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Background

The theory of attachment was initially proposed by John Bowlby in the 1950s. His ideas were further developed by Mary Ainsworth and then Mary Main. More recently, work has been completed by Kim Golding, and other work has extended this for example, investigating preterm infancy and the maternal bond. The following information sheet will discuss the key findings of some of these authors, and also discuss strategies that can help engage and support students who exhibit dysfunctional attachment patterns.

Attachment theory is the study of how we attach to people in the early stages of our development, and its impact on how we view ourselves and develop relationships throughout our lives (Golding, 2008). Attachments and relationships are hugely important in our lives and help us to maintain our emotional wellbeing. John Bowlby (1988) wrote: 'The propensity to make strong emotional bonds to particular individuals is a basic component of human nature'.

Bowlby devoted extensive research to the concept of attachment, describing it as a 'lasting psychological connectedness between human beings' (Bowlby, 1969). He proposed the view that early experiences in childhood have an important influence on development and behaviour later in life. He also believed that attachment has an evolutionary component aiding survival.

Forming secure attachment leads to the development of self-esteem, positive affect, good peer relationships, good relationships with adults, and a strong personal autonomy (Carr, 2003). Creating and maintaining relationships are a vital part of our lives and help to support our social and emotional health, thus impacting on our cognition or how we look at and perceive the world. Infants are born biologically predisposed to form relationships from which they can experience security and comfort (Golding, 2008).

It is important to remember that elements of brain development are experience-dependent. There are also sensitive periods for development of memory, motor control and the modulation of emotion. This is especially important for the development of the 'emotional brain'. Although some of the aspects of the emotional brain are already functioning at birth – for example, the amygdala or the part of the brain that experiences fear (Golding, 2008) – the development of emotional regulation is very dependent on the infant experiencing a regulating relationship with an adult (Golding, 2008). Infants will attune to the voice of the mother and other primary care givers, and seek comfort in these. The child uses the parent as a secure base (a relationship that creates confidence in the availability of a specific protective caregiver if needed and supports exploration when it is safe to do so (Cooper, Hoffman, Marvin and Powell, 2001)), as a way of increasing feelings of security when in a situation that might arouse feelings of insecurity (Golding, 2008).

However, if secure attachments are not made and maintained within the early years of life, students will evidence insecure patterns of attachment. These attachment patterns are first evident between 9-12 months of age, (Champion, 2010). Students with special educational needs can be at higher risk of developing a mental health disorder, such as an attachment disorder, for a number of reasons, including those outlined below.

- Students with particular diagnoses are more likely to be in the foster or care systems. Streissguth et al (1985) identified that 73–80% of children with full-blown fetal alcohol syndrome (FAS) are in

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foster or adoptive placement. This figure is supported by support groups for FAS such as NOFAS-UK (National Organisation Fetal Alcohol Syndrome-UK).

- Premature and neonates in intensive care are exposed to disregulating environmental surroundings, repeated invasive procedures and prolonged illness (Miles et al, 2005). They are also more likely to have to undergo invasive procedures or surgery at a young age when the attachment to the maternal figure should be occurring. This can directly affect the attachment that is made, and can therefore affect behaviour patterns.

- Students with special educational needs may be in residential care or attend a respite placement. In these placements, students are exposed to a high number of staff providing care. This can result in inconsistent and instrumental care giving as so many people are involved within that student's life.

- Students with a disability are six times more likely to present with a mental health difficulty throughout their lives (Emerson and Hatton, 2007). This can be compounded even further as students with attachment disorders have been found to be at higher risk for developing psychological difficulties (Carr, 2003).

The classroom is a consistent and safe place for the majority of these students and it is important they are supported correctly to minimise the distress that can occur as a consequence of attachment disorder or difficulty.

How attachment patterns present

Golding (2008) offers the following categories as a framework for understanding attachment behaviour:

Attachment style	Parenting style	Attachment behaviour
Organised secure attachment	Sensitive and empathetic	Enables the child to use the parent as a secure base, developing patterns of behaviour that allow the child to search their environment actively, but also to seek comfort from that secure base when needed.
Organised insecure attachment 1. *Ambivalent-resistant attachment*	Inconsistent parenting, with parents/carers having difficulty in attuning to the child's needs, resulting in inconsistent and unpredictable responses	Results in the child maximising their attachment behaviours to ensure they receive care. The child cannot predict when someone will be emotionally available for them, so they

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		attempt to ensure someone is there for them all the time. Their emotions drive behaviours such as: • displaying emotional distress to apparently minor events • resistance to being soothed or comforted • displaying helplessness with low self esteem and low expectations • social incompetence and poor peer relationships.
2. Insecure avoidant attachment	Parents/carers find the emotional needs of a child demanding, and cannot support that emotional need. This results in the child expecting the parent to back away when emotions are expressed.	The child minimises their behaviour to ensure that the parent/carer remains close and keeps the child safe. The child relies on knowledge to guide behaviour which includes: • being passive and withdrawn behaviours • displaying little emotional distress • self sufficiency.
Disorganised attachments	The parenting style is frightening to the child or the parent is frightening.	The child experiences conflict between where they would normally seek safety and the source of discomfort and fear; this can result in: • distress with little provocation within relationships • expression of violent anger • anxious dependency • a dislike of being touched/held.

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It is important to remember that these insecure patterns may also be symptomatic of other disorders and it is also necessary to acknowledge differences in gender (boys and girls often present differently) and culture. Always refer to clinical services for formal diagnosis and further support.

Definition of attachment disorder

The Diagnostic and Statistical Manual of Mental Health IV (DSM-IV) (American Psychiatric Association, 1994) describes attachment disorder as 'Reactive attachment disorder of infancy or early childhood'. It is commonly referred to as RAD. The DSM-IV focuses the core of its definition on the child's inability to relate appropriately in most social situations, describing RAD as severe and relatively uncommon behaviours characterised by markedly disturbed and developmentally inappropriate ways of relating socially in most contexts.

Prematurity and attachment

Although prematurity does not in itself create the possibility of an attachment disorder it does place a stress on the attachment system. Higher numbers of premature infants are currently surviving at younger gestational ages, with a high number of premature infants having developmental delays (Bozzette, 2007). The medical consequences of this are well known, such as increased risk of cerebral palsy, intraventrical haemorrhage and developmental disability (March of Dimes, 2009). However, there are also emotional implications of having to undergo invasive medical procedures at a stage in life where parts of the brain will be further developing outside of the womb and at a stage when the mother–infant relationship is being formed. Bozzette (2007) reported that premature infants do not often provide clear behavioural cues, making them difficult social partners. She found that the major differences between the social behaviours of premature and full-term infants were in looking and facial expression.

It must be acknowledged that separation from the child, interruption of pregnancy, fragility of the infant, medical complications leading to fear and anxiety, the possibility of extended periods in neonatal intensive care lead to ongoing issues of caring for a fragile infant. The infant may also have disrupted sleep and feeding patterns, and may require ongoing medical support, e.g. oxygen. Fear of infections may lead to limitation of normal social contacts and therefore disruption of normal social relationships (Champion, 2010).

What are the implications for teaching and learning?

Students in the **avoidant attachment** group may:

- show an apparent indifference to uncertainty in new situations
- deny the need for support and help, and avoid proximity to the teacher
- need to be autonomous and independent of the teacher, and will be hostile towards the teacher when directed towards a task
- have limited use of creativity
- be likely to underachieve and have a limited use of language

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- need to be presented with task focused interventions (the task acts as an emotional safety barrier between the pupil and teacher); the relationship between teacher and student can be made stronger by games with clear boundaries and rules, together with a high degree of structure in order to enable close proximity without causing a defensive reaction. Activities must have a clear start and end, and the expectations need to be clear, with all materials at hand for that task.

Students in the **resistant-ambivalent attachment** group may:

- have high levels of anxiety and uncertainty
- show a need to hold on to the attention of the teacher, and have an apparently high dependency on the teacher in order to engage and learn
- have difficulties attempting to complete tasks if unsupported, and are unable to focus on the task for fear of losing the teacher's attention
- be likely to underachieve; language development may not be consistent with levels of achievement
- need help to build their independence skills, such as tasks being broken down into small independent steps, with the teacher working alongside
- need turn taking tasks that act as a model of how two separate people can work alongside one another
- need transitional objects to be provided when the teacher is out of the room (eg Can you hold this for me until I come back?).

Students in the **disorganised attachment** group may:

- become more controlling as they become more anxious
- be unwilling to accept authority within the school or allow themselves to be taught
- face difficulties in accepting 'not knowing', which can create overwhelming feelings of fear and humiliation
- be most likely to appear to be at a very immature stage of learning and be underachieving; they will have difficulties with creativity and conceptual thought
- need reliable and predictable routines
- benefit from having a secure base within the room (this could be a safe box or a physical object) to begin the initial stages of making secure attachments
- benefit from attuned teachers who offer a high level of emotional support and positive reinforcement. This in itself-can be a difficult and draining task for the teacher due to the behaviours these students can exhibit (the students themselves experience a high rate of fostering breakdown due to this); support should be offered to the teacher to encourage reflection and allow them to positively support the student.

Supporting students with attachment disorder within the classroom   (taken from Golding, 2008)

Firstly, the student needs to feel safe in order to reduce anxiety. This is imperative as an anxious student does not learn within the classroom.

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The environment

A student must feel safe within the environment, and this includes a decrease in stress and an increase in support. The environment needs to be predictable and reliable. This may be achieved using the following strategies:

- Provide a schedule, which is accessible and appropriate to the student, that shows what is expected of them that day. The schedule should reflect the student's level of understanding; for example: a 'now'/'next' may be enough for some students, while others may cope with a half- or full-day schedule; one student may be able to read words, while another may need objects, symbols or photos to make the schedule understandable.
- Display a 'who is in' board with pictures of staff that the student can ask for help.
- Personalise the classroom with the student to ensure their ownership of the space.
- Limit demands when the student is anxious.
- Make targets achievable.

The relationship

Teachers must remain emotionally available, sensitive and responsive to the student. When the student is exhibiting increased arousal such as distress or excitement the teacher should attempt to support, empathise and nurture. This may be by reflecting what the student is saying back to them or providing appropriate physical proximity. This should increase the likelihood of relaxation from the student, so an attachment can be made and emotional regulation can take place. Positive interaction should be provided at every available opportunity. This should increase the student's self-worth and self-esteem.

Attunement

When disciplining students with attachment disorders, it is important to retain firm boundaries and expectations. However, when a student is disciplined, they will experience a sense of shame that is amplified in attachment disorders. It is important to attune to this. This means that instead of focusing on the behaviour, you use reflective language to demonstrate understanding of how the student feels. This will increase the trust the student has in you, and also reminds the student that you are there to support them.

Therapeutic interventions

Students with a diagnosis of attachment disorder or with professionally recognised attachment issues acknowledged would benefit hugely from therapeutic input, such as music, art and play therapies. Speak to external agencies working with and supporting the student in your class for strategies, suggestions and support. There may be an opportunity to integrate work to make the environment more consistent for that student.

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