Chapter 13: Attachment

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Background

Attachment theory was developed initially by John Bowlby, a British child psychiatrist and psychoanalyst, in the mid-20th century in an effort to explain two of his clinical observations: (1) disruptions in the mother-child relationship appear to be a precursor to later psychopathology; (2) children express distress, anxiety or anger on separation from parents (Bowlby, 1969; Cassidy and Shaver, 1999). Bowlby's observations and thinking were occurring at a time of profound challenges people were facing post WWII. For example, the sequelae of separation of children from their parents, often for reasons of safety, but then family disruption from loss and trauma. It was in this context that the WHO requested a formal report from him (Bowlby, 1951).

The psychoanalytic and social learning theories of the time focused on the feeding relationship between mother and infant, without appearing to account for the data from ethology that bonds seemed to form without this feeding. There was also a tendency to focus on the intrapsychic experience of the child and not consider the important relational interplay between caregiver/s and the child. The search to develop the theory led Bowlby down a sophisticated path, over a number of years, of synthesizing information from various disciplines such as evolutionary biology, ethology (Lorenz's work was foundational), cognitive science (including learning theory and the work of Piaget), developmental psychology, and control systems/cybernetics as well as psychoanalysis (Bowlby, 1951; Bowlby, 1969; Bowlby and Bowlby, 2012). This integration of knowledge and ideas continued to develop in collaboration with others including Mary Ainsworth to arrive at the notion of a motivational and behavioural system that supported the development of a bond between infant and caregiver, conferring evolutionary advantage. This advantage was multi-factorial, promoting protection, *feeding, development, self- and social regulation, and learning.* Although having its evolutionary origin in the

imprinting of birds, it was phylogenetically preserved and developed in mammals, primates and humans and is a central system for human development and our capacity to manage stress as individuals and as a species interconnecting with many other biopsychosocial systems (Cassidy and Shaver, 1999).

Evidence across a number of domains and types, including observational, epidemiological, experimental and longitudinal research, including research that spans several generations of families, has then continued to accrue and led to the idea of a Biopsychosocial Organizing System, that plays an organising role in neurological, psychological, psychophysiological and social development with important "cross-talk" with other systems. This has been termed the Attachment System, and disruptions within this system can impact normal attachment and may be risk factors for illness and disorders. Conversely, the development of a *secure attachment* can be protective and support resilience (Maunder and Hunter, 2001; Stovall-McClough and Dozier, 2016).

In the context of medicine, a biopsychosocial model of development and psychophysiological development is understandably complex. However, as attachment speaks to how personal and relational experience shapes individual homeostasis and stress regulation strategies, which are optimally social, attachment is contributing to models around symptom, syndrome and illness development, in psychiatric disorders and in medical disorders, including psychoneuroimmunology, and can contribute to frameworks and therapies for prevention and treatment (Kozlowska et al., 2015a; Maunder and Hunter, 2001).

We now understand that nature and nurture are thoroughly intertwined, and that attachment and parenting interact with genetics and epigenetics. Therefore, the transgenerational effects of protective care behaviour as well as the challenges of stress, loss and trauma are important considerations.

The Infant's Need for Care and Protection

The fundamental need for a system of Attachment is the fact that human infants will not survive without protection, safety, care and connection with others. There is a period of inevitable dependence during development. Functions as basic as temperature regulation, sleep, emotion regulation, and the functioning of the autonomic nervous system are not fully "programmed" at birth, but rather require the attuned care of another for optimal development of networks of regulation and safe exposure to experience. Attachment experiences are thought to lay down both "an internal working model" of human relationships (discussed further in section below) and social regulation but also connect up many stress response systems, like the autonomic nervous system. This developmental role of the attachment system

and relationship for establishing self-regulation and social regulation has been increasingly researched and recognised.

Bowlby

Bowlby formally studied the attachment system through children's experiences of separation and loss, demonstrating that infants are inherently motivated to attach to their parents/carers. This was in conversation with the work of James and Joyce Robertson, who had filmed the way children responded to parental separations for hospital admissions and then filmed responses of children, separated from parents and in foster care (Kennedy, 1969; Robertson and Bowlby, 1952). The strong emotional response to separation included distress, sadness, anger and, when it went beyond a certain period, lead to despair (Cassidy and Shaver, 1999). Once established, the system is activated when separation or stressors become too great, and proximity to the caregiver is increased: the infant cries, calls and reaches out, signalling for help. Once safety and soothing are re-established the bids for attention should cease.

Emotional Role

Affect, emotions and feeling are closely associated with the attachment system, which is an interpersonal motivational and behavioural system. Affect regulation is an outcome of the system: a child expresses distress or anger at separation and is soothed by parental approach and attention. We note the joyous forming of a bond, the delight shared between the parties in an attached couple, grief at the loss of the bond and the anxiety or angry protest aroused at threatened loss. These feelings can also form a regulatory function within the attachment relationship: "Many of the most intense emotions arise during the formation, the maintenance, the disruption, and the renewal of attachment relationships." Differences in patterns of affect regulation are seen across the different attachment patterns described below.

A flexible and balanced psychophysiological regulation depends on developmental experiences of *Affective Attunement*. Through empathy, the caregiver recognizes the baby's emotion and attunes to it: (re)-establishing safety and comfort; soothing; reflecting and validating experiences and emotions; modulating affect and body states both up and down, as needed. The down-regulated quiet child may need amplification, the up-regulated labile or anxious child needs settling. Without this, children need to develop strategies to maximise their own safety and comfort, often at a psychophysiological cost. Megan Gunnar and team's research shows that the seemingly "independent" infant, who has an "avoidant" attachment strategy shows raised markers of stress in the hypothalamic-pituitary-adrenal (HPA) axis during

parental separation (Hertsgaard et al., 1995) and up-regulation in children with non-normative attachment has been observed in stress system disorders such as Functional Neurological Disorder (Kozlowska et al., 2015a; Maunder and Hunter, 2021).

The early relational experience of care, comfort and safety allows the child to develop flexible regulation of the internal environment and a balance between safe rest, soothing and safe exploration. The attuned parent/caregiver also knows how to scaffold new experience for the child to foster optimal learning through play and exploration and to recognise when a child is blocked or limited, requiring more help to negotiate the next stage of development. This experience of regulation within the dyad from early in infancy is the beginning of the emergent capacities for *rest, play, love and work*.

Cognitive and Emotional Schema

Bowlby proposed cognitive components to the attachment system. These consisted of mental representations of the attachment figure, the self, and the environment that develop out of experience, not just phantasy. However, due to individual differences in managing, organizing and representing experience, seemingly similar experience can still result in different states of mind. These internal working models of relationships are powerful and predictive cognitive and emotional schema or templates underlying expectations about relationships (Cassidy and Shaver, 1999). We expect help from others to be available when needed if we have experienced responsive and sensitive help in the past. If acquired early or regularly enough, this experience is encoded as procedural memory, the "*way things are*", and so can be out of immediate conscious awareness but implicitly known and expected.

These templates, also referred to as schemata, are now considered to be seen in relationships beyond those with early caregivers as predictors of the likelihood of receiving help and mapping learned experience of the behaviours that will lead to care-giving from others. This can be seen in the *transference-countertransference (the unconscious aspects of relationships)* in medicine and psychiatry, and the patient's expectations of help versus harm. This underpins the potential consideration of attachment when dealing with patients as it may relate to their conscious and unconscious expectations of help and care and their pattern/s of self-regulation (Maunder and Hunter, 2001; Maunder and Hunter, 2009).

The Secure Base

The attachment system interacts with other systems, such as the fear system and the exploration system. There is an important relationship between the developmental need and drive of the infant to *explore* the environment in order to develop knowledge and skills and the need and drive to return to the carer, as "safe haven", for comfort and safety. The smooth working of these two drives is termed *"the secure base"* of the attachment figure, from which the infant explores. Ainsworth pointed out that equilibrium between proximity seeking and the need to explore is important for development and survival: a child who is safe and settled enough to explore and play, knowing they will be met with soothing and help if they encounter trouble, will optimise appropriate safe exploration for development (Ainsworth, 1972). An attuned parent will encourage and regulate this safe exploration and the child's return for reasons of needing safety, comfort or emotional and cognitive processing or restoration (Ainsworth, 1964; Ainsworth, 1972).

Deviations from the *secure* organization of attachment lead to *insecurity* of several types. Children who have come to learn that they need to rely on their own self-soothing, favour exploration over comfort and proximity to the care-giver and are described as having an *anxious avoidant* attachment; others who are difficult to settle back to exploration after stress are often fussy and clingy, and so seek but also resist proximity and comfort and are termed to have an *anxious ambivalent* attachment. One good way of seeing this in action is to look at the internet for the videos of the Strange Situation Procedure – an experimental procedure that assesses the nature and quality of the attachment relationship in infants (Ainsworth et al., 1978). The adult types of insecure attachment are dismissing, preoccupied and unresolved. Accounts of the various childhood and adult attachment classifications help clinicians "see" the way patients exhibit these (Main, 2000; Hesse and Main; 2000; Hesse, 2008; Maunder and Hunter, 2009).

The *fear system* or *fear cascade* also interacts powerfully (Kozlowska et al., 2015b) with the Attachment System. Fear management and protection is a goal of the attachment system. Humans are mammals with a social nervous system that has built on the simple autonomic nervous system of reptiles and offers not just the basic options of sympathetic arousal and parasympathetic withdrawal but a higher order opportunity for social soothing, networked with facial expression, gaze and voice (Porges, 2011) – we have a social nervous system, where optimal regulation is social. The attachment system initially links this opportunity to be soothed and protected socially to one or more specific attachment figures and scaffolds the template that expects help and soothing from these carers. As the internal working model develops and generalizes the child comes to expect a kind of relationship from others more broadly. In a clinical setting this then includes the expectations of help

or harm from clinical carers, and in psychiatric practice a large number of presenting patients have had childhood experiences where the parent may be a source of fear, either through actual direct frightening acts or because care-givers are themselves frightened or helpless. Even these *frightened* parental states are experienced as *frightening* by a child. Children need the parent to be the "strong, wise, soothing" one, not a source of fear. This places the child in a powerful dilemma, a confrontation between systems: the care-giver who should be comforting is *frightening/frightened* and research suggests this *disorganizes* the normal organization of the child's attachment strategies and cognitive and emotional processes. These are powerful moments of psychophysiological disorganization, associated with dissociation and appear to have a strong relationship with psychopathology (Hesse and Main, 2000; Main, 2000).

Clinical Strategies

Bringing Forward the Templates

Explicit use of attachment theory with patients and carers can foster the therapeutic alliance, helping to better conceptualize formulation, diagnosis, and management goals and then to tailor the management plan accordingly. By applying the principles of attachment, we can *listen* at interview as the patient relates the account of the development of the symptoms, for example, depression, as they saw it, and then we could enquire about early and current relationships, considering experiences of help, comfort, safety and fear. We listen closely to the information provided, both for *content* and *form,* listening for the *organization* of the account (whether *secure, dismissing or preoccupied*) and any moments of disorganization or dissociation (*unresolved loss or trauma).* These patterns of reasoning, language and behaviour have been elucidated in attachment research, including the Adult Attachment Interview (Hesse, 2008). In psychiatric samples we can also see *low coherence* or *competing strategies* likely based on childhood *disorganization* (Speranza et al., 2017).

If information relevant to medical health is considered as related to self-regulation, for example sleep, diet and exercise, the *biopsychosocial* information could then be tentatively integrated collaboratively with the patient, getting them to reflect on how they organize themselves and their relationships and any challenges/stressors/changes. Feedback can be offered, or questions raised where inconsistencies or gaps might suggest a slightly different reading. In this way a collaborative formulation can be reached with a more transparent way of discussing the older ways of organizing oneself, rooted in childhood or other experiences and so beginning to discuss things that are not immediately in awareness. The formulation can then be more collaboratively created. Treatment can then be

considered in the light of that information and a more collaborative contract for treatment made.

Applications: General, Medical, and Psychiatric

In illness of self or those close to us, and at other times of stress (e.g., childbirth) the attachment system may be activated. Those with a secure state of mind are going to be comfortable to be appropriately help-seeking as per the classic and normal "sick role" and, unless disrupted by trauma or loss, comfortably relinquish care as recovery proceeds (Parsons, 1951). The attachment state/s of mind can shape the clinical coping and interaction (See Table 13.1). Those who have a dismissing or avoidant strategy can be avoidant of care due to a need to be "independent" (here meaning an avoidance of dependence) whereas those who are ambivalent may require/ demand more reassurance or be *angry/blaming* or perhaps *passive* in their recovery. These are not the only possibilities, but some exploration of attitudes to care can often reveal how early experience has shaped them and help shape our therapeutic alliance. Those who are *disoriented/disorganized/dissociated* due to active unresolved loss or trauma, or *chronic complex trauma* may show unusual states of *immobility/ fragmentation/ disconnection* at assessment or during treatment, which will need attending to both directly and via general principles from *trauma-informed care:* a health wide approach that acknowledges stressful and traumatic experiences and their sequelae and the need for attuned responsiveness by clinicians and health systems.

Table 13.1. Orientation towards health care and sick role by attachment state of mind.

Attachment state of mind	Interactional quality	Impact on Sick role
Secure	Collaborative	Appropriate Sick role
Dismissing	Avoiding dependence	Avoids or resists health care
Preoccupied	Overly dependent	Clings to care/ blaming/ passive
Unresolved or complex traumatic attachment	Fear, fragmentation and disconnection	Traumatic or loss experience gets in the way of collaborative treatment

Applications to the Clinician's/ Team's Response to the Patient (Countertransference)

The theory facilitates understanding likely difficulties that may arise in patient-clinician interactions. For example, clinicians /teams with a more avoidant/dismissing strategy or culture will tend to label even normal help-seeking behaviour as "clingy" or overly dependent and will tend to validate stoical or minimizing responses to illness as "coping". Similarly, they will tend to label the ambivalent strategy "crazy/disordered". A reflective clinical practice can consider where we currently sit in the spectrum of attachment states of mind and is useful at the personal clinician and team level. Understanding how I and/or my team are organising to manage stress/ trauma/ loss will help me/us understand reactions and fluctuations in responsivity to patients and situations. For example, a team that has experienced a patient's recent suicide will be shocked, numb or perhaps hypervigilant and grieving for a time in a way that may influence interactions with other patients. The team and its members will need to resolve *losses and traumas*. This approach dovetails with a reflective and supervisory approach to team supervision and trauma-informed care (Maunder and Hunter, 2001; Maunder and Hunter, 2009).

Summary of Conceptual Overview

So, in summary, attachment theory can provide a general understanding of human beings under stress. It affirms that we never outgrow our healthy need to be dependent at times, especially during stress and illness and that we may need attachment relationships throughout our lifespan. It articulates that healthy, flexible, personal development occurs optimally from a secure base as does healthy grieving and recovery from substantial stress, loss, illness and trauma. It maps out the framework that early attachment relationships are strong determinants of physical, emotional, cognitive and social development. It directs attention to the specific current organization of the stress response for the individual, dyad or family and offers points for intervention to help the individual or system regain a healthy homeostasis and recover.

Clinical Approach

The patient-doctor, client-clinician interaction should basically be functioning as if it is a secure relationship, where both parties feel safe enough and fear and strong emotion is manageable between them, and the process is collaborative. Clearly new caring relationships cannot be fully developed attachment relationships, as bonds take time. However, when both parties bring the capacity for security and the clinician can foster this, then those templates can be accessed and a secure enough working relationship co-constructed. The corollary will be that the

doctor is useful in helping the patient manage their unmanageable feelings and fears. However, the patient's and the clinician's attachment states of mind will powerfully influence the kind of interaction. This is the heartland of *transference-countertransference,* where experiences that are not immediately conscious shape our feelings, thoughts, behaviours and relationships.

The *assessment* of a patient is then conducted with the following strategy: to explicitly explore the different possible attachment patterns and collaboratively identify ongoing patterns and the impact of stress, loss and/or trauma in the story of the presentation. Exploring past and current state(s) of mind with respect to attachments will help formulate the presentation – why this patient presents with these symptoms at this time, due to stress regulation being insufficient for the current challenges of stress/loss/trauma and perhaps associated with a breakdown in organization due to being traumatically overwhelmed. It can then help differential diagnosis and offer possible areas for intervention/management, attending to symptoms in a patient-centred way, while encouraging better social and personal regulation. Sometimes a presentation to health care does mean that a person may need to shift their coping strategies, and this might entail some supportive or other psychotherapy.

Given that in a psychiatric population many patients are *unresolved with respect to loss or trauma* or have more incoherent attachment strategies at point of presentation it becomes crucial to spot those who have unusual states of *disorganization* or *dissociation* and states of unregulated fear. For work on this see the work on the Fear Cascade (Kozlowska et al., 2015b).

Applications – General, Medical, and Common Problems

Normal Bereavement and Significant Trauma

In adults, bereavements and traumas will often lead to a state of temporary disorganization (usually at least 12 months for the loss of a close relationship). For bereavement this normally resolves, especially if normal responses to grieving are validated. The process is not dissimilar for trauma. The person may resolve the loss/trauma or will dismiss it or continue to be preoccupied by it or remain disorganized (*unresolved*). However, there is growing evidence that unresolved losses and traumas are associated with psychiatric conditions of significance that have a degenerative effect on mental life: complicated grief and chronic PTSD (see Chapter 20) (Stovall-McClough and Dozier, 2016). Therapeutic work is then focused on

resolving the loss or trauma after *safety* and *stabilization* are established and involving *integrating* the experience, *cognitively, emotionally and procedurally*.

Other Important Consequences

Children born to parents who have not resolved loss or trauma are at risk of insecure and potentially disorganized attachments. The way a parent's own disorganized state of mind affects the interaction with the child and the child's organization described above is one of the pathways to childhood and family distress and *transgenerational transmission* of psychopathology. This indicates the importance of perinatal and family support for at-risk families and communities (Hesse and Main, 2000; Slade et al., 2020).

Applications and the Attachment Meanings of Treatment

Treatments will have relational meanings and are likely to *elicit the background attachment template* as the template is activated by stress (Bowlby, 1969). For example, with medication, some may enact their attachment pattern as a side effect sensitivity, and patterns of adherence (Maunder and Hunter, 2001; Maunder and Hunter, 2009). A recent systematic review has highlighted different patterns of engagement for this with dismissing/anxious-avoidant attachment strategies versus preoccupied/anxious-ambivalent (Adams et al., 2018). Surgery has a powerful implicit requisite of safety and trust of others and systems, whereas some patients including many psychiatric patients have never had safe, trustworthy relationships and experiences of care. This is part of the reason for our current focus on *trauma-informed care*. It helps us understand the central role of creating trust and collaboration with patients in order to deliver the health care they need.

Psychodynamic psychotherapy and therapies such as schema therapy explicitly aim to set up new templates of relationship while necessarily mobilizing the old attachment templates set up in childhood. One goal is then to move patients from a disorganized or insecure template towards a more secure state of mind and better interpersonal and self-regulation (McLean, 2012; McLean and Korner, 2014).

Conclusion

Working with an awareness of attachment allows us to understand how our patients have come to organize their coping responses and helps us to approach construction of our therapeutic alliance as founded on the idea of *secure base*, and the challenges to that. From early in assessment and treatment we can recognize and address the breakdown of organized coping strategies and the *disorganizing role of*

overwhelming stress, loss and trauma. It can help us think about interpersonal and self-regulation and patient attitudes to treatment based on past experiences around help, shaping current attitudes to medication, surgery, rehabilitation and psychotherapy. It also helps our reflective practice if we can acknowledge our own ways of organizing our own responses to stress and consider where this interacts with the patient/family we are treating in the *transference-countertransference.* We are also supported by evidence to argue for the public health importance of good care of families perinatally and in at-risk situations of mounting stress, loss and trauma, so that adults and parents are supported and children and young people have the chance of safely, optimally developing, and to ameliorate the transgenerational transmission of loss and trauma.

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