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Attachment and the schools

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Abstract

In order to be effective workers in the schools, school staff members must be able to form some sort of relationship with individual students. The ability of students to form relationships depends upon the attachments they have formed with their caretakers. The purpose of this literature review was to explore different types of attachment, interventions that can be used with students who have attachment issues, and how attachment can affect schools all of which are given from. the perspective of a school counselor. The literature review investigates and summarizes the impact both healthy and unhealthy attachment has on a student in cognitive, social, emotional, and behavioral areas. The paper concludes by giving interventions and strategies to help counselors work with students with attachment problems.

ATTACHMENT AND THE SCHOOLS

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Attachment and the Schools

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Abstract

In order to be effective workers in the schools, school staff members must be able to form some sort of relationship with individual students. The ability of students to form relationships depends upon the attachments they have formed with their caretakers. The purpose of this literature review was to explore different types of attachment, interventions that can be used with students who have attachment issues, and how attachment can affect schools all of which are given from the perspective of a school counselor. The literature review investigates and summarizes the impact both healthy and unhealthy attachment has on a student in cognitive, social, emotional, and behavioral areas. The paper concludes by giving interventions and strategies to help counselors work with students with attachment problems.

Attachment and the Schools

With the new American School Counseling Association (ASCA) model, schools need to address the work with the "whole child". Working with the whole child includes working with the child academically, socially/personally, and in regard to careers. In order to successfully work with a child in each of these areas, the counselor will need to effectively form a relationship with the child. The child's ability to form a relationship depends on whether or not the student can form attachments with people and greatly influences all areas of a student's life. Through the relationship, the counselor will be able to help the student in each of the following areas: career, academic, and personal/social. It will become the responsibility of the schools to have to effectively work with students who have attachment issues, because attachment issues affect students in each of the career, academic, and personal/social realms. The purpose of this paper is to look at attachment and interventions for attachment issues through the perspective of a school counselor.

Healthy Attachment

Attachment was defined as the affectional bond or tie an infant forms between herself and her caretaker by Ainsworth, Blehar, Waters, and Wall (1978). This bond is likely to be lasting and independent of specific conditions. Bowlby (1982) describes attachment as a lasting psychological connectedness between human beings and is considered an important factor for healthy human development. By attaining the attachment bonds, children are able to view themselves as worthy of love, praise, attention, and attain a foundation for positive relationships in the future (Bowlby, 1982).

Attachment behaviors are the actions that will bring about a desired degree of proximity to the caretaker. Bowlby (1982) suggested attachment behaviors are intended to achieve four principal goals: security, safety, proximity, and regulation of the child's affective states. Attachment behaviors serve the biological function of protection. This behavior can mediate, maintain, and further develop the attachment bonds (Ainsworth et al., 1978).

Children who are securely attached display a range of typical behaviors. Securely attached children seek help when needed, have a willingness to comply with requests and redirections with minimal conflict, seek an attachment figure for comfort when hurt, and have no pattern of controlling or directing the behavior of caregivers (Berlin & Appleyard, 2007). Insecurely attached children do not display these behaviors (Berlin & Appleyard, 2007). Children who are securely attached are more prosocial than insecurely attached children; they also have a more positive depiction of their peers in vague social situations (Cassidy, Scolton, Kirsh, & Parke, 1996). Securely attached children were also found to be the best adjusted when compared to insecurely attached children, they were better able to constructively cope, had greater ego-resilience, were rated as less anxious and less hostile by peers, reported little distress, and indicated high levels of social support (Kobak & Sceery, 1988).

In most literature on attachment, healthy attachment is referred to as secure attachment. Secure attachment is largely attained through parenting behavior (Berlin & Appleyard, 2007). Behaviors from parents typically related to secure attachment include giving responsive and sensitive care, especially giving comfort when the child is upset and giving support for independent exploration (Berlin & Appleyard, 2007). Parents of

securely attached parents also give the child consistent, clear, and developmentally-appropriate expectations and supervision; as well as demonstrating warm, positive, and responsive verbal interaction (Berlin & Appleyard, 2007).

Unhealthy Attachment

Insecure Attachment

Unhealthy attachment is referred to as insecure attachment in attachment research. Insecure attachment is known to negatively impact the child in the emotional, psychological, social, and cognitive realms. These effects include intellectual processes like language and abstraction, certain parts of personality, the ability to establish and maintain interpersonal relationships, and impulse control (Ainsworth et al., 1978). There are three manifestations of insecure attachment: overly dependent children, overly independent children, and a disorganized/disoriented attachment (Ainsworth et al., 1978). These manifestations are classified as Insecure/Ambivalent, Insecure/Avoidant, and Disorganized Attachment. Cassidy, Scolton, Kirsh, & Parke (1996) found that parental rejection was related to insecure attachment.

Insecurely attached children behave in certain ways. Insecurely attached children: lack warmth; display promiscuous, sexualized behavior; show excessive dependence; fail to seek contact and comfort when needed; are disoriented or frightened in presence of parent; and have indiscriminate friendliness or seeking of contact (Berlin & Appleyard, 2007). Insecurely attached children have poor peer relationships and often perceive both familiar and unfamiliar peers more negatively than securely attached peers (Cassidy et al., 1996).

Insecurely attached children who are avoidant have unique behavioral characteristics. These children have intense anger, loss, and hostility; are overly critical of others; are very sensitive to blame; lack empathy; view others as untrustworthy or undependable and are extremely self-reliant; view self as unlovable, or too good for others; relationships feel either threatening to one's sense of control, not worth the effort, or both; indicate having low levels of perceived support; have difficulty getting along with co-workers, often preferring to work alone; can use work or doing work as an excuse to avoid personal relations; fear closeness in relationships; avoidance of intimacy; and have a tendency toward self criticism (Anderson, 2009). In one study, it was found that avoidant children were rated low on ego resilience and higher on hostility by peers as well as report more distant relationships in terms of more loneliness and low levels of social support from family (Kobak & Sceery, 1988).

Insecurely attached children in the anxious/ambivalent category have characteristics different from both securely attached children and insecurely attached children who are avoidant. While both the avoidant and the ambivalent group were rated as more anxious than the secure group in a study, the ambivalent group was the most anxious of the three (Kobak & Sceery, 1988). The ambivalent children were seen to be less ego resilient and more anxious by peers and reported high levels of personal distress, while still viewing their family as more supportive than the avoidant children (Kobak & Sceery, 1988). The ambivalent children also reported themselves to have lower perceived competence and higher levels of symptoms (Kobak & Sceery, 1988). According to Anderson (2009), in relationships anxious/ambivalent children feel overly involved and underappreciated, lack relationships which are long-term, provide

compulsive care giving; idealize others, have a strong desire for partner to reciprocate in relationship, over invests their emotions in a relationship, perceive relationships as imbalanced, and they feel a relationship is the primary method by which one can experience a sense of security. Anderson (2009) also found anxious/ambivalent children are likely to identify others as difficult to understand; are unlikely to view others as altruistic; are very sensitive to rejection; have discomfort with anger; exhibit extreme variations in emotions; and are jealous, possessive, and view self as unlovable in regards to relationships.

Reactive Attachment Disorder

Insecure attachment comes from a weak or damaged relationship with the primary caregiver; it is not a diagnosable condition. A diagnosable condition stemming from attachment problems is Reactive Attachment Disorder (RAD), and this is a more severe than insecure attachment and has certain behaviors which identify the condition. Reactive Attachment Disorder is referred to in the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR)* as Reactive Attachment Disorder of Infancy or Early Childhood. The main characteristic of RAD is a "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care" (American Psychiatric Association, 2000, p. 127). Pathological care can be disregard for the child's emotional needs or physical needs or repeated changes in the caregiver which prevents the child's formation of stable attachments.

There are two types of presentations for RAD: the Inhibited Type where the child fails to initiate and respond to most social interactions in a developmentally appropriate

way and the Disinhibited Type where the child displays a pattern of indiscriminate ability

or a lack of selectivity in the choice of attachment features. Differential diagnoses for

RAD include mental retardation, autistic disorder and other pervasive developmental

disorders, social phobia (for inhibited type), attention-deficit/hyperactivity disorder (for

disinhibited type), Conduct Disorder, and Oppositional Defiant Disorder. Unless an

appropriately supportive environment is provided, there is not improvement and the

disorder will follow a continuous course. Unfortunately, there are no proven interventions

for RAD at this time. (American Psychiatric Association, 2000)

Like the other forms of attachment, children with RAD display certain behaviors.

Parker and Forrest (1993) point out the vast assortment of maladaptive behaviors such as

stealing, destroying property, bullying, aggression, hoarding food, and cruelty to people

and animals. Children diagnosed with RAD "score higher on general behavioral

problems, social problems, withdrawal, somatic complaints, anxiety and depression,

thought problems, attention problems, delinquent behavior, aggressive behavior, lack of

empathy, excessive self-monitoring, higher rates of hyperactivity and other behavioral

and emotional problems" (Buckner, Lopez, Dunkel, & Joiner, 2008, pps. 289-290). In

way of social competence, it was found that children with RAD have tendencies to be

more anti-social, aggressive, and harm other children at school (Floyd, Hester, Griffin,

Golden, & Canter, 2008).

To find a more complete understanding of children with RAD, Kay-Hall and

Geher (2003) investigated by including both the caretakers of RAD children and

caretakers of children not diagnosed with RAD, as well as including the children who are

diagnosed with RAD. Children with Reactive Attachment Disorder (RAD) were found to

have lower scores on empathy but had higher scores for self-monitoring than children without RAD. The higher self-monitoring could imply that children with Reactive Attachment Disorder are better able to present themselves as more socially desirable than should be warranted. Children with RAD were also found to report themselves in a more positive light than their parents. Children with Reactive Attachment Disorder also were indicated to have significantly more problems with behavior than the control (non-RAD) children. The authors found "children diagnosed with RAD display significantly more violent and detrimental behavioral and personality difficulties than non-RAD children and on a more frequent and more intense basis than do non-RAD children" (Kay-Hall & Geher, 2003, p. 158). Children diagnosed with RAD have difficulties in self-regulating and adapting their emotions and behaviors. (Kay-Hall & Geher, 2003)

Schools

Interacting with the school staff is inevitable for students in the school, but it takes willingness and work to create a healthy relationship between students and school staff. The child's type of attachment to the caretaker influences the kinds of relationships students will form at home and in the school. A child's form of attachment will also influence how the student will react and relate to his peers and school staff (Cassidy et al., 1996). The quality of the child-teacher relationship is the most important variable for the child's adaptation to the school environment (Kennedy & Kennedy, 2004). This relationship is vital for a child's functioning at school. Over time, this relationship will help provide a sense of safety and security and will help enhance self-regulation which may enable children to develop the sense of trust needed to explore the environment,

regulate emotions and behaviors, and join others in the process of learning (Kennedy &
Kennedy, 2004).

Aside from relationships at school, attachment influences a student's cognitive
ability and academic performance. Moss and St-Laurent (2001) did a study investigating
this relationship. Children with secure attachment had higher scores on communication,
cognitive engagement (extent to which the child participated in the cognitive operations
needed to solve the task), and mastery motivation (motivation towards academic
learning) when compared to their insecurely attached peers. Children with insecure
attachment had the lowest scores on mastery motivation and cognitive engagement. It
was found secure attachment was the principal significant predictor of a child's mastery
motivation as well as the fact that children with secure attachment scored significantly
better on three of the five performance measures given, including task engagement.
Moss and St-Laurent (2001) posited the lower task engagement may yield fewer
experiences of mastery in school tasks, which can hinder the development of goals in
mastery. (Moss & St-Laurent, 2001)

While the DSM-IV-TR (2000) indicates Reactive Attachment Disorder is rare,
schools are increasingly facing the problem of how to manage the behavioral problems of
children with RAD and learning how to educate them. Children with RAD are apt to
scare, hurt, and bully other students at the schools (Parker & Forrest, 1993). Reactive
Attachment Disorder may be exacerbated by the academic and school arena (Floyd et al.,
2008). It is vital for the school staff to help students gain the ability to regulate his or her
own feelings in the classroom (Schwartz & Davis, 2006; Floyd et al., 2008). For children
with RAD, "schools can become triggers of increased anxiety and possible rejection for

students with RAD given the conflicting requests brought about by the natural

consequences of delayed gratification, coupled with their inability to regulate emotions"

(Floyd et al., 2008, p. 53).

Interventions and Strategies

It seems as though a lot of the standard interventions for children with behavior

disorders are not thought to work with children who have attachment disorders. These

standard interventions include certain praise, problem solving questioning, behavior

management plans and punishment level systems, and zero tolerance policies (Smith,

2008). This knowledge begs the question of what would work with students who have

attachment issues. Bakermans-Kraneneburg, Van Ijzendoorn, and Juffer (2003) did a

meta-analysis showing interventions which are time limited, goal directed, and

behaviorally oriented as well as plans focused around parental participation have shown

to be more effective with attachment-based therapies. While these are great suggestions,

some of these suggestions are just not practical in the school setting. Most of the

suggested interventions for the traditional attachment-based therapies are not feasible in

the school setting (rebirthing, holding therapy, therapeutic parenting).

On an individual level, counselors can do certain things with children who have

attachment issues. Perry (2009) advocated several ideas for working with children who

are not securely attached: nurture these children both physically and emotionally and try

to understand the behavior before using punishment or consequences. Perry (2009) also

proposed to interact with the child based on their emotional age and not their

chronological age. All of the school staff should be consistent, predictable, and repetitive

to help the child feel safe and secure (Floyd et al., 2008). Teachers and counselors have

the opportunity to model and teach the child appropriate social behaviors. Since teachers are often busy with an entire class, it is important the counselor make time to listen and talk with the child. When having progress with the student, have realistic expectations and be patient with the progress of the child and be patient with yourself (Perry, 2009; Floyd et al., 2008). Children with RAD have difficulty maintaining eye contact, especially when being untruthful. Anderson (2009) also recommends using an individual setting would be the ideal time to work on eye contact with the child, which can be practiced and generalized to other settings. It is also recommended to utilize narrative therapy and play therapy which help give the child freedom to express himself in an indirect way while still giving them control over the direction of the session (Lake 2005).

In a small group setting, there are also specific interventions to use with children who are insecurely attached. This is the ideal setting to model and teach the child appropriate social behaviors as Perry (2009) suggested. This small group would ideally have securely attached children as well as insecurely attached children. The group can work on basic trust issues as well as social skills and how to express emotions in a safe and healthy way.

To be effective, interventions will need to encompass individual and small group settings, as well as involving the entire classroom. Building trust in the classroom is vital because it is never too late to improve on the stage of Basic Trust in Erikson's model (Mongrain & Vettese, 2003). To work in the classroom, interventions need to facilitate the building of basic trust. It has also been found that attachment is connected to the ability to judge the cause of another person's feelings (Mongrain & Vettese, 2003), so if a child has acquired basic trust he can predict another person's responses to a situation.

Another objective of a classroom intervention would be to help students take on another person's point of view and describe it while appropriately labeling the feelings the person may have (Parker & Forrest, 1993). Parker and Forrest (1993) also provided some exercises to use in class as well as additional interventions such as modeling trust-invoking behavior through drawing, puppet play, story telling, and role play; class activities to recognize the feelings of others; having your school provide a safe day-care option; and having patience with the students.

A significant amount of research on attachment suggests involving the caretakers of the child. This can be through talking with both the parents and child together, or educating the parents on techniques which might alleviate some of the behavior issues. Creating a healthy relationship with the caretaker of the child will both serve as a united front to help the child and serve as a model of a healthy relationship for the child (Berlin & Appleyard, 2007). Berlin and Appleyard (2007) also make these suggestions for parents: do not interfere with a child's attempts at explorations; give consistent and reliable responsiveness; and avoid hostile, threatening, and frightening behaviors.

Berlin and Appleyard (2007) also gave some recommendations for management of the disorder for school counselors. The authors suggest that "the school can become part of a team that will help in the identification and treatment of attachment-disordered children" (p. 4). Attachment can be an antecedent to other disorders as well as maladaptive and inappropriate behaviors. The school can also be part of the treatment process for students with mild attachment issues. Counselors can be an important information resource for people involved with the child who has an attachment disorder. The greatest challenge for the counselor will be to build a relationship with the child who

has an attachment disorder. Some recommendations from Forrest and Parker were given: research attachment disorders, having knowledge of the disorder, help educate to improve parenting. Berlin and Appleyard (2007) also suggest to help the parent understand the two principal parenting jobs, which are to comfort and soothe child and to facilitate the child's exploration in the world. This will help parents to understand their children's needs, along with giving the caretakers information on developmental milestones and typical development of children.

Conclusion

The purpose of this paper was to look at attachment and interventions for children with attachment issues through the perspective of a school counselor. Healthy attachment develops through a relationship with the primary caretaker. While healthy attachment is the ideal, schools will inevitably have to work with students with unhealthy attachment. This unhealthy attachment can be insecure attachment or Reactive Attachment Disorder which can stem from damaged, weak, or nonexistent relationships with the primary caretaker. Insecure attachment and RAD will adversely influence the child at school in the social, cognitive, behavioral and emotional domain. To counteract these negative influences, school counselors will need to employ interventions and strategies with these students on an individual, small group, and classroom level. Through employing the given interventions, the counselor may be able to foster a relationship with the child and the counselor will be better able to help the student in each of the career, academic, and personal/social areas.

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