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Attachment Disorder, Basic Trust and Educational Psychology.

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ABSTRACT

The label Attachment Disorder (AD) is used as either a description of a child's presentation, or as a diagnostic category. It is unclear whether this label is intended to be identical with the DSM-IV Reactive Attachment Disorder (RAD) diagnostic category, or if it is a separate diagnosis based on Randolph's Questionnaire and the premises underlying this instrument. The third option is that any allusion to "attachment" relates to a position which has evolved from Bowlby. All three variants of this diagnostic label allude to early parent-child interactions, and thus imply the need for remedial interventions at the parent-child level. There are limited options for such interventions at school. A more fruitful interpretation is that the inference of inadequate early childhood interactions designates an incomplete early psycho-social task (the development of Basic Trust) and this perspective leads towards credibly promising school-based interventions.

Introduction

The present paper reminds the clinician of the basis of Bowlby's work (see for example Bretherton 1985), reviews both Randolph's (2000) Attachment Disorder (AD) and the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV: APA, 1994) on Reactive Attachment Disorder (RAD). The problems of school-based interventions for disorders of attachment are noted. Finally, an underlying unity and the potential for fruitful school-centred intervention is suggested by viewing "attachment" difficulties in the light of the pre-existing model of child psycho-social developmental stages (Erikson 1968) linked with the psycho-social contributions of Arsenio (1988) to provide a credible outcome for school-based interventions (recognition and appropriate labelling of emotions).

There are at least three possible meanings behind the notion of an attachment explanation of a client's problems, these being (i) an abbreviated nomenclature of the DSM-IV-TR (2000) classification, (ii) the somewhat distinct Randolph (2000) definition, or (iii) "none of the above". A unifying framework for many uses of the label AD exists in Erikson's stage of Basic Trust. The mastery of this psycho-social stage is a pre-requisite for successful subsequent identity formation. A compromised path in the process of trust acquisition directs the clinician towards achievable therapeutic interventions with the individual.

By way of contrast, as long as the clinical focus is upon the attachment experience then interventions which logically follow are likely to target more complex family interactions.

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For example attachment-derived interventions may aim to tease out and to compensate for long-since completed faulty parent-child dyadic constructs. However, if Basic Trust is addressed, the clinician can target therapeutic goals which are comfortably amenable to individual school-based therapy and/or classroom-based approaches. The positive corollary to the Erikson/trust model is that symptoms of AD could be clinically regarded as signs of an incomplete or non-mastered early stage (Basic Trust) and therefore as evidence of the need for specific here-and-now therapy.

Overview of the Diagnosis Attachment Disorder (AD).

It is an uncontroversial proposition that early childhood interactions help to shape subsequent patterns of responding to other humans. Bowlby (1988) is recognised for defining different mother-infant attachment styles[2] which may lead to relatively enduring childhood and adult personality styles. Around half of any representative sample is described as having a "secure" attachment, which is not only a description of the infant bonding experience but also an enduring, possibly life-long attitude which comes from the consistently rewarded expectation of trusting that the parenting figure will be available to provide comfort and safety. It is regularly reported that the remainder of the population (both children and adults) have intimate interactive styles which derive from (and then perpetuate) the infant experience of inconsistency and uncertainty.

Where early infant experiences are marked by doubts and/or rejection (rather than consistency and reliable nurturing) then progress in the development Basic Trust may be impeded (Erikson, 1968). This "trust" includes the outward focussed capacity to regard other people as reliable. At the same time, the internalisation of reliable and trust-evoking experiences is occurring (as though the infant says "what is out there is also what I am like") and this process builds in the child a sense of self-confidence, leading to the subsequent ability to face, to tackle and to cope with challenges - whether these challenges be social or educational.

The possibility of a disorder in the attachment process logically follows from the above summary. There are two overlapping diagnostic categories which describe a 'disorder' in the attachment process, and a third use of what might be better regarded as a description rather than a diagnosis.

1. The widely accepted psycho-medical diagnostic manual DSM-IV TR (APA, 2000) defines *Reactive Attachment Disorder* (RAD) which is clearly linked to certain childhood experiences, and marked by a list of current symptoms and signs.

2. The non-DSM diagnosis *Attachment Disorder* appears to flow from, or at least include, Randolph's work which in turn has as a central plank the Randolph Attachment Disorder Questionnaire (RADQ) (Randolf, 2000; Cappelletty, Brown and Shumate, 2005). The RADQ assists in the diagnosis of AD – but does not necessarily define the disorder. RAD is not necessarily the same as AD although the 30 items on the Randolph questionnaire are represented as having clear overlap with the DSM-IV (APA, 1994) diagnosis.

3. Finally, the descriptive term *Attachment Disorder* may be found in welfare agency reports[3] with reference to neither the DSM-IV (*Reactive* Attachment Disorder) criteria, nor to any other objective standards (Randolf's or other) which define *AD*. Thus, the informal use of

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"Bowlby's theory predicts that attachment representations are significantly stable across time (continuous) . . . Two main aspects of this continuity have been the focus of extensive theoretical thinking and empirical evidence: the continuity between mother's attachment security and infant's attachment security and the continuity of attachment representations from infancy through adulthood. " (Besser and Priel, 2005, p 1053)

3 this label "has been applied more and more frequently in recent years to describe a variety of problematic behaviours" (Cappelletty, Brown and Shumate, 2005, pp71-72)

AD may be a loose and undefined suggestion that is a *description*, rather than a psychological diagnosis.

Various roughly coherent views of "Attachment Disorder" may be sourced from WWW documents. These views are tentatively interpreted as suggesting a dichotomy between "secure attachment" or "not secure attachment", as an almost once-and-for-all quality. This position, based upon the assumption that early events make for an *indelible* attachment style, either implicitly or explicitly has foundations which are based upon Bowlby's attachment model. The Bowlby model also underpins the interpretations of attachment style in adults (Hazan & Shaver[4], 1987; Besser and Priel, 2005). While it is not the purpose of the present paper to either support, nor refute, the Bowlby attachment model, nor even review the extensive Bowlby literature, it is the present interpretation that the various versions of attachment disorder are coherent in that they ascribe great weight to what has happened to the child (an attachment style which develops between infant and caregiver), treating these early experiences as a causal, and therefore to some extent, an immutable factor.

Therapy and Interventions for AD.

The diagnosis of Randolf-based AD has been linked with specific Attachment Therapy (AT) interventions "including controversial techniques such as *rebirthing* (outlawed in Colorado in 2000) and *holding* techniques" (Cappelletti et al, 2005, p 73). "*Holding therapy* involves less serious restraint . . . and appears to have been associated with deaths only when used by parents of children being treated by attachment therapists . . . *Therapeutic parenting* is coercive in nature and employs both physical and psychological seclusion of the child" (Mercer 2001, p 106). These interventions and even the more benign suggestions ("For example, in interventions that teach parents to follow their child's lead or to observe their child on videotape, parents learn to concentrate (more) on the child's behaviour" (Juffer & Bakermans-Kranenburg, 2005, p 272)) are neither appropriate nor easily implemented by school-based Educational Psychologists. Considering that there is limited scope for the use of school-based attachment therapies or interventions, there is limited practical value to the school-based psychologist of an "attachment disorder" diagnosis.

The need for Basic Trust

Alternate to the attachment models, the transition from (and hence the input of) early childhood experiences to the development of subsequent personality qualities has been represented as the successful passage through a series of hierarchical stages. Mastery of each stage at the relevant age is the ideal scheme for healthy adolescent/adult personality formation to occur. When the interpretative focus is upon the question "has the individual *adequately* or only *partially* built target interactive capacities?" (for example the ability to ***trust,*** which underpins the subsequent stage of developing the ability to apply *foresight*) then, although it is credibly preferable that each stage be successfully completed at typical ages, it is never 'too late' for a child to enhance or augment these psycho-social building blocks. Therefore at later stages of childhood the inadequacies of early infancy experiences may be redressed and this intervention may lead to a more robust, stable and socially acceptable identity formation.

Erik Erikson (1968) and Peter Blos (1963) were two representative theorists who have made landmark contributions to the understanding of the effects of early childhood experiences upon subsequent identify formation. The benefits of the Erikson/Blos position is

[4] Although there are some variation in the labels given to the attachment groups, a relatively robust 3-way classification is used to indicate the long-term enduring nature of infant-mother attachment style, and the same three descriptors have been appropriated to describe adolescent and adult relationships (Hazan & Shaver, 1987) with relative frequencies in each adult group similar to those found in infant attachment studies : 56% secure, 24% avoidant, 20% anxious/ambivalent. However, while "*Some researchers designate three adult attachment groups (secure, dismissing, preoccupied* (from the Adult Attachment Interview)*. . . some use a four-group approach that adds the 'unresolved' attachment group"* (West & George 2002, p 280).

that it leaves open the door to the possibility of successful subsequent school-based interventions which might undo the problems flowing from home-based infant psycho-social deficiencies.

Blos explains that child and adolescent problems often have as their sources the tensions of the early childhood experience of learning to balance the needs of self against the demands of the outside world: "the complex phenomena of adolescence are built on specific antecedents which reside in early childhood . . . *le présent est chargé du passé* (Leibniz)" (Blos, 1962, p 17). In this observation, Blos was referring to the successful or else the incomplete development of Basic Trust which derives from the infant's interaction with the caregiver: "the child soon becomes inextricably interwoven with his environment, on which need gratification depends." (Blos, p. 3) "The infant is a totally dependent organism, who needs the caring and feeding mother for his (sic) survival . . . which operates as a circular response between mother and child (and) creates an interdependence. Attached to these processes are emotional qualities that have remarkable endurance in the conscious and unconscious life of the human being (p. 17) . . . This state of affairs is consistent with the infant's . . . disposition to consider those physical and emotional states that are good as representing self, while that are bad as belonging to non-self." (p. 18).

To the extent that this tension (self to non-self in Blos' terminology) achieves a harmonious balance – to that extent we can see that Erikson's stage of Basic Trust (trust in self and in others) is mastered: "the most fundamental prerequisite of mental vitality (is) a sense of basic trust" (Erikson, 1968, p. 96).

It is true that the text-book course of development nominates the first year of life as the time for mastery of the stage of Basic Trust through normal maturational and social interactional processes, as Blos himself would say, Basic Trust is best acquired through "needs gratification" at the time when "the infant is a totally dependent organism". However Blos never considered it "too late" for an intervention - a *therapeutic* intervention, that is. Just as Erikson saw a balance between the two extremes of each developmental stage, a recent review saw a compensatory symmetry between naturally stimulated environmental and the deliberately imposed therapeutic developmental progress, elaborating on the "Two strands of change . . . one maturational, the other therapeutic or developmental. . . . [and proffering the role of the therapist as augmenting the contribution of the parenting caregiver] Therapeutic change is analogous to developmental change in that both involve the crucial presence of another [a significant other person, which can in this context be a school-based psychologist]" (Downy 2001, p 39).

Building Basic Trust in the Classroom

Summarising the unfolding position, it has always been recognised that the way an infant experiences the world might well affect the way the child turns out (in a psycho-social, or "personality" way). If early childhood experiences are marked by disruption, by unpredictability, and by a failure of the infant to form strong expectations of reliable nurturing bonds with a care-giver, then that child may fail to develop a sense of 'trust'. This idea is common to all developmental theories canvassed in the current discussion, but the terminology differs.

The various versions of an attachment model, when applied to a child or adolescent with psycho-social difficulties, make it is easy to conclude that early childhood experiences have had an indelible effect on the "sort of person" that child will/has become.

A more even-handed and optimistic interpretation is available from the works of the giants of developmental theory, of Erikson and of Blos, where the "tasks" of infanthood and childhood are defined. Although it is *preferable* that these psycho-social tasks be completed at certain ages, it is *never necessarily too late* for a person to build upon earlier impoverished psycho-social development. It could be argued that both Blos and Erikson would comfortably embrace the term "Attachment" as but another label for the *task* of acquiring *basic trust* (finding first the target quality and then the balance of that quality - trust - in self and in others). From this position the mother-child interaction is just one (albeit a common one) of

an infinite number of instances through the life of the human where (and when) the acquisition of basic trust can occur.

Measuring Attachment and Basic Trust: *Certain Well Known Tests*.

Accepting the present proposition, a school-based psychologist needs to first identify students with impoverished Basic Trust as an underlying component of their presentation. This "identification" presupposes that the results of "certain well known tests" would be available to support the psychologist's opinion[5]. A recent discussion of precisely this issue (tests which distinguish children with early unsupportive histories) concluded that the Achenbach Child Behaviour Checklist (CBC) scored "a higher level of clinical symptoms" in a group of children with dramatically disrupted early childhood experiences, while of the Randolf Attachment Disorder Questionnaire it was concluded that: "its usefulness in clinical assessment is questionable" (Cappelletty et al., 2005, p 84). For the present discussion, it is accepted – in line with Cappelletty – that the social malfunction as indicated by the CBC be regarded as a candidate sign of impoverished Basic Trust. It is likely that other tests will emerge as more targeted indicators of the need for augmented Basic Trust.

Specific Interventions – New Directions

Classroom- or school-based strategies should be interventions which facilitate the on-going development of Basic Trust. The original concept of Basic Trust ("I can rely on someone's help for needs gratification") was founded upon a nurturing figure being always ready and able to help. Both Blos and Erikson discuss the importance of tension as the developing child discerns that not all needs will be gratified by this external figure. By the age of five years the quality of "trust" has formed the basis of, and is interwoven with the ability to recognise or predict the likely different attitudes and responses of other people (adults and other students). This social foresight involves the child's capacity to anticipate (demonstrated in operational terms by the ability to *name*) the emotional responses of other people. The appropriate (contrasting with the inappropriate) naming of others' feelings is observable in children from as young as age five as they learn to use "feeling" labels appropriately. Examples of feeling labels are words such as "happy, sad, angry, afraid". [6] Around about the age of 8, the normal transition is to a stage of psycho-social development whereby the child should be increasingly capable of making more society-oriented judgements, and therefore acts progressively with a less self-centred focus.

This gradual movement to a society-centred point of view is compatible with (but not restricted to) concepts of psycho-social development described in Piagetian ages and stages. The ability to see another's point of view, the development of a more societal perspective, all depend upon the foundation stage of Basic Trust described above and the transformation such that with the passage of time this quality is diminishingly manifested in its primitive, strongly egocentric modality. However for some children there is a consistent thread of behavioural or social difficulties and these problems are found to co-exist with a weakness in the child's ability to the appropriate naming of other people's feelings: the feeling judgements of socially dysfunctional children depart from "average conceptions" (eg Arsenio 1988; Arsenio and Ford, 1985; Hughes, Tingle and Sawin 1981, Tisak and Ford, 1986). These same children are also less able to judge the cause of a person's feelings. They appear to act

[5] "In Lowery v The Queen [1974] AC 85 the evidence of a clinical psychologist as to *the personality and character* of the accused was admitted . . . the clinical psychologist applied what the Privy Council described as 'certain well known tests' and further, ... *'scientific evidence* as to the respective personalities . . . *as revealed by certain well-known tests'* and held that the evidence *was admissible* . [however when an opinion by a psychologist is given and] . . . there was no evidence of any psychological tests having been carried out . . . . the opinion . . . is not admissible." (Keall, 1989, emphasis added)

[6] An excellent and reasonably comprehensive compilation of feeling words is found in the description of the development of the Profile of Mood States (McNair, Lorr and Droppleman, 1981).

as if they believe that their actions will have different affective consequences than do children with more typical conceptions (Arsenio, 1988). A supportive thread of studies has followed through subsequent decades, confirming that pro-social behaviours are correlated with correct recognition of emotions (Denham, Couchoud, 1991), demonstrating the age-associated capacity to make finer distinctions between the recognised affective states (Szagun, 1992), illustrating the expected position that, for children following the normal socio-affective developmental trajectory, age differences in children's search for social information and prosocial behaviour parallel judgments of emotion (Rotenberg and Eisenberg 1997), and at the same time validating Arsenio's (1988) proposition that inappropriate use of emotion labels goes hand in hand with established social deficiencies (King, 1998). Completing the circle (the present paper's proposition that post infancy "attachment disorder" is more fruitfully interpreted as impoverished progress in the nominated domains of basic trust and identification of affect) more recent studies have established the postulated link between "attachment style" and capacity to identify emotions (Mongrain and Vettese 2003).

Put simply, school age children who have not mastered the stage of Basic Trust cannot predict the responses of other people. Such children will become increasingly marginalized since their social judgment is somewhat awry, and their behaviour is seen as correspondingly out of step with the social norms. These anticipated problems are, of course, totally compatible with the pattern multiple anti-social diagnoses which co-exist with putative "Attachment Disorders". The broader ability to "plan ahead ... to see consequences" are compromised by the fundamental problem of impoverished Basic Trust.

Following Arsenio's clarification of the problem as it manifests at school age, it would be wrong to demand that teachers (or other students for that matter) should somehow mimic the supportive mothering role by responding to all of the school-age child's perceived needs. *Au contraire*, the Social Objective of a school-age intervention for Basic Trust would aim to *enable students to take one point of view ... and then describe (understand, or even support) another person's point of view.*

Corresponding to this outcome would be the Social Objective that children should learn to *use labels of "feelings" in an appropriate manner*. In this way they can demonstrate an important part of the overall skill of learning to understand other people's feelings and therefore to predict others' responses – the quintessential corollary of Basic Trust at this age.

Using classroom-based "feeling" exercises built upon the work of Arsenio (1988), these potentially ill-adjusted children will have the opportunity to grow socially, as they learn to understand and to anticipate conventional feelings to social interactions.

> *When Children attempt to understand the emotional reactions of others ... they may be able to rely simply on a knowledge of ... how most people respond in that situation (however) ...they sometimes need to take into account someone's unique personal perspective of psychological state*
> (Arsenio, 1988, p 1611)

Example 1: A Physical Point of View
This unit could start with the physical point of view.

- Place a teapot, or a vase of flowers, or any other irregular object on the table.
- Ask the children to draw what they see.
- Then on the same page, ask them to draw what the teacher (or the students on the other side of the room) can see, not what they themselves see.

Discuss the idea that there is no "correct" or "best" view of the object, that there are a number of different views.

This exercise could be incorporated into the Group work by having two groups face each other with the Object in between. Each Group must construct a drawing of what the other Group sees. Beginning with a simple object, this type of exercise could escalate with ever more complex three dimensional items as a target. The group would have to discuss and plan how best to describe and draw these difficult items from the other side, and the class can award points for "accuracy" of the Group result.

This lesson can easily fit into any art class.

Exercise 2. Blame and Responsibility

A little boy called John is in his room. He is called to dinner. He goes into the dining room. But behind the door there is a chair, and on the chair there is a tray with fifteen cups on it. John couldn't have known that there was all this behind the door. He goes in, the door knocks against the tray and bang go the fifteen cups and they all get broken.

Once there was a little boy whose name was Fred. One day when his mother was out he tried to get some jam out of the cupboard. He climbed up on to a chair and stretched out his arm. But the jam was up too high and he couldn't reach it and have any. But while he was trying to get it he knocked over a cup. The cup fell down and broke.

- *What does mother feel*
- *how does she <u>feel</u> when she sees the broken cups?*
- *How does each little boy feel, immediately after the cups are broken,*
- *and then a bit later when mother finds out.*

Exercise3. On-going Exercises in Feeling Recognition

Draw attention to real-life situations in the classroom by, for example, if when putting out classroom materials (art, reference books, calculators etc) on the table there are one or two people who miss out.

- *Observe what happens in these situations;*
- *ask how the children feel; ask the one child how another feels;*
- *seek a solution that reduces the "bad feelings", rather than simply telling them to "share".*

Further interventions may involve more routine therapies (for example modelling trust-invoking behaviour through picture-drawing, through puppet play, and through story telling and role play), but would also involve class-based group activities designed to enhance and reward recognition of other student's feelings, as well as positive interactions which involve cooperation, and mutual support, and building self-confidence – these all being the sub-molecular components of Trust.

Remembering that there are preferred or typical the nominal ages nominated by Erikson for these psycho-social stages, but also bearing in mind that the tasks for each stage are not necessarily completed, then it follows that every child in the class could receive benefit from exercises aimed at building and strengthening the internal feeling of "trust equals confident anticipation" which combines the idea of relying appropriately on peers and leads to an internalisation of this trust in oneself. This balance represented by the mastery of Basic Trust is in the middle road of social development which falls between the pathological extremes of avoiding a close and mutually supportive relationship with other people, or, of desperately and obsessively clinging dependence.

The internal strength which flourishes in parallel with Basic Trust is self confidence, self reliance, and the capacity to trust one's own ability to cope with either success or disappointment. Further work to be done in developing a truly practical set of guidelines for the school psychologist will divert the inquiry away from the question "what sort of infant mothering is revealed here?" but rather lead to the productive attitude: "how can we, at school, help this child to develop Basic Trust?"

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