ATTACHMENT AND BONDING BASICS

John Bowlby, considered the father of attachment theory, defined attachment as the reciprocal process between two individuals who form an enduring affectual bond. He considered attachment and bonding to be an innate biological need of the infant. From Bowlbys original work to more recent leaders in the attachment field, the importance of attachment and bonding to healthy human functioning cannot be understated.

In the last decade, neuroscience has provided a deeper understanding of attachment and brain development. It is now possible to see the detrimental effects of neglect on the developing brains of children in comparison to nurtured children through imaging technologies. This has served to further demonstrate the importance of the attachment process for healthy brain development. Furthermore, many people believe that attachment and bonding actually begins in utero where the developing fetus somatically experiences the heartbeat, sounds, rhythms, and biopsychological states of the biological mother.

Bowlby identified the following as important elements to forming a secure attachment.

1. Biological Synchrony/Affective Attunement refers to the primary caregiver's ability to attune to the infant's somatic and affective needs. This attunement between mother and infant/child builds the neural connections that are the infrastructure for relationships. Additionally, the infant's nervous system develops the capacity to self regulate through the mother's facilitation of the distress/comfort/calm cycle.
2. Secure Base – A secure base is the infant/child's internal sense of security. The parent facilitates an infant/child's secure base by being consistently and predictably responsive to his/her physical, sensory, and emotional needs. This predictability provides the infant/child with the security to develop natural curiosity resulting in the confidence to then explore his or her environment.
3. Internal Working Model – Over time the infant/child develops a template or internal representation of him/herself in relationship to others. Repetitive interactions between infant/child and caregiver will create the neurophysiologic template that becomes the child's internalized model for relationships.
4. Selective Bonding - According to Bowlby, the infant/child prefers and seeks closeness to his/her mother above all. From an evolutionary biology perspective, this proximity seeking behavior was thought to insure the safety of the young from predators.

PRIMARY DEVELOPMENTAL TRAUMA: FAILURES IN ATTACHMENT

A failure in attachment is the most elemental trauma a child can experience since attachment and bonding is the basis for all that makes us human. When an infant is neglected, meaning that his/her physical and emotional needs are not met, he/she may withdraw from human contact as a pleasurable and rewarding experience. This may lead to life long difficulties in forming healthy relationships. Further, since an infant's brain organizes around his/her interactions with his/her primary caregiver, an impoverished attachment relationship and environment will produce an impoverished brain. An infant/child exposed to chronic stress states may develop in ways that are not relational but are instead survival based.

Rather than depending on caring adults to provide warmth and safety, a survival driven child is motivated to get his or her needs met in ways that exclude relationships. Such children are often highly dys-regulated and attempt to manage internal fear states by exerting an inordinate amount of control onto their environment. This behavior may be viewed as a child's natural reaction to survival stress as the world is perceived as unsafe and uncaring.

Attachment trauma is not always due to maltreatment. Failures in attachment may also be situational, such as an infant who is medically fragile and is hospitalized in his or her first months of life. In addition, there are always additional factors that bear on a child's attachment resources. These include genetic factors, natural resilience, temperament, and mitigating buffers that may offer some protection against the detrimental effects of attachment trauma. An example of a buffer may be a loving grandparent.

Below is a sampling of the type of symptoms that have been observed in children with primary attachment trauma:

- Difficulty regulating strong affect.
- Chronic hyperarousal, hypoarousal or a combination of both.
- A false self (superficiality) used to get needs met rather than an authentic ability to ask, give and take in relationships.
- Dysregulated sleep patterns.
- Intense insecurity masked by precocious behavior.
- Excessive need to control the environment out of fear.
- Cognitive distortions, e.g., externalizing blame; inability to perceive the environment accurately.
- Difficulty understanding cause and effect.
- Disinterest in modeling self after the parent or seeking parental approval.
- Perceiving self as victim; likes to be rescued by strangers.
- Poor conscience development, lack of empathy for other living beings.

- Learning problems, language problems.
- Behavior that may alternate between regressive and overly self-reliant.
- Inability to make friends.
- Rejection of parents, will not allow parent to nurture him or her; cannot trust adults.
- Unable to make friends, lack of meaningful relationships with others.

Failures in attachment are also complicated by exposure to neurotoxins in utero, e.g., alcohol, drugs, poor nutrition of the mother, excessive maternal stress, mother's exposure to domestic violence during gestation.

SECONDARY DEVELOPMENTAL TRAUMA: PHYSICAL, EMOTIONAL AND SEXUAL ABUSE

Secondary developmental trauma often co-occurs with failures in attachment. The infant who is pre-verbal or the young child who is helpless to protect him/herself is left with a storm of confused feelings and thoughts about the world. Living in chronic states of danger imposes two survival based patterns in the child. At one end of the spectrum is hyper-arousal associated with flight/flight and at the other end of the spectrum is hypo-arousal, freezing and dissociation. Sometimes unseen insults such as traumatic brain injury (TBI) due to physical abuse or fetal alcohol effects go unrecognized and reduce the child's ability to function. The psycho-social-biological effects of secondary trauma reinforce any failure in attachment, complicating the over all picture. Often these children come with a long list of diagnoses, none of which fully capture the complexity of issues of children who have experienced multiple traumas in their young lives.

LOSS, SEPARATION, GRIEF AND ATTACHMENT

When children are placed in foster care, institutions, or are adopted, they not only lose their birth parent(s), they lose siblings and extended family members as well. Infants and children who experience early loss often carry deep emotional pain and unresolved grief associated with a childhood lost.

Bowlby described a sequence of grief reactions that he observed in infants/children who experienced prolonged separation from primary attachment figures. These stages are also applicable to children who have experienced multiple separations in their young lives. The first stage he called protest. In this stage the child cries, kicks, or screams in order to get the primary attachment figure to return in order to regain close proximity. If the protest does not produce the return of the attachment figure, then the infant/child begins to despair in the second stage. Despair is expressed as withdrawal and apathy in the child, sometimes misinterpreted as acceptance by unknowing adults. If the condition of loss of the attachment figure persists, the infant/child detaches or de-invests from relationships. Detachment is a protective measure that a child assumes against the psychic pain of the loss. Permanent detachment may occur if the grieving process persists unresolved. In this final stage the child divests his or her loving feeling from any attachment figure and invests this into his/herself, no longer considering relationships necessary for needs fulfillment.

TREATMENT OF DEVELOPMENTAL TRAUMA

Treatment of developmental trauma continues to evolve as neuroscience and treatment models mature. Not that long ago the public was unaware of interventions such as neurofeedback, EMDR or neuro-reorganization. These interventions are becoming more accepted as they prove to be effective tools for helping children heal. Additionally, the work of Bruce Perry, MD and his Neurosequential Developmental Model is gaining attention for treating childhood

trauma. Perry's model contains many of the elements that have long been promoted by professionals working with developmental trauma, namely, a relational model of therapy that integrates attachment theory, somatic psychotherapies and expressive arts therapies. Some examples are nurturing touch, art therapy, movement, music, and even infant massage.

To address childhood developmental trauma in treatment, relational treatment models that include the primary caregivers are strongly recommended. Thus, the primary caregivers, who are the core attachment figures, are essential participants in the healing process. When therapist and parents work together to understand the whole child, i.e., somatic, neurological, emotional, psychological, behavioral, and social domains, then strategies can be applied to build and optimize the child's systemic resources.

Children with developmental trauma are usually fearful if not terrified of allowing themselves to be close or vulnerable to others. Somatic approaches that provide positive sensory input may be helpful for facilitating relational safety for such children. One of the goals of therapy is to create a safe context where the child is able to allow somatic and emotional closeness with his/her parents.

Sometimes we expect children who carry heavy loads of developmental trauma to get on with it. Many children with developmental trauma will not follow a smooth developmental path as critical windows have been interrupted due to the trauma. This requires careful navigation through regressive issues to support the child in a progressive manner while also addressing unmet needs as the child expresses them. Developmental movement therapies are a good example of re-working developmental movement patterns (regressive) in order to build neural resources so the child may progress.

The goal of therapy is to create a loving and secure attachment between parent(s) and their child(ren) and to optimize neurological resources. It is

gratifying to see a child who grows to trust his/her parent and discovers comfort, love, and security in his/her family. When children begin to shift out of chronic states of abnormal arousal, when they allow familial intimacy, when they trust that they will not be abandoned, and when they finally believe they are lovable, the healing unfolds.

Children who have been traumatized teach us about the human condition, compassion, and the courage that it takes for many children to reinvest in life itself. Adoptive families also deserve community support and understanding as they provide a safe and loving home for very wounded children.

THE CUTTING EDGE

There is a growing emphasis on providing children who have experienced developmental trauma with integrative therapy approaches that emphasis a neuro-developmental approach. This approach emphases the need to build neurological resources as the optimal path for children to overcome developmental insults that interfere with the functioning and well-being of a child. Interventions that are recognized as being helpful for neuro-development include neurofeedback, neuro-reorganization, brain gym, bio-medical interventions, nutrition, and acupuncture in addition to attachment based psychotherapy.

Please refer to the NACAC power point presentation under Services for further information on integrated and complementary approaches.