

Summary and conclusions of “The Treatment of Attachment Problems”

Anniek Thoomes-Vreugdenhil

In 1999 and 2000 the three methods described in this book were presented for the first time and were supported by the knowledge available at that time about attachment. Since 1999 the number of studies and publications about attachment has increased dramatically. That was the reason to re-evaluate the three methods on the basis of new insights.

From the health-care practice, in which these three methods have been used, came requests for examples.

This book is therefore divided into a theoretical section and a case-study section.

In my 1999 publication I distinguished two types of attachment problems: attachment disorders and relational disorders. The characteristics of both types of problems are described in the *Introduction*.

In attachment disorders the behaviour is characterised by a failure to retain rules, and a lack of care for the environment and relationships. In terms of behaviour this means: being everyone’s friend, showing no specific preference for a particular adult, indifference towards people, clothing and objects. It has been ascertained that seeking negative attention by exceeding boundaries belongs to this disorder. In relational disorders the behaviour is characterised by ambivalence with regard to closeness because closeness is actually both desired and resisted. This ambivalence can be construed as an internal conflict and leads to loneliness, depression, passivity and anxiety. There is also a form of exceeding boundaries observed in relational disorders, namely clinging behaviour.

With regard to the attachment history we presume the following distinction: in attachment disorders there is no history of an attachment relationship. From birth there has been a varying upbringing situation so that there is no continuity in experiencing an available adult. In relational disorders there has been a period of continuity, as well as experience with an attachment relationship. However, the relationship was broken, by which (in a traumatic sense) the disappointment in the attachment began.

In chapter 1 three methods of treatment for the two distinct types of problems are discussed: differentiation therapy, phase therapy and basis therapy. These three methods of treatment were developed in the psychotherapeutic practice. Studies of the effects of these treatments is a necessary next step in the development of these treatments.

The method of treatment for children with an attachment disorder is called differentiation therapy; the method of treatment for children and adolescents

with a relational disorder is called phase therapy; and the method of treatment for adults with a relational disorder is called basis therapy.

The presumption with differentiation therapy is that the ability of children with an attachment disorder to differentiate precedes attachment. The treatment is divided into different phases in which the ability to differentiate is developed. In phase therapy the central focus is on closeness. The basic assumption is that each phase of development has its own form of closeness and that it is necessary to experience each form of closeness. A pre-condition of this is forming boundaries. Several times a week the possibility is given to briefly (10 minutes) experience a form of closeness. This is prepared and guided in the therapy sessions but carried out by the care-givers of the child/youngster (biological parents, foster parents, adoptive parents, group leaders).

In contrast with the other two methods of treatment, basis therapy is not directed towards experiencing that which was missed, but towards the consequences of attachment problems. The goal is formulated as coping with intimacy such as occurs in partner relationships and friendship relationships, dealing with traumas and building up a positive self-image. The development of the mentalization process plays an important role in the treatment.

In chapter 2 publications on attachment and attachment behaviour are discussed. Attachment is described in terms of a long-lasting and loving bond (Ainsworth) which is characterised by an adult looking for closeness as a guarantee of permanence and continuity (Bowlby). In recent studies (Zeanah, Trevarthen, Greenberg) attachment is primarily considered a relational concept because of its being a matter of reciprocity, inter-subjectivity and interaction. In the relationship with its attachment figures, the child develops an internal working model built up on the basis of the experience of the interaction patterns with them (Bretherton & Munholland). A classification of attachment behaviour is given by Ainsworth: securely attached and insecurely attached, whereby insecure attachment is divided into avoidance attachment and ambivalent attachment. Main and Solomon added the category disrupted attachment to these. A description of these manners of attachment together with a number of characteristics makes it possible to determine the manner of attachment. Attachment not only affects childhood; attachment has an effect on the entire course of one's life ('from the cradle to the grave', Bowlby). Bowlby and Ainsworth regard secure attachment during early childhood as defining for the well-being of the child. Research has confirmed this assumption: a connection has been ascertained between secure attachment and mood, flexibility and positive feelings. Securely attached children are less aggressive and less quickly frustrated than insecurely attached children. They have more friends, are accepted more readily and are more independent.

In addition, their playing is better developed and they play more. Since playing is considered to be important for the development of a child, the significance of

playing has been examined. Playing gives the child the chance to deal with daily occurrences; playing has the function of discovering the world and having control over the world so that the child can get a grip on its world.

Likewise a connection has been ascertained between attachment and self-image. Securely attached children describe themselves in positive terms; their self-assessment is positive (Crittenden, Egeland & Erickson, Cassidy).

In adolescence this development continues; securely attached adolescents do better in school and have better quality friendships than insecurely attached adolescents. They assess themselves positively and are less depressed.

Adolescents are able to look at themselves and others in attached relationships because of their continuing cognitive development. The close relationship with their parents does not change; the dependence on their parents changes.

Friendships take up an important position. During the primary school age the extension of the relationship with the parents through friendships has already started. In this phase they experience what it is to do things together, share and help each other. During adolescence friendship gradually changes into more intimacy. In this phase friendship also gets an attachment function.

For insecurely attached adolescents this phase develops differently; they have fewer friends and develop no, or few, intimate and equal friendship relationships. Zimmermann distinguishes between the manner in which insecurely attached adolescents experience these friendships. He distinguishes between ambivalently attached and avoidance attached youngsters, each with their own way of appraising friendships.

The great importance that Bowlby puts on secure attachment is confirmed in these studies.

The *secure base* (Ainsworth) is also determining for well-being in adulthood. It is the feeling of security in which daily tasks are carried out and it is the experienced security which determines well-being in relationships. In the section on adulthood and attachment, studies are mentioned concerning the nature of the relationships of insecurely attached adults. In the manner of forming relationships with a partner, it appears that the differences between the preoccupied and reserved manners of attachment can also be seen.

Finally, in this chapter on attachment and attachment behaviour, the process of mentalization is discussed because of its influence on the process of attachment.

In chapter 3 the influence of environmental factors on the development of the child is examined with attention to neurological aspects. Emphasis is placed on the mutual influence of the internal and external world and on the fact that genetic expression is dependent on environment. The structure of the brain is formed by the psycho-socio-biological environment in which the child is raised, in an inextricable unit with its genetic potential.

In chapter 4 the connection between insecure attachment and problems is examined. Such a connection is not easy to ascertain because it is not clear just

what attachment problems are. Zeanah (2000) and Greenberg (1999) assume that attachment is a relational concept. In a child's relationship with its attached figures one can ascertain the manner of attachment. That has been made clear in examples of behaviour in which there is self-endangerment. In the classification of Zeanah (Zeanah & Benoit, 1995; Zeanah & Boris, 2000), in non-attachment, the lack of a secure base and a broken attachment relationship, one again sees the classification of attachment disorder and relational disorder. Subsequently, a number of studies are discussed in this chapter which deal with the connection between attachment and psychopathology during childhood, during adolescence and during adulthood. The results of these studies show that such a connection can be discerned.

Furthermore, in the framework of this book, special attention has been paid to whether the symptoms of the observed problems correspond with the symptoms of attachment disorders and relational disorders. The difference in the manner of attachment as described in both types of problems, respectively avoidance (reserved) attached and ambivalent (preoccupied) attached, is also compared. The conclusion is that the distinction made with regard to both the symptoms as to the manner of attachment in children and adolescents can be found in the studies mentioned. This is not as clear in adults; we can draw the tentative conclusion that such a distinction seems to be confirmed but that more research, with more sensitive measuring instruments and measurements over a longer period of time, is necessary.

In chapter 4 disrupted attachment is discussed because the connection with psychopathology is most clearly demonstrated in this form of attachment and because disrupted attachment occurs in relational disorders.

Disrupted attachment is characterised in children by contradictory behaviour. This behaviour begins because the parents are a source of both anxiety and consolation (Main & Solomon, 1990).

The seven characteristics by which Main and Solomon describe this manner of attachment are mentioned. The development of the child and the adolescent with disrupted attachment is problematic. They have a great chance of developing both externalised and internalised problem behaviour. Examples of this are aggressive and disruptive behaviour and, respectively, fear of failure and limited self-confidence. In adult life there is also a question of psychopathology, especially caused by a lack of coherence. The attachment experiences have a threatening character and therefore cannot be integrated in organised representations of attachment. Separate systems develop with pathology as a result: dissociative symptoms, depersonalisation, anxiety disorders, aggression and violence. Next, dissociative symptoms are discussed as an example of pathology whereby the internal and external worlds are not experienced as connected. A description is given of the most complex form of this, the dissociative identity disorder (DID), also because I use phase therapy with DID

(not to be confused with the phase-directed model used to treat DID!). This application is illustrated by an example.

Chapter 4 ends with a discussion of a number of treatments for attachment problems whereby differentiation therapy, phase therapy and basis therapy are also compared. To begin with, attention is paid to the therapeutic attitude since the relationship between the client and the therapist in the treatment of attachment problems determines the success of the treatment. By means of a combination of mirroring, discussing the behaviour of the client in the interaction between the client and the therapist, the therapist's being available and showing this through warmth, empathy, acceptance, sensitive responses and understanding the client, the therapist lets the client experience what attachment is or can be.

In the second part of this book, the floor is given to the practice. In a number of examples the three methods of treatment are illustrated. The example of differentiation therapy in chapter 5 is primarily about the build-up of differentiating, the attitude of the therapist towards differentiating, and the changes this process brings about in a child.

Chapter 6 illustrates the example of how most phase therapies with a child work out as a process, but at the same time it becomes clear that each treatment of this type has its own difficulties. In this example, 'forgetting' (of objects and actions) is an intractable phenomenon; in other examples something else entirely can be a hindrance.

Chapter 7 shows that other difficulties emerge with adolescents and that the environment can put up other obstacles. In this example the frequent changing and leaving of care-givers during a stay in a psychiatric centre is a disrupting factor. In addition, the lack of prospects for the future makes the treatment more difficult.

Chapter 8 focuses on the possibility of combining differentiation therapy and phase therapy. Such a combination is preferred in the treatment of attachment disorders because a child with an attachment disorder has missed the intimacy phases.

Chapter 9 discusses the possibilities, but also the risks and difficulties of phase therapy. In this chapter an example of a difficult situation for phase therapy is given.

Chapter 10 gives two examples of the treatment of adults with a relational disorder, two examples whereby basis therapy is offered. Basis therapy has various versions which are illustrated in both examples.

Both in our work in clinical practice as in the research described, it has been established that in adults with various types of problems, attachment problems also play a role, so that there is a question of co-morbidity. In the two examples we observed attachment problems together with compulsive behaviour and a post-traumatic disorder in one example and a dissociative problem in the other. For this reason the two treatment progressed differently.

Finally: in this book another attempt was made to give a solid foundation to the three methods of treatment for attachment problems on the basis of attachment theory. The first question was whether the distinction made between an attachment disorder and a relational disorder was to be found in the research. For that reason we looked at whether the studies differentiated between problem behaviour that differed as a result of avoidance attachment or of ambivalent attachment. That turned out to be the case. After that attention was paid to whether the symptoms of the various types of problematic behaviour mentioned corresponded with what was described as an attachment disorder and a relational disorder. That, too, turned out to be the case.

The connection that I made in both types of problems between attachment and the development of a self-image is supported by both research and treatment. The importance given to the attitude of the therapist in the three methods of treatment presented in this book can be found in the treatments which are described and in what is said about the content as well.

Differentiation therapy, phase therapy and basis therapy can therefore be presented as treatments for attachment problems.