ATTACHMENT

What Is Attachment and Why Is It Important?

Our introduction to the world begins in childhood and is largely shaped by our environment and our caretakers. A safe, predictable, and responsive environment allows our nervous system to feel safe, for us to feel connected with others, and to learn how to tolerate and regulate our emotions in healthy ways. Safe caretakers help us learn how to deal with emotions by a process called co-regulation—literally a process that allows us to learn how to modulate our thoughts, feelings, and behavior through safe relationships. We develop a large window of tolerance and learn how to express positive social engagement behaviors such as smiling, moving toward others, reaching out, and eye contact. If we grow up in environments that are scary, unpredictable, chaotic, and/or not responsive to our needs, our window of tolerance is small because it is not safe to be there. We learn defensive and protective strategies such as physical withdrawal, develop chronic body tension, and to stay for longer periods of time in hyper and hypo arousal states. As caregivers are unable to offer co-regulation, we learn other methods for dealing with our emotional, physical, and relational needs that can sometimes be harmful or self-destructive (like drinking, cutting, moving frequently, binge eating, etc.).

ATTACHMENT TYPES

Secure attachment:

- Created by reciprocal, attuned somatic and verbal communication with infant
- Quickly soothed upon distress and can easily return to exploratory activities
- *Secure attachment provides the primary defense against trauma induced psychopathology*
- Wide window of tolerance
- Able to mentalize (being aware of what's going on in our minds and other people's minds)
- Form effective social engagement systems
- Achieve overall adaptive functioning of parasympathetic and sympathetic systems
- Can sustain arousal in the optimal zone or return quickly to that state when arousal is excessive
- Seek proximity to others with little or no avoidance or angry resistance and can tolerate relational frustrations and disappointments
- Actions of moving forward, reaching out, otherwise seeking contact
- Can receive soothing and calming without ambivalence, also able to self-regulate
- Can unambiguously and congruently display their intentions, mood, desires and motives on a cognitive, emotional, and sensorimotor behavioral level

  Regulates by self and seeking others

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Balanced sympathetic and parasympathetic systems

Can optimistically evaluate safety, danger, and life-threatening situations and shift adaptively

Avoidant attachment:

- Caregivers actively thwart or block proximity seeking behavior of the infant, responding instead by withdrawing or even pushing the child away. Caregivers have a general distaste for physical contact except on their terms. Caregivers may respond to needs by wincing, arching away, or avoiding mutual gaze.
- Child expresses little need for proximity and does not sustain it when contact is made.
- Avoids eye contact and shows few visible signs of distress upon separation although autonomic arousal is happening
- As adults they often distance themselves from others, undervalue interpersonal relationships, becomes self-reliant, and tend to view emotions with cynicism. They withdraw under stress and avoid seeking emotional support
- Minimize their attachment needs and find dependence frightening and unpleasant and avoid situations that stimulate attachment needs
- Body tendencies very: Muscular tonicity or rigidity, defensive movements. May pull back or become armored. May withdraw through a demeanor of passivity, often reflected in low muscular tonicity, and lack of response to relational overtures. Mixed tone: High tone in certain areas of the body and low tone and others, likes strong legs and weak arms.
- Lack of emotional expression and eye contact and lower overall arousal

Parasympathetic (dorsal vehicle) dominance

Curtails the expression of emotion

Learned to modulate arousal solitude and through ways that do not require another's presence

May express frustration in peer relationships where avoidant attachment behaviors are sometimes associated with hostility, aggressiveness, and conduct problems. The ability to resolve interpersonal conflicts are underdeveloped

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Anxious attachment:

- Caregiver is inconsistent and unpredictable. Either by over arousing or failing to help infant engage. Their interactions are in response to their own emotional needs and physical needs rather than the infant's and may stimulate the infant to high arousal even when the infant is attempting to down regulate emotion.
- Child isn't sure of the reliability of the caregiver's response and this results in infant appearing cautious, distraught, angry, distressed, and preoccupied. They often appear irritable, have difficulty recovering from stress, show poor impulse control, fear of abandonment, and engage in acting out behavior.
- Alternate between angry, rejecting behaviors and contact seeking behavior. Tendencies to intense expressiveness and negative mood responses, slow adaptability to change irregularity of biological functions.
- Preoccupied stance toward adult attachment meets, overly dependent tendency towards enmeshment and intensity with a preference for proximity. Focus is on internal distress and pursuing relief.
- Hard to recognize safety.
- Increased affect and bodily agitation, increase or loss of muscular tone at the prospect of separation.

Sympathetic dominant nervous system with low threshold of arousal

Has been taught to increase signaling for attention

They are vulnerable to under regulatory disturbances and less able to auto regulate. They find isolation stressful including to relational contact, becoming overly dependent.

They lack the ability to be easily calmed and soothe and relationship

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Disorganized attachment:

- Caregivers are frightening (looming, sudden movements, sudden invasion, attack postures) or frightened (backing away, exaggerated startle response, retraction in reaction to the infant, fearful voice, or facial expression)
- Caregivers exhibit role confusion, disorientation (trancelike expressions, aimless wandering in response to the infant's cries), intrusive behavior (pulling the child by the wrist, mocking and teasing, withholding a toy), or withdrawal (not greeting the infant, not interacting verbally, gaze avoidant).
- Often provokes sudden state switches without providing interactive repair. Sometimes caregivers may be abusive or neglectful-- extreme levels of stimulation and arousal, either too high or too low and no repair
- Infant is left hyper or hypo-aroused for extended periods of time

<u>Behavior</u>

- Sequential contradictory behavior like proximity seeking followed by freezing, withdrawal, or dazed behavior
- Simultaneous contradictory behavior like avoidance combined with proximity seeking
- Incomplete, interrupted, or undirected behavior and expressions like distress accompanied by moving away
- Mistimed, stereotypical, or asymmetrical movements, and strange anomalous behavior like stumbling when the mother is present when there is no clear reason to
- Movements and expressions of freezing, stilling, and underwater actions
- Postures that indicate fear in expressions and body language
- Behavior that indicates disorganization or disorientation like aimlessly wandering around, labile affect, or dazed, confused expressions

- Incongruent and contradictory behavior

Tendency towards hyper and hypo-arousal sympathetic activation accompanied by startle responses, elevated heart rate, respiration, blood pressure, and crying followed by quick shift to hypo-arousal when they are not regulated. The body undergoes sudden and rapid transition from one unsuccessful strategy to another

Compromised auto regulation and social engagement system

Physical, emotional, sexual abuse typically produces either chronically heightened autonomic arousal or biphasic alterations between hyper and hypo-arousal states

Neglect typically leads to flattening of affect which has a more negative effect than abuse alone due to decreased arousal and behavior associated with chronic increase in dorsal vagal tone

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