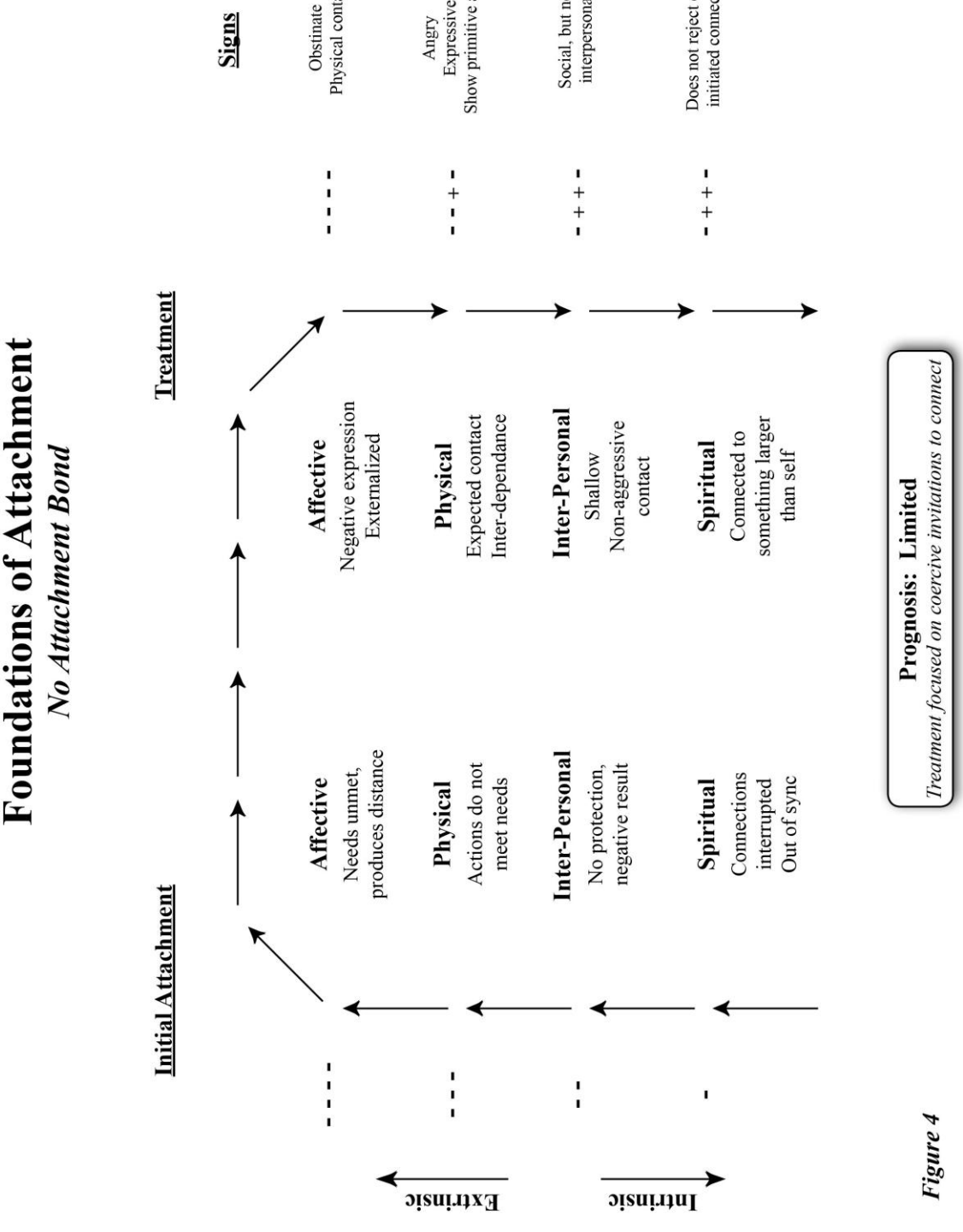
Foundations of Attachment
No Attachment Bond
Initial Attachment
Treatment
Signs
Extrinsic
Intrinsic
- - - -
- - -
- -
-
Affective
Needs unmet, produces distance
Physical
Actions do not meet needs
Inter-Personal
No protection, negative result
Spiritual
Connections interrupted
Out of sync
Affective
Negative expression
Externalized
Physical
Expected contact
Inter-dependance
Inter-Personal
Shallow
Non-aggressive contact
Spiritual
Connected to something larger than self
- - - -
- - + -
- + + -
- + + -
Obstinate
Physical contact
Angry
Expressive
Show primitive affect
Social, but not interpersonal
Does not reject other initiated connection
Prognosis: Limited
Treatment focused on coercive invitations to connect

Figure 4

It may sound unpleasant, but the process of habilitating an attachment with an unattached child is inter-personally coercive. At the same time, it is important to differentiate this from the physical and emotional coerciveness of "holding therapies." Physical and affective coercion cannot be implemented without the child experiencing pain and abuse. This is neurologically processed with past abuse and, at best, a trauma bond is developed.

It can be compared with spanking and physical discipline—it may appear effective in the short run, but it produces many more problems than it solves in the long run. These same negative results do not occur with inter-personal coerciveness, which is a function of social interaction, not physical or emotional pain. The reason treatment is inter-personally coercive is that if you wait for the child to come to the realization that they need connection with you, it may never happen. From the perspective of their internal intuition and "set points" (Bowlby, 1982), the last thing in the world they will ever need is connection with you. They are personally, neurologically and socially prepared to live their life with no closeness to anyone. This is exactly what will happen if effective interventions do not alter this direction. The constant interplay of treatment becomes: 1) in the context of a safe and secure setting, 2) the child is cared for and their basic needs are unconditionally met, 3) constant invitations are extended to the child to take the next step on the building blocks in Figure 1, and 4) on this playing field, the child learns the tough love condition that for them to get gratification of their many wants, they must socially pay for it with interaction, negotiation and mutual interplay where no one is used or abused. Treatment consists of the interaction each time the unattached child wants something and the parent says what it will cost. This teaches the nature of social interaction that is ingrained in children with some level of healthy attachment. It also sets out a process of a) an environment accepting the child's expressed affect (even though it is negative), b) physical wants are for the most part obtainable with c) inter-personal contact. Whether the unattached child will ever reach a spiritual or core connection is uncertain, but it will be the last aspect to develop with children who have no early attachment experience.

At best, the preceding discussion of the attachment process is a road map. Taking the trip and not heading the wrong way is the challenging part. It is naïve to believe that unattached children will improve with treatment in the therapist's office alone. There is very little the child wants from the therapist. The most frequent desire of the child is to manipulate the therapist, and they often do a remarkable job. There is seldom time to counter the manipulation, much less develop the coercive process where their wants are met when the therapist gets something in return. It is a total environment that effectively treats attachment disorders. These therapeutic environments include biological families, adoptive families, treatment foster care families, and the environmental milieu of residential treatment centers (the latter is often the most effective response to the truly unattached child).

A Realistic Look At Prognosis

With dozens of serious treatment concerns, as well as biological, historic, psychological and behavioral factors working against the treatment process at every step, is it realistic to hope for positive results in a parent's lifetime? The qualified answer to this question is "yes, it is realistic." The qualification is that it has taken time to create the attachment disorder and there are no effective shortcuts to taking the time to create an attachment in its place.

As noted above, not all attachment problems are the same. The three general scenarios described earlier all have a somewhat different prognosis. With disrupted attachment, the likelihood of successful bonding is excellent. The length of time the process of rehabilitation takes will depend on the level of disruption and a variety of factors already discussed. With anxious attachment, the prognosis must be downgraded to helpful. One of the many reasons for this is the real possibility that an affective attachment may well be out of reach, at least during childhood. The prognosis and length of time it may require of a professional working with a family will depend on the specific case. It can be from months to years. One thing is clear, the inventors of managed care and brief therapies were not experienced attachment disorder therapists. The greatest concern for prognosis must rest with children with no attachment. In general, the prognosis for these children is limited. It is limited in part because there is the likelihood that a spiritual bond may be temporarily or permanently out of reach. Spiritual or core attachment is an intrinsic experience and not one that is necessarily available to cognitive or behavioral discovery. Affective attachment is also extremely problematic for these children. The nature of loving human contact is that there are equal parts of pleasure and pain. As good as it feels to be loved, at some point the beloved will undoubtedly disappoint and cause pain. To the unattached child, they do not experience connection as pleasure, and are so focused on impending pain that when it comes, it reinforces the avoidance of vulnerability to anyone. Can this be overcome? Realistically the answer is perhaps it has the best chance of success in adulthood.

For unattached children the process of professional coaching and specific daily treatment interventions may take five to seven years to show major results. This is a far cry from the claims of a variety of quick attachment approaches. To those who shudder at seven years of treatment, they may do well to ask how long it takes a healthy attached child to learn responsibility and to develop an informed functioning conscience. It takes a human being many years to be physically self-sufficient, why would anyone be surprised that it would take equally long to be socially and morally well developed. It may not take years of individual art therapy, play therapy or even professional coaching in family therapy, but it will take years for healthy attachment patterns to form in the day-to-day environment the child is in, if initial attachment was disrupted, partially developed, or absent entirely.

For parents and therapists who interact with these children, the personal demands are high and the rewards are often meager. As in any long and arduous journey (and this fits working with attachment disorder children), possibly the most important characteristic of the weary traveler who eventually reaches their destination is endurance.

The fabric of our social system is dependent upon healthy attachments in children. The future success of our social institutions may well rest in our ability to counter the rampant anti-social consequences of needy children, teens, and adults who have grown up in trauma, having never developed a conscience, and who now have a score to settle with society.

References

Ainsworth, M.D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). Patterns of Attachment: A Psychological Study of the Strange Situation. New Jersey: Lawrence Erlbaum Associates.

Ainsworth, M.D.S. (1979). Infant-Mother Attachment. American Psychologist, 34, 932-937.

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: American Psychiatric Association.

Bates, J.E., & Bayles, K. (1988). Attachment and the Development of Behavior Problems, From Clinical Implication of Attachment. New Jersey: Lawrence Erlbaum Associates.

Belsky, J., Nezworski, T. (1988). Clinical Implication of Attachment. New Jersey: Lawrence Erlbaum Associates.

Bowlby, J. (1982). Attachment. New York: Basic Books Inc.

Caspi, A., Elder, G.H., & Bem, D.J. (1987). Moving Against the World: Life Course Patterns of Explosive Children. Developmental Psychology, 23, 308-313.

Crittenden, P.M. (1981). Abusing, Neglecting, Problematic, and Adequate Dydadds: Differentiating by Patterns of Interaction. Merrill-Palmer Quarterly, 27, 1-18..

Erickson, M., Sroufe, A. & Egeland, B. (1985). The Relationship Between Quality of Attachment and Behavior Problems in Preschool in a High-risk Sample. Monograph for the Society for Research in Child Development, 50, 147-166.

George, C., and Main, M. (1979). Social interactions of young abused children: approach, avoidance and aggression. Child Development, 50, 306-316.

Greenberg, M.T. & Speltz, M.L. (1988). Attachment And The Ontogeny Of Conduct Problems. From Clinical Implications Of Attachment. New Jersey: Lawrence Erlbaum Associates.

Greenspan, S.I., & Lieberman, A.F. (1988). A Clinical Approach to Attachment. From Clinical Implications Of Attachment. New Jersey: Lawrence Erlbaum Associates.

Hermann, J.L. (1992). Trauma and Recovery. New York: Basic Books Inc.

Hershberg, L.M., Svejda, M. (1990). When Infants Look To Their Parents: Infants' Social Referencing of Mothers Compared to Fathers. Child Development, 61, 1175-1186.

James, B. (1994). Handbook for Treatment of Attachment-Trauma Problems in Children. New York: Lexington Books, Macmillan Inc..

Kochanska, G. (1991). Socialization and Temperament in the Development of Guild and Conscience. Society for Research in Child Development, 62, 1379-1392.

Kochanska, G. (1993). Toward a Synthesis of Parental Socialization and Child Temperament in Early Development of Conscience. Society for Research in Child Development, 64, 325-347.

Lewis, M., Feiring, C., McGuggog, C., & Jaskir, J. (19984). Predicting Psychopathology in six-year-olds from early Social Relations. Child Development, 5555, 1123-1136.

Lieberman, A.F., & Pawl, J.H. (1988). Clinical Applications Of Attachment Theory. From Clinical Implications of Attachment. New Jersey: Lawrence Erlbaum Associates.

Matos, L., Arend, R.A. & Sroufe, L.A. (1978) Continuity of Adaptation in the Second Year: The Relationship Between Quality of Attachment and Later Competence. Society for Research in Child Development, 49, 547-556.

Polansky, N.A., Gaudin Jr., J.M., Ammons, P.W. & Davis, K.B. (1985). The Psychological Ecology of the Neglectful Mother. Child Abuse and Neglect, 9, 265-275.

Rubin, K.H., & Lollis, S.P. (1988). Origins And Consequences Of Social Withdrawal. From Clinical Implication of Attachment. New Jersey: Lawrence Erlbaum Associates.

Sroufe, L.A. (1986). The Role Of Infant-Caregiver Attachment In Development. From Clinical Implication of Attachment. New Jersey: Lawrence Erlbaum Associates.

Trickett, K.T., Kuczynski, L. (1985). Children's Misbehaviors and Parental Discipline Strategies in Abusive and Nonabusive Families. Development Psychology, 22, 115-123.

van der Kolk, B.A. (1989). The compulsion to repeat the trauma: Re-enactiment re-victimization, and masochism. Psychiatric Clinics of North America, 12, 389-406.

Ziegler, D.L. (1990). Attachment Disorder Assessment Scale. Unpublished.