

Disorganized attachment in infancy: a review of the phenomenon and its implications for clinicians and policy-makers

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Disorganised child-parent attachment refers to the concept of conflicted, disorientated or fearful behaviour shown by infants towards their carer in a laboratory setting which has led to much research examining the key assumptions relating to its causes and implications. The theory of disorganised attachment has supported clinical practice regarding child welfare, although at times it has also reflected serious misapplication of attachment theory and related research.

Theories around infant attachment were developed in a laboratory situation where an infant explored an unfamiliar room and its toys and how the infant then responded to its carer when alarmed or distressed by two brief separations. (a) Secure attachment refers, firstly, to the confidence the infant has in the carer to be responsive and comforting when the infant is alarmed or stressed. Secondly, it refers to the child's confidence that their carer provides a secure base from which to explore; thus the infant, during its play, can expect support and can fully explore whilst feeling calm. Responsive care at home leads to the securely attached child having the confidence to strike a balance between attachment and exploration.

Some children experience a rebuff of their distress signals by their parents and thus develop (b) an 'insecure-avoidant' attachment pattern where their response to alarm leads to them exploring their environment rather than communicating their feelings to their carer. If the carer provides reasonable protections and monitoring with more emotional distance the child can achieve an organised, workable attachment strategy.

Other children who experience unreliable responsiveness from their carer learn to be highly vigilant about their carer's accessibility. These infants tend to develop (c) an 'insecure-ambivalent/resistant' attachment, seen as inconsolable distress and/or anger in a strange situation which retains the attention of their carer. Even in less stressful situations these children may engage in attachment behaviour such as clinging to their parent rather than playing, or mixing whiny or angry behaviour with distress. These children may also develop an organised workable attachment strategy as the carer responds by giving attention to the child's heightening of attachment behaviours.

These three infant-carer patterns have been shown to be relationship-specific, meaning that an infant may show one pattern to one particular carer and a different pattern to another carer.

(this Summary may be photocopied)

Disorganised attachment theory developed from the realisation that not all infant responses in a strange situation could be placed in the original patterns. On reuniting with their carer after being in a strange situation some infants displayed conflicted, disoriented or fearful behaviours. Seven specified classes of behaviours were identified which, if they were seen at sufficient intensity and in the presence of a parent in a strange situation, could lead to being classed as disorganised attachment. This classification system should only be used for infants under 20 months, as after that age children develop more sophisticated strategies for coping with carer behaviour and may no longer show the disorganised behaviours.

Disorganised attachment occurs when a child has been moderately alarmed and where the behaviours reflect a disruption of the child's attachment response to their carer in the context of that alarm. This can occur for a variety of reasons. Some infants, because of dispositional or neurological factors, have more difficulty achieving a single strategy for using the carer as a safe haven. This could increase their odds of showing conflicted behaviour in a strange situation. They may be influenced by their caregiving environment as well as relationship-specific factors. Infants may show disorganised attachment in a strange situation because they have experienced their carer as a regular source of alarm. Alarming behaviours can include frightening or frightened parental behaviours, the care being psychologically unavailable, threats of harm or unusually extended absences. A child may associate alarm with a carer whom they have seen subjected to violence by a partner. Experiencing the carer as a source of alarm can lead to the infant moving away, withdrawing or fleeing from the carer when alarm occurs. This leads to a paradoxical situation for the infant as the attachment response can also lead the infant to seek safety from their carer.

A child's attachment system includes multiple behavioural systems, such as the child wanting to approach a familiar carer when there are cues to danger or when s/he has been unexpectedly separated from their carer. This is one of the core elements of John Bowlby's attachment theory. It has been reasoned that at an evolutionary level proximity to even an alarming carer would have helped an infant survive, given that infants are unable to fend for or regulate themselves.

Disorganised attachment with a particular carer should be seen as a risk factor for later social and externalising problems. However, a child with a disorganised classification may not necessarily develop behavioural problems: any subsequent problems may be due to other difficult life circumstances.

Maltreatment is one possible cause of disorganised attachment. However, infants from families experiencing five or more socioeconomic risk factors experience high rates of disorganised attachment. This may be caused by the accumulation of socioeconomic risks creating a frightening and distressing situation for a carer who may otherwise be able to provide adequate care.

Disorganised attachment is completely different to attachment disorder. The former is a technical term from examining infant behaviours in a laboratory situation, with no research yet establishing whether children would exhibit the same behaviour in a naturalistic setting such as the child's home. Conversely, attachment-related disorders

are associated with experiences of extreme social neglect or with children being raised in environments that limit chances to form selective attachments, such as orphanages. These can be divided into two types. Firstly, reactive attachment disorder (RAD) relates to children who are inhibited or withdrawn from their carers and do not show proximity-seeking or contact maintenance to their carer even when they are experiencing high distress. The second, disinhibited social engagement disorder (DSED), is characterised by a failure to show a preference for familiar carers even when a child is frightened or distressed. Both attachment disorders are assigned to children between the ages of nine months and five years. They also are both related to behaviours permeating naturalistic situations in a child's life. Disorganised attachment is much more prevalent than either of the attachment-related disorders.

Attachment theory and research have a major role to play in supporting clinical and welfare work with children and their families. It is suggested that among the children placed in the disorganised classification, there is a diversity in terms of their antecedents and these implications for development, and therefore their potential risk. There is evidence that some forms of disorganisation may be more associated with genetic or attachment and development factors; others may be more associated with an infant's adverse experiences with their carer.

The principles derived from attachment theory can inform clinical practice. For example, if a child cannot use the carer as a safe haven when distressed, and as a secure base for exploration, then supportive work can be targeted accordingly. As disorganised attachment is relationship-specific, clinicians need to observe the child with all their carers in order to make more informed recommendations in the best interests of the child.

Attachment theory has been an important framework for designing clinical and child welfare interventions. For example:

1. **Child-parent Psychotherapy** is a weekly 10-12 month attachment-theory-informed intervention. Joint sessions between the carer and their child promote protective caring and secure attachment and target maladaptive attributions between parent and child. This was the first intervention to demonstrate that disorganised attachment was modifiable.
2. **The Attachment and Bio-behavioural Catch-up Program** is a 10-session 'at home' intervention, for carers at high risk of abusing or neglecting their children. This intervention targets three domains of caring: (i) helping carers to be nurturing when their child is distressed: (ii) helping them to follow the child's lead: and (iii) showing how to avoid displaying frightening behaviours. The combinations in this intervention have been shown to substantially reduce rates of disorganised attachment.
3. **The Video-Feedback Intervention** promotes Positive Parenting and Sensitive Discipline and allows a parent, or carer, to watch their video-recorded interaction with the child, leading to subsequent helpful discussions. This intervention is based on attachment theory and social learning theory. This has been shown to be effective in improving parental sensitivity and in lowering rates of disorganised attachment.

4. **The Group Attachment-Based Intervention** targets trauma and poverty-exposed families of children aged 0 to 3. The families meet three times each week as a group in parents-and-children, parents-only and children-only components. The families involved may have experienced parental trauma and poverty, domestic and neighbourhood violence, health disparities and an inability to find an adequate place to live. This type of intervention has been shown to improve maternal sensitivity, child engagement and child-parent security in free-play observations.

These interventions have all shown that the carer conditions contributing to disorganised attachment can be changed even among high-risk families. For an infant the parent is the world, so by changing the parent's behaviour we change the infant's world. This in turn transforms the child's behavioural regulation and sense of confidence in the carer. In the UK one in five children born in 2009-2010 was referred to children's social care before their fifth birthday, with one in 19 receiving an assessment for child maltreatment. These figures contrast with the slim availability of supportive services for families in the UK.

The effectiveness of some supportive interventions for families in reducing rates of child maltreatment and disorganised attachment show that such interventions should be a public health priority, as well as an area of further investment. Policies that curb maltreatment may contribute to the reduction of disorganised attachment but will not necessarily lead to its eradication as it may be caused by factors other than maltreatment.

Attachment theory, and in particular disorganised attachment, has sometimes been misapplied, often resulting in child removal decisions. Such misapplications may harm already underprivileged families, such as those facing multiple socioeconomic risk factors or with a parent with functional impairments. These misapplications may violate children's and parents' human rights and may also represent discriminatory practice against minorities in need of social and material support. However, attachment theory, assessments and research have major roles to play in clinical formulation and supportive welfare and clinical work. Attachment-based interventions as well as stable, safe and nurturing relationships can break intergenerational cycles of abuse and lower the proportion of children displaying disorganised attachment. The real practical utility of attachment theory and research resides in supporting the understanding of families and in providing supportive, evidence-based interventions.

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