

ATTACHMENT THEORY: A BRIEF OVERVIEW

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Developed from the seminal work of Bowlby (1969) and Ainsworth et al. (1978), attachment theory (AT) is concerned with the relational and affective bond between infants and their primary caregivers. AT posits that, based upon a genetic predisposition common to humans and many mammals, attachment systems are associated with a need for close proximity to the caregiver, and are triggered in response to fear and distress. Attachment behaviour in infants may include crying, clinging and searching, with these strategies essentially functioning as an evolutionarily advantageous means of eliciting care, safety and containing affective distress. Effective attachment provides a predictable ‘secure base’ from which to explore the world, develop independence and to return to in times of danger or distress (Bowlby, 1969).

A key element of Bowlby’s theory is that early attachment leads individuals to develop Internal Working Models (IWMs) of themselves and carers (Bowlby, 1969, 1973, 1980). IWMs can be broadly described as “...defining beliefs about the self, others, and the relations between the two. They influence the meaning people ascribe to interpersonal experiences, and they influence thoughts, emotions, and behaviours in close relationships” (Cobb & Davila, 2008. p. 209). IWMs are developed through the interactions between an infant and their primary caregivers, and promote internalised expectations and beliefs about self and caregivers. Crucially, the child also learns ‘what works’ in relation to getting their needs met (Bowlby, 1980). Over time and repetition, IWMs become automatic and generalise to other relationships, operating outside of conscious awareness and influencing thoughts, perception, feelings, memory and behaviour (Cobb & Davila, 2008). IWMs therefore come to underpin predictable patterns in experiences, responses and behaviour within close relationships.

Attachment style can be assessed from direct observations of infants (Ainsworth et al. 1978), adult narratives of their early attachments (Main & Goldwyn, 1985/1991), and self-report measures regarding relationships (Hazan & Shaver, 1987). Four main *attachment patterns*, incorporating dimensions of anxiety and avoidance, have been identified from research: secure, avoidant/dismissing, ambivalent/preoccupied, and disorganised (Ainsworth, 1978; Main & Soloman, 1986). Though genetic factors are also implicated (Gervai, 2009), each attachment pattern is theoretically and empirically linked to parenting styles and care-

giver responses to signals of infant distress and communication (Weinfield et al. 1999). If this is disrupted in some way then secure attachment can be jeopardised, leading to problematic themes in subsequent intrapersonal and interpersonal functioning and presenting a vulnerability to psychopathology (Bowlby, 1980).

Secure attachment develops in infants where care-givers are attuned, responsive, consistent, sensitive and caring. This leads the child to feel safe, confident and able to explore the world knowing that the 'secure-base' exists to return to. Such children develop beliefs that their needs are important and, if communicated, will be responded to appropriately. They characteristically display distress upon caregiver separation, but approach them eagerly on their return and are easily soothed (Ainsworth et al. 1978). As they develop, individuals with secure attachments typically hold a positive self-image, show comfort with autonomy and relationships, and demonstrate the ability to manage and tolerate distress (Berry et al. 2014). Despite large cultural variations (van Ijzendoorn & Kroonenberg, 1989) up to 70% of infants in Western countries are classified as securely attached (Ainsworth et al. 1978).

Avoidant attachment is associated with predictably unresponsive caregivers who are rejecting, distant, disengaged and/or controlling. In such scenarios, the child learns to 'deactivate' their attachment system since it does not function adequately as a means of getting their physical and emotional needs met and is, instead, a source of disappointment and pain (Berry et al. 2014). The child therefore learns that their needs are not important, or that they will not be met even if communicated, meaning that they distance themselves from attachment needs and distress (Dozier et al. 2008). These children show limited shared affection and exploration with caregivers; in situations involving caregiver separation, they demonstrate little distress, and although they may acknowledge their caregiver's return, they do not tend to approach them (Ainsworth et al. 1978). As such individuals develop, there are themes of excessive independence, distrust, discomfort with relationships and lack of emotionality (Mikulincer & Shaver, 2012).

Ambivalent attachment patterns are linked to caregiver responses involving unpredictability and inconsistency. Caregivers may be sometimes caring and attuned, yet at other points neglecting of the child's requirements. Consequently, the infant comes to believe that they cannot rely on their needs being met consistently, and therefore 'hyper-activate' attachment behaviours by escalating signs of distress. Such children are frequently insecure and reluctant to explore away from the caregiver. They become highly distressed on separation, and resist soothing following the caregiver's return, with the child often demonstrating clinging and angry behaviour (Ainsworth et al. 1978). As they develop, there may be themes of anxiety, insecurity, a negative self-image, fear of autonomy and abandonment, and a predisposition to being overwhelmed by emotions (Berry et al. 2014).

The final 'disorganised' grouping of infant attachment patterns represents confusing, contradictory and bizarre behaviour towards care-giver separation and reunification (Main & Solomon, 1986). Such children are typically the victims of severe abuse, neglect and/or mistreatment, or else when the caregiver is confusingly extreme, frightened or passive. Infant disorganised behaviour has been associated with intense fear due to the caregiver being a source of threat, which runs counter to the innate attachment

system (Berry et al. 2014). This leaves the infant severely confused, and with no predictable strategy available to get their needs met. Approximately 19% of infants in the general population will be classified as having disorganised attachment, although this rises to 82% in samples with a history of maltreatment (Carlson et al. 1989).

Though developed in infancy, attachment style remains key to interpersonal functioning and behaviour throughout a person's life (Hazan & Shaver, 1987); however, this can be influenced by later emotional and relational experiences, as well as context (Mikulincer & Shaver, 2007). Insecure attachment has been theoretically and empirically linked to a wide variety of mental health difficulties including depression (Cantanzaro & Wei, 2010), anxiety (Bosmans et al. 2010), eating disorders (Illing et al. 2010) and schizophrenia (Liotti & Gumley, 2009). Furthermore, there are also neurobiological correlates of disrupted attachment involving neurological systems underpinning stress sensitivity, emotional regulation and processing of self and others (Schore & Schore, 2008). Germane to the thesis presented in this paper, attachment insecurity is also associated with many personality disorders (Crawford et al. 2007). Disruption in secure attachment is therefore seen as a general vulnerability factor for psychopathology, although is unlikely to be a sufficient *causal* factor in most conditions (Mikulincer & Shaver, 2012).

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