

Chapter 1**ATTACHMENT
AND EMOTIONAL RESILIENCE**

Whenever a child or adult is faced with traumatic life events, particularly the loss of a loved one, the ability to survive the emotional and physical pain associated with the event will be influenced by the individual's level of personal resilience.

RESILIENCE

The ability of a child or adult to mentally represent himself and others without distortion is thought to be a major factor in understanding the nature of resilience. Therefore, a positive view of the self can help the individual to develop a range of personal strengths to cope with life's adversities, including the trauma associated with death in the family.

Resilience is not just a matter of constitutional strength or a robust temperament, it is also a product of how people perceive, appraise, approach and tackle stresses and challenges.

Factors associated with resilience are thought to include secure attachments to significant others, absence of early loss and trauma, high self-esteem and social empathy, and an easy temperament. (*Fonagy in Howe, 1994*) Thus trauma and maltreatment that disturbs a child's ability to represent and understand his own and other's emotions and behaviours, reduces his ability to make sense and cope with distress, conflict and social failure. However, if a maltreated or a bereft child can relate to a responsive figure outside of the traumatic situation, he or she might be able to develop the capacity to manage relationships mentally with increased accuracy and understanding, and without distortion, self blame and negative self image.

Therefore, it is important for any person that is in a helping role with both children and adults who are grieving and trying to come to terms with drastically changing personal circumstances, to take into consideration the child's experiences and model of attachment to his significant others. Understanding the situation for members of the child's family, who are also grieving, is equally important, as a better understanding of how the family as a whole relates to each other will not only increase the likelihood of forming a positive working alliance between helper, child and family, but also give the helper some information to assist the healing process. At this time, the helper may need to temporarily serve as the responsive adult figure outside of the home environment, and to a child, the helping relationship may be the only one that is emotionally safe and devoted to his needs.

ATTACHMENT

Attachment behaviours in humans, as indeed in lower forms of animal life, ensure survival of the species. Throughout an individual's lifetime, attachments provide connections to others, an aid in the quest for identity, they influence the nature of future relationships, and it is widely accepted that they change in focus and importance across the life cycle. The child's attachments in early years are usually focused towards the parent figure who provides emotional and physical security. These attachments shift towards peer group in adolescence, and towards partners, and eventually towards children of their own in adulthood.

Therefore, during the life cycle, loss of a loved one may have a different effect upon individual members of the family, and styles of grieving and methods of coping may vary accordingly. The worker, who has some understanding of the nature and process of how attachments develop, is in a better position to form therapeutic relationships with grieving children and families.

THE PROCESS OF ATTACHMENT BETWEEN ADULT AND CHILD DURING EARLY PSYCHOLOGICAL DEVELOPMENT AND SOCIALISATION

The concept of attachment theory became more widely known following a report to the World Health Organisation, in 1951, when John Bowlby suggested:

"What is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother... The long period of helpless infancy of the human species entails serious risks, so it is of crucial importance to survival, that the child and its mother should become attached."

Attachment is thought to be "an affectionate bond between two individuals which endures through space and time and serves to join them together emotionally". (Klaus and Kennell, 1976) The work of John Bowlby during the 1950s originally concentrated on the relationship between the child and the mother, but later he and others came to accept that significant others, extended family members and primary care givers could also be 'attachment figures'.

Since the 1950s much has been observed about the process of parent-child relationships, but what has stood the test of time is the belief that the quality of this relationship constitutes a central aspect of positive parenting. The development of social relationships occupies a crucial role in personality growth, and abnormalities in relationships are important in many types of psychopathology (emotional or mental ill health). (Rutter, 1991) There are many positive long-range effects of strong healthy attachments, but, as helpers of bereaved children, it is vital that we are aware of the risks posed to them as a result of damaging parent-child relationships or of separation of children from their caregiver. Attachment theory, therefore, provides a theoretical base for practice and informs decision-making and planning in accordance with the best interests of vulnerable children.

QUALITY OF ATTACHMENTS

Positive attachments help the child to attain his full intellectual potential, think and perceive in a logical manner, develop social emotions and conscience, and begin to trust others as a result of this. Quality relationships help children to become self reliant, develop self worth, better cope with frustration, envy and jealousy, and overcome common fears and worries. A child, who is well attached to one care giver, can more easily develop attachments to others, such as siblings, extended family and eventually to friends.

ATTACHMENT BEHAVIOUR AND THE ATTACHMENT SYSTEM

'Attachment behaviour' is any behaviour designed to get children into a close and protective relationship with their attachment figure when they experience anxiety. This attachment system is an inbuilt mechanism for seeking proximity to a caregiver for protection, food and social interaction. It provides opportunities for learning about relationships and the environment. Three main attachment behaviours in infants are: signalling, such as cooing, laughing and smiling; aversive behaviours such as distressed crying; and making a direct approach towards caregivers.

Anxiety activates the attachment system, which increases attachment behaviour. Therefore, behaviours and emotions associated with attachment are clearly seen in situations of anxiety and distress.

Anxiety invoking factors come from three main sources:

| | | |
|------------------------------|---|---|
| The child | → | For example, through sickness or tiredness |
| The environment | → | Through perceived threats or fear |
| The attachment figure | → | Uncertainty about the location and availability of the attachment figure, or of their likely response |

HOW THE PROCESS OF ATTACHMENT WORKS

The work of Donald Winnicott had a major influence on how psychologists and others came to understand the developing relationship between the infant and the primary carer. (*Jacobs, 1995*) Following birth, the 'good enough' primary carer becomes preoccupied with the welfare of the infant, a state known as 'Primary Pre-occupation.'

This process begins when the infant cries if he is uncomfortable, hungry, wet, or in pain. When the mother responds immediately and pacifies the infant, he feels safe and secure. When sufficiently developed, the infant smiles. This process aids the attachment and allows the mother to bond with the child. The mother will then return the smile, and he begins to feel good about himself. This helps the infant to develop trust in external people, and the mother remains preoccupied with the child until it is safe not to do so.

In children, anxiety and fear, as well as illness, tend to increase attachment behaviours, and when a person is associated with relief of anxiety an attachment is fostered. It is believed that the intensity of relationship is more important in forming attachments than the length of time spent with the child. It is the speed of the adult's response to the child's fear that will influence the quality of the attachment.

THE DEVELOPMENTAL PROCESS

Between birth and two months old, it is thought that the infant commences the development of social behaviours. He can engage in social responsiveness and demonstrate an interest in one person or another by visually tracking their movements and listening. This is a pre-attachment stage.

Between three and six months old, the child is usually able to discriminate, recognise and show a preference for particular adults. There is greater vocalisation and smiling. At this stage attachments are beginning to form.

At seven months to three years, the child will actively initiate proximity and contact. One attachment figure is usually selected, with whom they will actively seek out and maintain contact. However, they will already have formed an opinion about the reliability and availability of that person, and this opinion will have been firmly fixed in their emotional internal world.

This process is known as the '**Internal Working Model**' because it will come to be used as the model for the way that the child perceives other people, and consequently sets the pattern for the way that child interacts with others. The infant will develop the innate ability to expect certain responses from others, according to their past and present experiences with attachment figures. Therefore, their subsequent approaches and responses to others are likely to be purposeful and deliberate.

From three years onwards there is a more sophisticated partnership and an understanding of their own and mother's behaviours. The child can begin to see other people's points of view, discussion and negotiation in relation to goals is possible, and there is less need for physical proximity. This is the process of developing independence, and the child, with increased emotional security, can achieve this independence through 'internal working models' of 'safe' and 'anxiety reducing' parent figures.

THREE WAYS THAT ATTACHMENTS DEVELOP

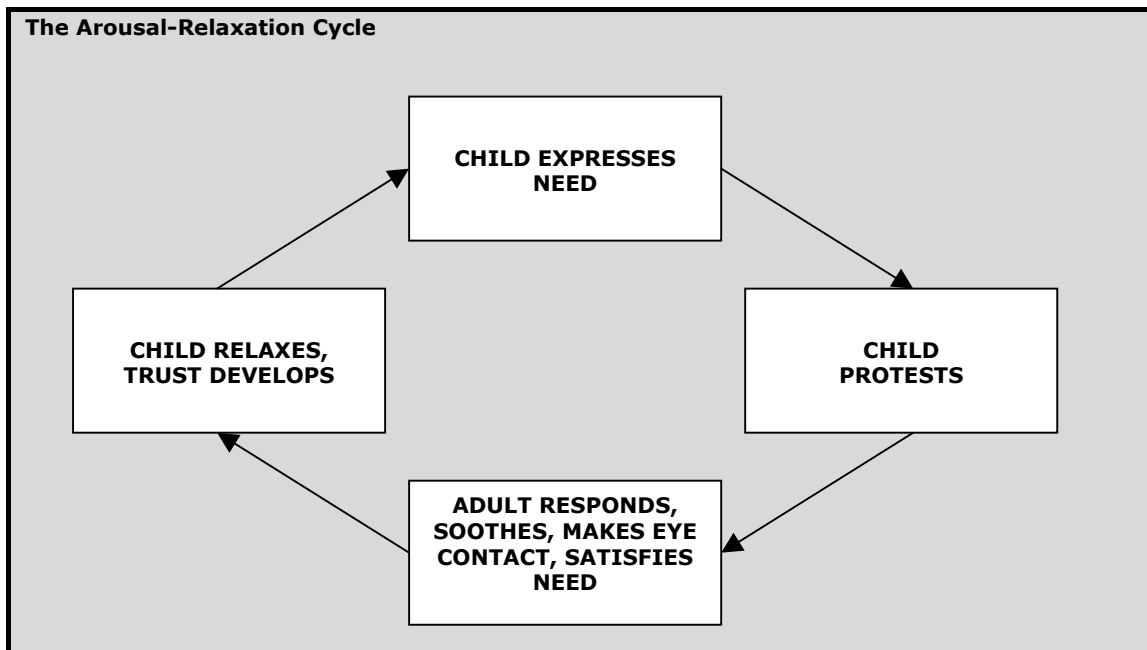
- **The Arousal-Relaxation cycle**
- **The Positive Interaction cycle**
- **Positive Claiming**

All of these can be used to facilitate relationship building between adults and children beyond infancy.

THE AROUSAL-RELAXATION CYCLE

This cycle is triggered by the child's needs, and when the parent meets that need and alleviates discomfort, the child develops trust in the parent. Repeated cycles help to reinforce the child's strong sense of identity. However, the diagram below can reveal several places where the positive process can be interrupted, prompting the reverse reactions in the child.

Some parents consistently fail to respond to the child's communication, or maintain that children should not be 'spoiled' or 'get what they want', and this can interrupt the 'arousal-relaxation' cycle. Some children are difficult to relieve, e.g. those who are unwell, or exposed to harmful substances during pregnancy, and premature infants. Also those who are separated at birth can have difficulty in signalling discomfort, and some can become more isolated.

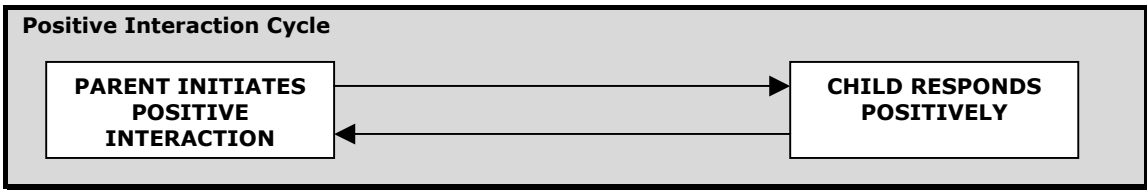


POSITIVE INTERACTION CYCLE

This cycle increases the child’s self worth, self-esteem, trust and security.

The parent can initiate positive contact with the child in a number of ways including cooing, smiling, caressing, offering favourite foods or by providing the child’s favourite toy or comforter. Such contact assists the bonding process.

This style of psychological and social interaction is thought to contribute more to attachments than responses to the child’s physical needs. The more social interactions an adult has with a child, the more likely it is that an attachment will form, and the more loveable the child feels. This is important to the building of a child’s self-esteem - the important factor in resilience.



POSITIVE CLAIMING

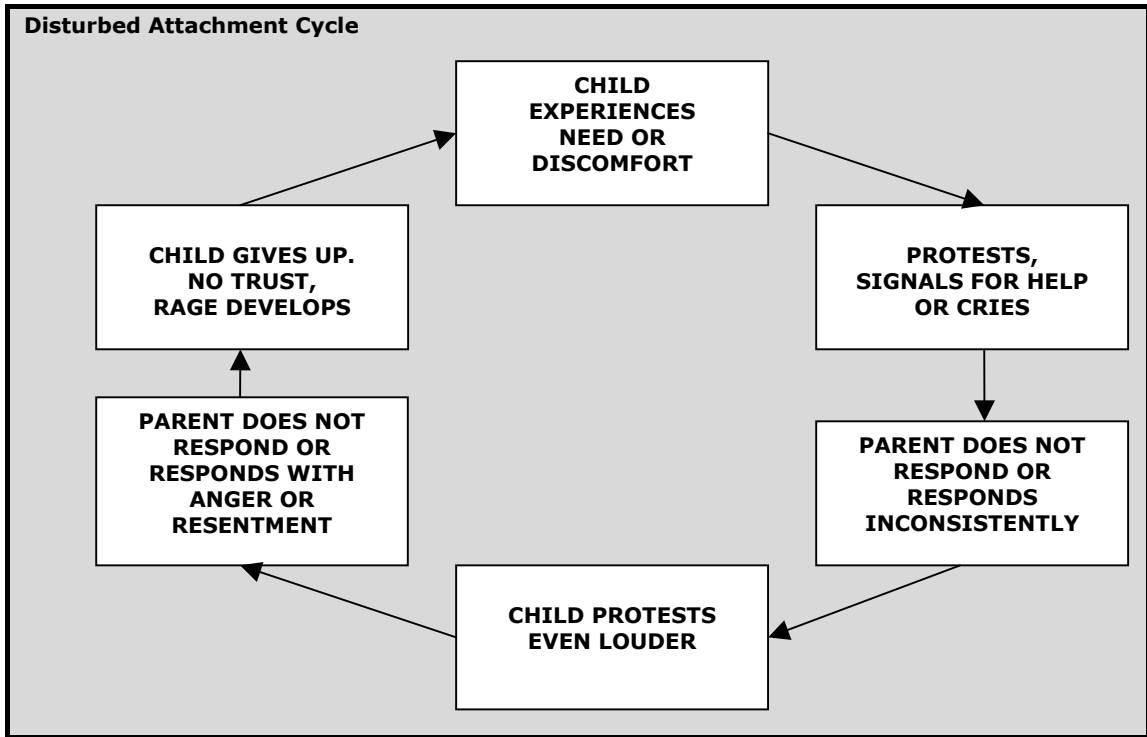
Claiming is a way of beginning the process of attaching the baby to the family of origin. The child is ‘claimed’ as ‘special’ by the parent or parents, and a detailed examination at birth of their ‘unique features’ reinforces the ‘ownership’ of the child. It is the physical similarities (e.g. ears, nose, eyes etc) to the family of origin that add to the feelings of entitlement to become part of the family.

However, claiming behaviours can be both positive and negative and have implications for the way the child is perceived or perceives himself in the future.

The child may be likened to a family member who is disliked or in conflict with others, or he may be associated with a parent whom the extended family dislikes. This can also happen if the child has a disability, and he can be disclaimed as a result.

DISTURBED ATTACHMENT CYCLE

This cycle, illustrated below, does not relieve the child’s anxiety or satisfy the child’s emotional needs. It can lead to frustration and eventually despair. This model of the external world becomes ‘internalised’. In other words, negative expectations of what adults have to offer are developed in the child’s internal world, influencing the child’s ‘Internal Working Model’.



FACTORS THAT AFFECT THE STYLE OF ATTACHMENT

Before the birth, parents develop images of what the child will be like, and the mother develops a relationship with the foetus as 'part of herself'. However, not all images may be positive, and such things as wrong timing of the pregnancy, dysfunctional relationship between the parents, or the presence of pre-natal conditions or complications, may affect the attachment by parents to the foetus. Psychiatric disorder in the parents may also have a harmful effect upon the relationship, and result in the child perceiving the parent as unavailable.

Further conditions that can affect the physical and emotional health of the child include inadequate nutrition, being subjected to harmful substances during the gestation period, trauma or accident, or disability, such as Downs Syndrome, which can reduce the capacity of the child to smile or to signal distress. This can result in the parent figure missing the attachment signals and perceiving the child as unresponsive.

MODELS OF ATTACHMENT

These have been classified as:

- Secure
- Insecure – Avoidant
- Insecure – Ambivalent
- Insecure – Anxious
- Disorganised
- Unattached

INTERNAL WORKING MODELS

Attachment theory states that young children within close relationships acquire 'Internal Working Models' which help them make sense of their environment, based upon people's availability and their willingness to provide care and protection. It is the beginnings of a child's ability to plan, reflect, analyse and see other's points of view. This view of the world is influenced by experience and is subject to change, and social competence is achieved by the way the child perceives:

- Self
- Others
- Relationship between the two

Research shows that parents' own history of social relationships influences the quality of relationships they have with their children as well as each other. Parents often treat children as they were treated themselves. (*Howe, 1995*)

INTERNAL WORKING MODEL OF SECURE ATTACHMENT

Secure attachment experiences help the child to see himself as lovable, worthy and effective, and others as available, loving, interested and responsive. Such experiences help the child to manage trauma and anxiety with some degree of trust. They are less likely to believe that the whole world is always so painful, and more likely to believe that positive outcomes are possible, and that death of a loved one does not mean total abandonment by everyone. In adulthood, this is particularly important in enabling the parent who is bereft to still provide emotional stability for the child.

INTERNAL WORKING MODEL OF AVOIDANT ATTACHMENT

Where the parent avoids responding to the child's immediate needs, makes them wait for relief and comfort, or responds frighteningly or inconsistently to their needs, this internal working model develops.

Sometimes children will use avoidance themselves, as a way of physically and emotionally managing the disappointing interaction with their primary carers. These children need to be self-reliant, self contained and emotionally strong, as others are perceived as only conditionally available.

Others are perceived by them as likely to be rejecting, distant and hostile, and a punishing response is predictable. These children tend to be rather isolated and

do not particularly care whether or not they have relationships. They do not enjoy being with others because they do not feel safe. Such people tend to be overly independent and become enraged or highly anxious when forced to rely on others for help. Their belief is that nobody can make them do anything they do not want to do, and they delight in showing others this.

They are often sullen and openly oppositional, but primarily in a passive-aggressive way. Such behaviour is characterised by frequently 'forgetting' to do things, being persistently late and breaking things 'accidentally'. They attempt to avoid all feelings, but when they cannot ignore how they feel, they almost always experience negative emotions such as anger, frustration, and boredom. Taking such children on treats can result in them being unable to enjoy themselves.

INTERNAL WORKING MODEL OF AMBIVALENT ATTACHMENT

These children have usually been subjected to widely differing responses by parent figures, from overly affectionate to angry and neglectful. As adults they often feel unloved and ineffective, and they have a strong need for love, attention and approval. They have positive expectations, but low satisfaction, and see others as unavailable, unreliable and disinterested. They can be quite hyperactive and sometimes use coercive behaviours to control others, for example by making them feel guilty.

Although they have the ability to allow some closeness with others, they tend to quickly sabotage this. The relationships they do form tend to be short-lived because they easily feel rejected and often push people away first to avoid facing rejection. Their charming behaviour can change quickly for no apparent reason into an excessive expression of anger, and destruction. Most of their behaviour has a high degree of inconsistency about it, and this often prevents their own children, when they are infants, from perceiving them as reliable and predictable. Hence the cycle repeats itself in the next generation.

INTERNAL WORKING MODEL OF INSECURE ANXIOUS ATTACHMENT

This working model sometimes develops from the belief that the attachment figure is available, but only with certain conditions, and that she/he is likely to withdraw that comfort and support if the child no longer meets those conditions – such as being well behaved or co-operative.

These children and adults tend to be overly clingy and become excessively upset when separated from their mothers or significant others. In children this clinginess differs from what is seen as age appropriate dependence on the adult caregiver.

They are able to make friends, but usually demand attention and unconditional acceptance from others, in a clingy manner. In their teens these young people use sex to hang onto boyfriends/girlfriends, or they buy gifts to keep friends. These people usually allow others to physically or emotionally hold them and they are seldom openly defiant. However, they have a tendency to switch mood and become overtly destructive when their safety is threatened.

INTERNAL WORKING MODEL OF DISORGANISED ATTACHMENT

This working model usually comes about by the child experiencing the most negative and extreme aspects of care giving from all of the models. It means that these infants are unable to make sense of any style of parent-child interaction, as it is constantly changing. Interaction can range from affectionate, rewarding responses at one time, to avoidant and distant, or blatantly aggressive the next. Such children who experience disorganised care giving are likely to adopt strategies in which they take charge of the relationship and control the parent, as a desperate attempt to achieve predictability in their lives. Their controlling strategies reflect these extremes and can be either care giving or punitive. These children, and indeed adults, displaying this style, are particularly vulnerable and can form a major part of the helper's workload.

Disorganised children and adults will view others as threatening and will be wary of them, preferring to adopt caution in readiness for the predictable changes. They often alternate between defensive aggression and control, and apprehensive withdrawal and helplessness. Initially they can be quite engaging with strangers and are likely to have early sexual experiences, but alternately they dislike being touched and will defend against this. People with disorganised styles of attachment often have abnormal eating patterns, poor hygiene and self-neglect, reflecting the chaotic nature of their internal working model.

Features of this internal working model include restlessness, telling tales and exaggerating stories, anti-social behaviour and stealing, which can become out of control. They are most likely to be unable to cope with conflict, as they are easily aroused by aggression and distress. Constant blaming of other people and high levels of resentment can lead to violence, and as a result, they are likely to be socially withdrawn and unpopular with others. People with this lower level of personal resilience, who present with complicated patterns of grief, will usually benefit from a referral to specialist therapeutic services.

THE UNATTACHED CHILD

This working model is far less usual, but has been described in rare cases. It usually develops as a result of constant and predictable behaviour by the attachment figures. This predictable care giving is usually hostile, sexually, emotionally, or physically abusive, and extremely neglectful. Such children never have the opportunity to experience love and affection, so develop a hostile and irresponsible sense of self. They have no trust in others, which results in them becoming very untrustworthy and sometimes dangerous to others. The traits are more apparent than any of the other models, and include a real lack of connection and empathy towards others, hence their potential danger to others.

Such children and adults develop relationships that are short lived and exploitative. They are skilled at deceit and are unable to give and receive affection. They cannot be trusted with animals because of their cruelty, and they have a tendency to engage in risk taking behaviours. They believe that other people have no value, and thus have the ability to hurt or even kill others. They do not have a secure base or personal resilience from which to withstand the trauma of loss, and are therefore likely to react in complicated or dangerous ways. Generally speaking, these people are also more likely than most to need specialist therapeutic services.

ATTACHMENT AND LANGUAGE DEVELOPMENT

It is generally believed that for optimum language development the child needs consistent reinforcement by parental figures, particularly attachment figures. Moreover, children with fewer primary carers acquire skills better than those with multiple carers. An added challenge for neglected children, or for those who have to be cared for by siblings, particularly young siblings, is the fact that children rarely progress beyond the verbal skills of their superiors. The result can lead to children acquiring a restricted verbal code, and reduced ability to conceptualise abstracts.

UNDERSTANDING ATTACHMENT AND BEREAVEMENT: RESPONDING TO CHILDREN AND FAMILIES IN WAYS THAT CAN PROMOTE THE BEST POSSIBLE OUTCOME

It is worth bearing in mind that most children will have experienced some negative forms of parenting during their childhood as it is unlikely that many, if any, families are 'perfect'. In the words of Donald Winnicott (*Jacobs, 1995*), the parent does not need to be perfect, just 'good enough.' The Positive Interaction Cycle (described above), however, demonstrates how interaction can be promoted in ways that help to form strong attachments, or begin to redress the deficits for less fortunate children.

Having a greater understanding of how attachments develop can aid the helper in making a more accurate assessment of the child's situation, and in forming an opinion about the degree of risk to that child. These skills are even more important when the child is not known to the statutory agencies and the helper is keen to ensure that the traumatic events in the home do not place the child at risk of receiving inadequate care or of being abused in some way. If at any time the helper is worried about this, the local statutory procedures to protect children should be followed.

After traumatic loss, family members are most likely to be suffering emotionally themselves, so the normally accepted pattern of interaction could be interrupted. However, there may also be a pre existing pattern that is unhelpful to the child, which may be interfering with the child's ability to come to terms with the loss. The family's reduced level of resilience may provoke attachment seeking behaviours by the child, and these could be misunderstood by stressed relatives. Observing the interaction between the child and its primary carer, in as comfortable setting as possible, will allow the helper to plan how best to support the child and family and how to offer advice aimed at sustaining or improving the primary relationship and the emotional security of the child. Using the Arousal-Relaxation Cycle (described above), the helper can observe how the child signals intense feelings, and whether the primary carer is able to respond adequately to achieve comfort. Is the carer able to indicate her or his own intense feelings, and how does the child respond?

Using the Positive Interaction Cycle, it is possible to observe how frequently the child or parent initiates positive interchanges, and what response they receive from the other person. Do the interchanges encourage a positive response from the former, or are they one sided, leaving the other feeling rejected or abandoned? If a negative cycle is constantly noticed, then the helper can begin to offer advice about more positive ways of interacting with the child. However, this advice needs to be delivered in a manner that supports the family rather than criticises them.

The helper can use Attachment Theory to promote a positive relationship with the child when working with them individually. Actively listening to the child and responding to them promptly will be more likely to enhance the therapeutic relationship. This will begin to help the child experience a positive model of communication. It is very important that the helper has the ability to react consistently to the child and family's requests or demands, thereby helping them all to predict how the support will be delivered.

In some cases, where the attachment style of the family is less helpful, it may take all the helper's skill not to react in a similar way to the family model. Such feelings from the family, which are directed towards the helper, are a usual part of this very challenging work, and therefore should be expected as part of the role. These strong feelings could be a high degree of dependence or neediness, as well as withdrawal or hostility. What is important in the work is that these feelings, which are transferred to the helper, should not result in the helper believing that they must take all the responsibility for the child or family's welfare. Of course, the first consideration is the protection of the child, but so long as the child is safe, helping the family to retain their independence, once the shock has subsided, will be the best course of action for their recovery.

The worker must also remember that the child's negative and sometimes hostile feelings are most likely to be as a result of their situation, and should not be taken personally. The response to negative outbursts or rejection from the child needs to be delivered with empathy, and not reflect the mood of the child. By remaining constant in their interaction with that child, the worker can help the child to feel emotional safety in the therapeutic relationship. This does not mean that children can be exempt from the normal boundaries set by appropriate parents. Rather these boundaries need to be established in a firm but compassionate way. Remember that undue criticism may well be perceived by such children as persecutory, and will reduce the chance of a positive outcome.



ATTACHMENT AND EMOTIONAL RESILIENCE

Points to remember:

- Resilience is not just a matter of constitutional strength or robust temperament. It is also a product of how people perceive, appraise, approach and tackle stresses and challenges.
- An individual's ability to survive the emotional and physical pain of a traumatic event, particularly the loss of a loved one, is influenced by their level of personal emotional resilience.
- The quality of attachments between infants and caregivers has a lifelong effect on how they relate to other people and form relationships.
- Positive interaction between the care giver and the child can build up self esteem – the important factor in resilience.
- When working with children, you need to take into consideration the child's experiences and model of attachment to his significant others.
- Workers who have some understanding of the nature and process of how attachments develop are in a better position to form therapeutic relationships with grieving children and families.
- It is important that you do not take the negative and hostile feelings of the child, which are often the result of the child's situations, personally.
- Interaction with the child should be consistent and responses to the child need to be compassionate and delivered with empathy.
- If at any time you are worried that the child is at risk of receiving inadequate care or of being abused in some way, you must follow the local statutory procedures.

See Annex 1 for the Emotional Resilience Checklist.