Insecure attachment and its consequences

Insecure attachment lies at the root of much poor parenting and many social ills. By reflecting on their clients' issues from an attachment perspective, practitioners can choose modes of therapeutic input that help to address these unmet needs, writes **Andrea Perry**

The importance of good relationships to mental wellbeing is widely recognised. The attachments we form in our early lives create a template for how we negotiate our relationships throughout life. Regrettably, problematic early attachment can lead to enduring difficulties. Good parenting, especially in the first year of life, gives children the best possible chance of a healthy, productive, satisfying life. The opposite is also tragically true, unless insecurities developed at this crucial stage of development can be later ameliorated by those in a position to help. Practice across the caring professions and in education, and research (particularly in neuroscience) has led to an awareness of the benefits of integrating an attachment approach into service provision, offering those with early experiences of deprivation a second chance to establish and benefit from satisfying relationships.

What is attachment?

Attachment is the name initially coined by John Bowlby in the 1950s[1] for the relationship co-created by a baby with his primary care-giver in the first year of life. The nature of this relationship, crucial to the survival and development of the baby, creates a stable 'inner working model' of how he relates to himself and to the world. If the baby receives sensitive and attuned empathic care from his care-giver[2] (usually but not always the mother) for the full range of his physical and emotional needs, he will regard her as his 'secure base', and develop an internal model of 'secure attachment'. Some 60 per cent of the UK population will have the experience[3] of receiving 'good enough' care from a care-giver. This person does not need to be perfect: but needs instead to be patient, reliable, understanding and responsive most of the time, and able to repair the ruptured relationship with the baby and soothe him when she is not. Secure with her, the baby will then be able to turn to explore the world.

Securely attached children grow up able to 'love in peace'[4], creating deep, stable relationships characterised by compassion and kindness. They will be able to explore, learn and ask for help, confident of response; reflect on thoughts and feelings; have positive self-esteem and good resilience to stress, and be able to enjoy life and be optimistic.

If, on the other hand, the baby's early needs are met unpredictably or not at all, if he is left alone or for too long to deal with distress, separation, loss or trauma, then he is likely to develop an 'insecure' pattern of attachment. This too will colour his world view. He will find relationships difficult, and trust impossible. Settling to learn will be problematic. Within the 'learning triangle'[5] made up of child, teacher and task, he will either have problems relating to the teacher, or to the task, or both, limiting his educational potential. Insecure attachment is a risk factor for the development of behavioural and associated problems[6]. Unmet early attachment needs and the development of insecure patterns of attachment can lead, in later life, to difficulties dealing with stress, to mental health problems such as depression, anxiety and phobias, and to challenging, antisocial or criminal behaviour, violence, drug and alcohol addiction, self-harm, eating disorders and other psychosomatic conditions. Recent work in Israel indicates that insecure attachment may also be implicated in such problems as autism and attention-deficit hyperactivity disorder (ADHD)[4].

In addition to those who experience early deprivation and neglect, such as looked-after children, specific populations such as refugees, unemployed people, those experiencing bereavement and the elderly may all struggle with aspects of attachment particular to their circumstances,

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potentially triggering pre-existing insecurities. Where disrupted attachment, separation and loss are involved, emotional and behavioural difficulties, mental ill-health and indeed some disorders that present with physical symptoms[7] may be viewed as a potential communication about unmet attachment needs. By reflecting on their clients' issues from an attachment perspective, counsellors and therapists can find ways of relating therapeutically to the client to address both the presenting concerns and, at the same time, the huge anxiety behind these unmet needs.

How secure attachment is created

Within a secure attachment, a parent empathically attunes to her child's painful feelings. She allows her own feelings to resonate with her child's distress, 'contains' the feelings by not allowing them to overwhelm her; thinks about the feelings and verbalises to her child her empathy for his suffering, what she thinks might be happening and possibly, but not necessarily, offers ways forward. So on hearing her baby's cries after a sudden noise from fireworks, a mother might say:

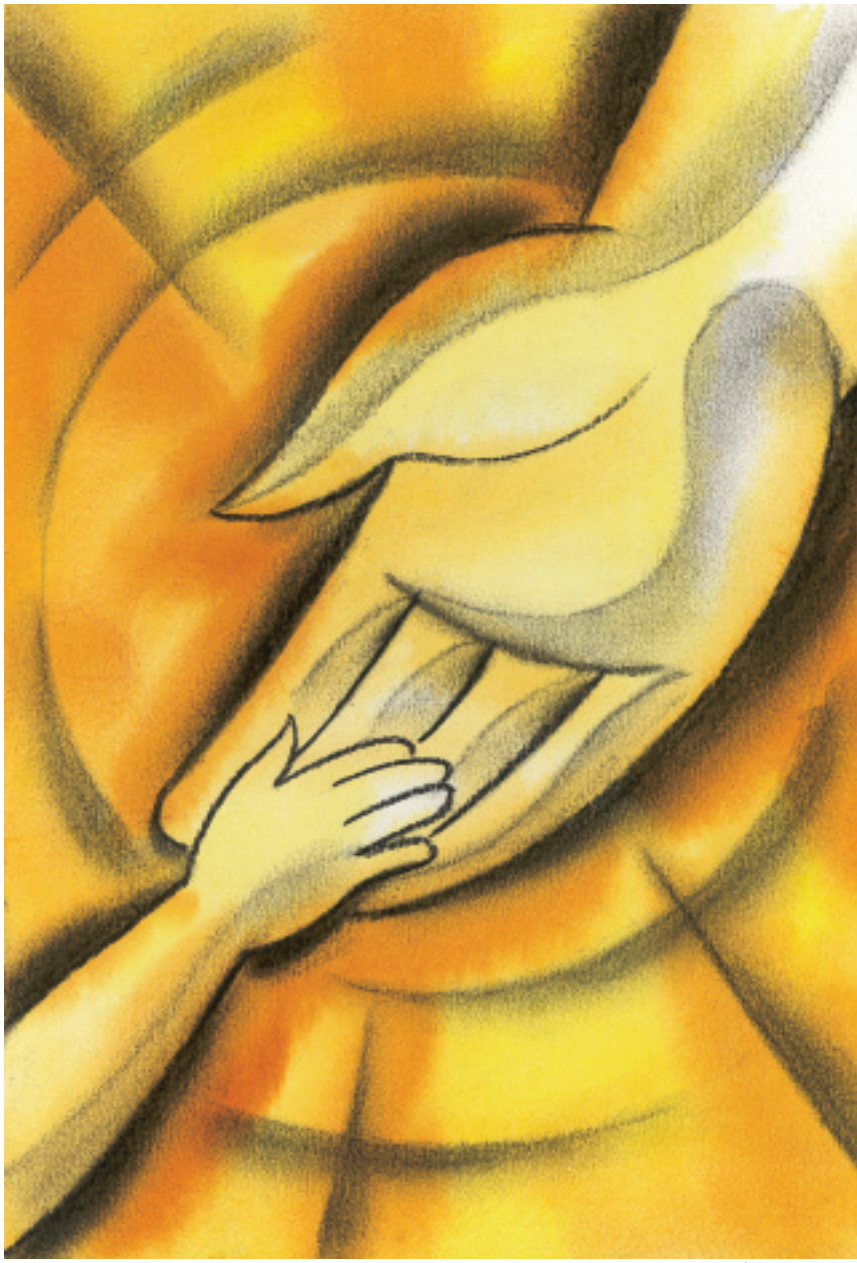
'Oh that was a loud bang, wasn't it! The fireworks frightened you, didn't they? You're safe, mummy's here, let's have a cuddle, you're safe.'

She is co-regulating her baby's emotions and level of arousal. She is helping to reduce his panic by the soothing tone of her voice, by her touch, by being able to think about his feelings without being alarmed by them herself. Comforting a screaming child helps reduce levels of the stress hormone cortisol, thereby developing highly effective stress control systems in the baby's brain, and activates the capacity of the vagus nerve[4], linked, as the child grows, to emotional balance, clear thinking, improved powers of attention and an efficient immune system. Each time she helps her child feel and think about his experience, the care-giver is helping to facilitate the growth of sophisticated communication networks in the brain involved with empathy, compassion, and self-regulation[4].

The primary attachment figure is the person best able to soothe a child's distress, but also the person who plays with, rejoices in and shares positive excitement with the child[3].

So strong attachment bonds are not only based on the removal of anxiety through proximity and care, but are strengthened and reinforced by tender loving contact and shared pleasure that releases natural opioids and oxytocin in the child's brain, leading to deep contentment.

Within an insecure attachment, however, the parent does not attune to, experience empathy for or take pleasure in the child's experience, or does so only intermittently and unpredictably. Such children grow up with a profound sense of insecurity in the world, and a restricted capacity for self-soothing or empathy. Too often left to cry, ignored or at worst punished for expressing protest at separation, the baby experiences high levels of cortisol which may leave its brain permanently 'hard-wired' to be over-sensitive to stress. Ongoing un-regulated distress may alter key systems in the immature brain, inhibiting brain development[4], leading to the development of emotional and behavioural difficulties, and problems with settling to learn, and with establishing and/or maintaining satisfying relationships.



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Patterns of insecure attachment behaviour

Insecure-avoidant attachment
After separation, a child showing this pattern will be more likely to avoid the attachment figure. It is likely that the care-giver has been insensitive to the chlld's needs, and neglected or rejected the child's attempt to seek care, especially physical soothing. Over time, the child avoids contact when anxious, tending instead to manage his own feelings by trying to stay in control of his circumstances. He has the sense of being unwanted and unlovable, and unconsciously carries anger towards the care-giver which he projects out.

Insecure-ambivalent attachment
This child has experienced care of a highly unreliable nature. The care-giver may have experienced mental health or addiction problems; they may have prioritised their own needs above the child's and have little sensitivity to the separate needs of the child. The child seeks proximity to the carer at all times, in terror at separation, and cannot explore or engage with the world with any confidence that the carer's attention will be sustained towards him, or that he will remain in his mother's mind. These children are either impulsive and tense, or helpless and fearful. Their behaviour tends to be clingy and they cannot concentrate on tasks for fear of losing a relationship, which, however, never completely satisfies them.

Disorganised attachment
A very small minority of children have had the most traumatic early experiences, characterised by being frightened of their care-giver, who should represent the secure base. The carer may also be frightened by the child's feelings. There may be actual abuse, violence, neglect and abandonment. Multiple carers may have been involved, resulting in little continuity of thoughts and feelings. These children are left in states of highly unregulated distress. They are hyper-vigilant, and may dissociate, or experience 'amygdala hijack', in which their fight-or-flight response is very readily triggered when they perceive threat. Concentration is extremely difficult, and they experience almost constant fear, anxiety and a sense of helplessness, feeling unworthy of anyone's care. They may self-medicate through substance abuse, or self-harm. Their behaviour is often unpredictable and erratic. Their expectation of the world is of threat, hostility and disregard.

Looked-after children and teenagers who have been fostered, adopted or have spent time in the care of the local authority may be particularly at risk of developing attachment difficulties. Their backgrounds often include multiple trauma, neglect and abuse, experience of violence or witnessing violence, and, without exception, loss. A parent may have been in prison and thus separated from the child, or have had mental health or addiction problems. Such early experiences can leave children and young people with little or no hope, trust or expectation that the world will care for or respect them.

Cherishing parents

Clearly the implications for early parental care are serious. Bowlby's early work on attachment influenced health service changes such as mothers and new-born infants sleeping in the same wards rather than being kept apart[8], and parents being allowed to stay with their young children undergoing surgery in hospitals, to lessen the pain of separation. But far more is needed in contemporary society. Adult attachment interviews conducted with pregnant women have shown that a prospective mother's recollection of how she was parented has an 80 per cent correlation with the attachment style with which she will go on to parent her own child[3]. This tragic transmission of insecure attachment has been shown to be correlated for three generations. If society values its children, it must cherish their parents[4].

There is a growing body of evidence to suggest that early intervention programmes designed to enhance maternal sensitivity, and develop more positive child/parent relationships through (child-led) play can offer small children their best chance of experiencing a secure attachment[6]. They also offer parents the best chance of enjoying being parents[7], leading to greater satisfaction and confidence in this role, and raised self-esteem and motivation.

Working with patterns of insecure attachment behaviour

Building on Bowlby's early work, Ainsworth[9] and colleagues identified three main patterns of insecure attachment behaviour – avoidant (Type A), ambivalent (Type C) and disorganised (Type D) (secure emotional attachment is labelled Type B). These patterns (see box above) are demonstrated whenever attachment behaviour is triggered, ie when anxiety arises and the need for a secure base is prompted. At the far end of the spectrum of these disorders, some children with extremely disturbed early experience may go on to develop attachment disorders, codified in the ICD10 as Reactive Attachment Disorders with Inhibition of Attachment Behaviour (F94.1) and Reactive Attachment Disorders with Disinhibition of

Attachment Behaviour (F94.2)[7].

Understanding the different patterns of insecure attachment can give us cues as to how to respond to clients who present for counselling or psychotherapy. Clients who present with insecure avoidant attachment are likely to need to define and be in control of what happens, to resist attempts to make a relationship, and possibly to avoid eye-contact. Their preference to sort things out alone means they may avoid seeking treatment until whatever problem they are struggling with becomes too much, too painful, or beyond their control. They are likely, at least initially, to be happier making a relationship with professionals by focusing on a third entity or task, be it an illness or a form of treatment, rather than on themselves ('the leg' or 'the panic attacks' rather than 'my leg' or 'when I feel anxious', for example), and are likely to respond best to respectful approaches which give them maximum choice and power over what happens. Professionals may be left feeling useless, or as if we are trying to force a relationship or care on them. We may be tempted to give up, or 'buy into' their go-it-alone stance, but there are alternatives. At least initially, a solution-focused approach may suit these clients.

In developing a counselling relationship with George, a fireman who presented with panic attacks, Preena found it helpful to make her comments to the floor rather than speaking to him directly. She found that George was more relaxed if she moved her chair to almost parallel to his, at a little distance, rather than sitting face to face, so that they could both look ahead as if 'his problem' was outside him. Over time, she found his eye contact improving, and he seemed better able to engage with their sessions. It emerged that George's mother had had depression throughout his childhood. George was the oldest of several children, and had been left to fend for himself. He could not rely on support from his mother, and had developed an independent, self-contained stance in life. He struggled to allow anyone close to him, and found developing any kind of intimate or trusting relationship extremely difficult. His professional role as 'rescuer' had suited him well.

Professionals working with clients presenting with insecure ambivalent attachment patterns, on the other hand, may come to resent the extra time they seek, in person or on the telephone. These clients seem to need to 'cling' to professional support rather than act independently. Their focus

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is on a desperate attempt to make and keep a relationship, rather than on the 'task' (of dealing with the presenting problem). Such clients often become well known to services, and may quickly become labelled as 'attention-seeking' or 'manipulative'. Understanding their behaviour as communication about unmet needs, on the other hand, is more likely to provide a respectful and constructive way forward. Indicating how the client is being 'held in mind' even when they are not present can help ameliorate their anxiety that once out-of-sight, they are equally out-of-mind. Interventions designed to support the gradual development of independent thinking and action, while recognising the need for recognition and reassurance, will be most helpful.

Tina, an unemployed mother of five, was known to everyone at her GP practice, and reception staff secretly groaned when she came in. Presenting with a series of complaints for which physical causes could not be found, Tina had finally agreed to counselling as a way to deal with her generalised anxiety difficulties. Her counsellor Claire felt hounded by Tina's incessant calls, notes and messages, and did not feel that any progress was being made in counselling.

Having discussed her reactions in supervision from an attachment perspective, Claire started to think that Tina's behaviour might reflect insecure ambivalent attachment. Tina's mother, an actress, had suffered drug and alcohol addiction when Tina was born, and Tina had spent much of her young life in a hyper-vigilant state, monitoring her mother's moods. When her mother was clean, Tina became her baby princess, but when her mother had a new boyfriend or started to drink again, Tina's needs would become sidelined and neglected.

Claire decided to offer Tina a pre-arranged phone call each week in addition to the counselling session. She created a notebook for Tina, and asked Tina to keep a journal of her

thoughts and feelings: Claire was proactive in asking to read the notebook together when Tina next came in. She wrote in the notebook herself so that Tina had a tangible reminder of Claire's input. Claire made sure to make eye-contact and smile at Tina if she saw her in reception, rather than trying to avoid her. She also asked the reception staff to do the same.

Through these small changes, Claire came to feel more grounded, less oppressed and irritated, and more empathic. She was able to have a better sense of Tina's fear that she could not rely on Claire to remember her, and that she would always be pushed away and forgotten.

The small minority of clients who present with disorganised attachment difficulties are likely to be those who create most problems for professionals. Any number of random triggers may set off their fight-flight reaction, possibly leading to violent outbursts. Moreover, their capacity to calm themselves will be limited, and their tolerance of delay or perceived disrespect or neglect minimal. They struggle to trust professionals. Their difficulties with concentration, organisation, motivation and memory may make cognitive approaches problematic.

The essential focus with such clients needs to be on safety, and recognising that strong and divided feelings are likely to be generated in teams who work with them. A collective and consistent approach to 'containing' these feelings and the client needs to be found, so that multidisciplinary teams around the client can avoid blame and think together about what may be happening and the best way forward. Support and supervision will be needed, creating, in the first instance, a secure base for staff to enable them to offer stability to the client. Small and steady tangible interventions, perhaps focused on improving the client's real-world situation, reliably carried through within the context of a stable key-worker relationship, are most likely to create trust and the beginnings of genuine relationships[10].

Within our families, schools, and the workplace, daily events may trigger many of us into insecure attachment behaviour. Understanding our own and our clients' patterns of such 'automatic' behaviour can help us all to become more empathic and resilient in the creation of a more securely attached society. Likewise, reflecting on problematic behaviour as a potential communication about unmet attachment needs may help us as counsellors reach to the child or the child within the adult we are dealing with, still looking for a second chance to experience secure attachment. We are not here to offer parenting but we can offer a stable, consistent, attuned response that contains unregulated distress, and empathises with, thinks about and names what might be happening for our clients. In this we offer ourselves as secondary attachment figures.

Recognising attachment difficulties may mean that we have to point out when approaches reliant on the presumption that a client will readily trust a professional are inappropriate. It may mean we have to argue for longer counselling relationships, so that we can work to establish ourselves as a secure base for our client before we start addressing the presenting problem. It may mean that we have to argue for funding or time to arrange meetings for the 'team around the client'[11], in order to jointly discuss clients too damaged to contain alone. And it may mean, as a consequence, we become more effective in our work. ■

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