Healing Hearts
Family Counseling Center

Understanding Attachment Disorders in Children

At least since Freud we have recognized that the infant-mother relationship is pivotal to the child's emerging personality. Freud (1940) said that for the baby, his mother is "unique, without parallel, laid down unalterably for a whole lifetime, as the first and strongest love object and as the prototype of all later love relations for both sexes." More recently, Greenspan (1997), Schore (1994), and Siegel (1999) have written convincingly about the ways that the early care giving relationship influences the child's developing cognitive ability, shapes her capacity to modulate affect, teaches her to empathize with the feelings of others, and even determines the shape and functioning of her brain. The attachment and care giving systems are at the heart of that crucial first relationship. John Bowlby (1969/1982; 1973; 1980) described the attachment and care giving systems in biological and evolutionary terms stating that, across species, the attachment system was as important to species survival as were feeding and reproduction. At the heart of the attachment and care giving systems is the protection of a younger, weaker member of the species by a stronger one. The infant's repertoire of attachment behaviors are matched by a reciprocal set of care giving behaviors in the mother. As the mother responds to the infant's bids for protection and security, a strong affectional bond develops between the two that forms the template for the baby's subsequent relationships. Attachment behaviors change as the child develops. A young baby who is tired, frightened, hungry, or lonely will show signaling and proximity seeking behaviors designed to bring his caregiver to him and keep her close. The baby may cry, reach out, or cling to his mother. Later when he is more mobile, he may actively approach her, follow her, or climb into her lap. A toddler may use his mother as a secure base, leaving her briefly to explore his world, and then reestablishing a sense of security by making contact with her by catching her eye, calling out to her and hearing her voice, or physically returning to her (Lieberman, 1993). By the time a child is four years old, she is typically less distressed by lack of proximity from her mother, particularly if they have negotiated or agreed upon a shared plan regarding the separation and reunion before the mother leaves (Marvin & Greenberg, 1982). These older children have less need for physical proximity with their mothers, and are better able to maintain a sense of felt security by relying upon their mental image of their mothers and upon the comforting presence of friends and other adults.

Bowlby (1969/1982) referred to attachment bonds as a specific type of a larger class of bonds that he and Ainsworth (1989) described as "affectional" bonds. Ainsworth (1989) established five criteria for affectional bonds between individuals, and a sixth criteria for attachment bonds. First, an affectional bond is persistent, not transitory. Second, it involves a particular person who is not interchangeable with anyone else. Third, it involves a relationship that is emotionally significant. Fourth, an individual wishes to maintain proximity or contact with the person with whom he or she has an affectional tie. Fifth, he feels sadness or distress at involuntary separation from the person. A true

attachment bond, however, has an additional criteria: the person seeks security and comfort in the relationship.

It is important to note that an infant does not have only one attachment relationship. Bowlby (1969/1982) posited that babies routinely form multiple attachment relationships, arranged hierarchically, although they most likely have a single preferred attachment figure to whom they will turn in times of distress if she is available. As the baby develops, however, he will form multiple attachment bonds and an even greater number of affectional bonds. And the need for attachment bonds does not end with infancy. Across the lifespan, we all experience times when we feel weak, ill, or vulnerable and turn to a loved person for support and comfort. This turning, we will see, is the echo of our infant attachments, and our expectations of what will happen when we turn to another are also built in infancy.

Patterns of Attachment

The quality of the child's attachment to his mother is determined by the way the mother responds to her child's bids for attention, help, and protection. As Ainsworth (1989) pointed out, the defining characteristic of an attachment bond is that it is marked by one person seeking a sense of security from the other. If the seeker is successful, and a sense of security is attained, the attachment bond will be a secure one. If the seeker does not achieve a sense of security in the relationship, then the bond is insecure.

Ainsworth and her colleagues (1978) established the most widely used research method for assessing quality of attachment: a laboratory procedure known as the Strange Situation which involves two brief separations from mother in which the baby is left with a stranger. The baby's behavior on reunion following these separations forms the basis for classifying her quality of attachment. Ainsworth (1978) described three basic patterns of attachment: securely attached, avoidant, and resistant.

Babies described as **securely attached** actively seek out contact with their mothers. They may or may not protest when she leaves the laboratory, but when she returns they approach her and maintain contact. If distressed, they are more easily comforted by their mothers than by the stranger, demonstrating a clear preference for their mothers. They show very little tendency to resist contact with their mothers and may, on reunion, resist being released by her.

Babies who are classified as avoidant in the Strange Situation demonstrate a clear avoidance of contact with the mother. They may turn away from her or refuse eye contact with her. They may ignore her when she returns after the separation. Some avoidant babies seem to prefer the stranger and appear to be more readily comforted by the stranger when they are distressed.

The third group, **resistant** babies, may initially seek contact with their mothers on reunion, but then push her away or turn away from her. They demonstrate no particular preference for the stranger, but on the contrary appear angry toward both their mother and the stranger.

Later, Main and Solomon (1990) described a fourth pattern of attachment behavior: **disorganized/disoriented behavior.** These babies seem to have no clear strategy for responding to their caregivers. They may at times avoid or resist her approaches to them. They may also seem confused or frightened by her, or freeze or still their movements when she approaches them. Main and Hesse (1990) have hypothesized that disorganized infant attachment behavior arises when the baby regards the attachment figure herself as frightening. Studies have demonstrated a higher incidence of disorganized/disoriented attachment patterns in infants whose mothers report high levels of intimate partner violence (Steiner, Zeanah, Stuber, Ash, & Angell, 1994) and in infants who were maltreated (LyonsRuth, Connell, Zoll, & Stahl, J., 1987). The babies of mothers who abuse alcohol have been shown to have higher incidence of disorganized/disoriented attachment behavior (Lyons-Ruth & Jacobivitz, 1999).

Even though some studies indicate that insecure attachment styles can lead to emotional and behavioral difficulties, it is important to keep in mind that insecure attachment styles are not mental disorders. They are strategies for protection seeking that occur in the normative population. Lieberman and Zeanah (1995) propose three separate categories of attachment disorders: (1) disorders of nonattachment, (2) disordered attachments, and (3) disrupted attachment disorder: bereavement/ grief reaction. This article will discuss only the first two categories.

Disorders of Non-Attachment

The disorders of non-attachment closely parallel the description of reactive attachment disorder that appears in the DSM-IV (APA, 1994). These disorders most frequently appear in children who have not had the opportunity to attach to a single caregiver, and they are of two major types, the first involving emotional withdrawal and the second, emotional promiscuity or indiscriminate behavior.

Example of non-attachment with emotional withdrawal

Ivan was born to a young mother overwhelmed by the demands of poverty. Ivan's active 19 month old brother, and her violent relationship with her children's father, who lived with her sporadically when he was not in jail. Ivan's mother, who reported a lonely childhood in which she sat alone in her apartment many hours each day waiting for her mother to return from work, coped with her negative feelings by drinking heavily. She was ambivalent about her pregnancy with Ivan and abused alcohol throughout. Ivan was born several weeks premature and small for his gestational age.

Example of disorganized/disoriented attachment behavior

Jill was 30 months old when she was removed from her parents' home because of their pervasive neglect of her. Both of her parents were heavy drinkers. They fought with each other, sometimes with knives as weapons, and they had been observed to punish Jill for small infractions by biting her. Jill did not see her parents for the first ten days that she was in foster care, and then was reunited with them for a visit in our clinic playroom. When they came into the room, Jill did not respond to them and

seemed not to see them or anyone. She sat frozen in her chair. She did not explore the room or play **with any of the toys.** When **her mother offered** her a toy or food, Jill sometimes seemed to be looking at her without seeing her, and sometimes turned away. When either of her parents spoke, Jill startled visibly, pulled at her hair, and shouted, "What?" in an alarmed tone. Other than that she spoke no words during the two hour visit. When the therapist said that it was time to leave, however, she fell screaming to the floor, refused to put on her coat, grabbed for her mother and clung to her as she tried to walk away. She remained inconsolable for nearly 20 minutes after her parents left the visiting room.

Internal Working Models and the Role of Attachment in Normative Development

Bowlby (1969/1982) believed that as the baby or child experienced his caregiver's responses to his bids for help and protection, he developed mental/emotional templates called internal working models of him and what he could expect in his relationships with other people. A baby whose mother responds quickly and sensitively to his cries comes to see himself as worthy of attention and help. He comes to anticipate that other people in his life will respond to him positively when he needs something. He gains a sense of efficacy and agency: a belief that he can make things happen. On the other hand, a baby whose mother does not respond to his bids constructs an internal working model of himself as unworthy and other people as unresponsive or, perhaps, as dangerous. The avoidant, resistant, and disorganized styles of attachment described above are in response to inconsistent or insensitive caregiver responses to the baby's bids.

The literature suggests that the internal working models of attachment that are formed in infancy and early childhood form the templates for a variety of relationships, not only attachment relationships. Preschool children with secure attachment histories have been shown to be more self-confident and less dependent with their teachers than insecurely attached children (Sroufe, 1983). The same children, at age ten, were less dependent on summer camp counselors than were children with insecure attachment histories (Urban, Carlson, Egeland, & Sroufe, 1991). Warmer and his colleagues (1994) also found that securely attached six year olds were more competent in play and conflict resolution with peers than were insecurely attached children. Other researchers have found that these increased competencies extended into later childhood (Grossmann & Grossmann, 1991) and adolescence (Weinfield, Sroufe, Egeland, & Carlson, 1999).

Further, insecurely attached babies have grown into children with problems in some areas of functioning. Cohn (1990) and Turner (1991) found that insecurely attached boys were more aggressive than securely attached ones at four and six years of age, respectively; and Turner (1991) found that insecurely attached girls were more dependent and less assertive than securely attached girls. Although other findings of increased aggression, particularly among avoidantly attached children, have been reported, many studies have failed to replicate them. and one must be cautious in suggesting that insecure infant attachment leads to any particular psychopathology. Recent studies have also noted that other factors besides inconsistent or insensitive

maternal care giving contribute to attachment insecurity. Some authors now suggestthat an interaction of child characteristics.. (such as a difficult or "slow to warm" temperament), insensitive care giving (including factors such as child maltreatment, maternal depression and maternal substance abuse), and high levels of family adversity and stress interact to result in insecure attachment (Greenberg, 1999).

Disorders of Attachment

He lagged behind in his development and from time to time during his first year of life slipped from his growth curve. He spent the year moving between the homes of his mother, his maternal grandmother, and a maternal aunt. When he was first seen in the clinic he was 17 months old. He could sit and crawl but could not walk and he had no language. He did not respond when his mother spoke or approached him; nor did he respond when the therapist approached him. He would sit quietly for up to an hour on a sofa without toys or anything else to entertain him.

Ivan appeared withdrawn from contact not only with his mother but also from the world. He did not seek stimulation from people or **objects in his environment,** and he seemed to have given up on asking for anything. It took **extraordinary effort,** over several weeks, for the therapist to begin to engage him so that he would make consistent eye contact, accept a toy from her or respond by vocalizing and smiling to her emotional expressiveness. Even then, his mother remained ambivalent about Ivan's development. She wanted him to walk so that she would not have to carry him everywhere, but she dreaded the loss of her "easy" baby, who placed so few demands on her. It was difficult for her to understand the importance of talking to Ivan or playing with him, and she seemed unable to follow the therapist's lead in trying to engage her son.

Example of non-attachment with indiscriminate behavior

Susan was 15 months old when she came to live with her paternal aunt and grandmother. Until then, she had been in the care of her crackcocaine addicted mother and had lived with her in a variety of crack houses and, sometimes, on the y street. Her mother also had left Susan sporadically with relatives, sometimes telling them that she would be back in several hours and then not returning to retrieve her daughter for days or weeks. When Susan's mother learned of her own HIV status, she left Susan with her aunt and grandmother, saying that she could no longer care for her. Susan was weak, dirty and malnourished, unable even to sit up. A physical exam disclosed that she had been raped. When she was first seen in the clinic, Susan had been with her grandmother and aunt for three months. She had regained her physical strength and was able to stand and walk. but emotionally she remained devastated. She clung to both her aunt and her grandmother, screaming if they left the room and waking up in terror several times each night to make sure that they were still there. She hugged strangers in line at the bank, and when her uncles came to **visit, she crawled into their** laps, embraced them, and tried to remove her clothing. She approached the therapist in the very first session, clung to her knees, and sat on her lap. At the end of the hour, she sobbed when the therapist got up to leave, and could not be comforted even by her grandmother. It took many months of sensitive

care for Susan to begin to develop a preference for her grandmother and to reliably turn to her for comfort.

Disordered Attachment

Lieberman and Zeanah (1995) make the important point that a child does not have to be nonattached to have disorders of attachment. This is a major step forward that they have made in diagnosing relational problems in infancy that put a baby at developmental risk. As they point out, the principal difference between a disorder of nonattachment and a disordered attachment is that in the latter, the child does express a preference for a particular attachment figure. The preference, however, is unlike normative attachment patterns (even insecure ones) in that it is characterized by intense conflict that pervades the relationship because of intense negative feelings such as anger, fear or anxiety. The child does not express these emotions directly, but masks them with defenses that interfere with the heart of his attachment relationship. Such a child may appear to be extremely inhibited, may engage in selfendangering behavior, or may reverse roles and offer emotional relief to the attachment figure to whom she would more appropriately turn for comfort and safety herself.

Treatment of Attachment Disorders

There are several models for treating attachment disorders. Some of them have sprung up in response to an increase in numbers of children in foster care and children adopted from institutions in the Eastern European block countries. Children from these backgrounds often present as non-attached to any particular caregiver. Keck and Kupecky (1995) use cradling in their work with poorly attached children and adolescents. Cradling is a technique in which the child is physically held on the lap of parent(s). The cradling is intended to provide physical containment, which can be reassuring if frightening feelings are aroused. Hughes (1997) describes a treatment method for working with nonattached children that encourages the caregiver to treat the child in a manner consistent with the child's developmental age, keeping the child under the constant close supervision of the caregiver.

Dyadic Developmental Psychotherapy has been shown to be an effective treatment method for the treatment of children and teenagers with trauma-attachment disorders. Another treatment method that has been tested and empirically demonstrated to facilitate secure attachment is infant-parent psychotherapy, originally described by Selma Fraiberg and her colleagues (1975). In infant-parent psychotherapy, as it was first conceived, the focus of the treatment was on the parent's emotional conflicts as they affect the infant. Fraiberg believed that a parent's emotional difficulties, originating in conflicted relationship histories, mental illness, family disruption, socioeconomic hardship, or a combination of these factors, could interfere with adequate physical and emotional care giving and lead to a disturbed relationship between mother and baby. More recently, infantparent psychotherapy has incorporated the understanding that infant constitutional vulnerabilities, and poorness of fit between the infants' characteristics and needs and the parents' care giving style, may also disrupt the parentchild relationship. Infant-parent psychotherapy now focuses on these factors as well as on the parents' emotional liabilities (Lieberman & Pawl, 1988).

In two empirical studies, Lieberman and her colleagues (Fraiberg, Lieberman, Pekarsky & Pawl, 1981; Lieberman, Weston, & Pawl, 1991) have demonstrated that infant-parent psychotherapy can affect changes in the quality of infant-parent attachment, converting insecure attachments to secure ones. This therapy, which combines nondidactic developmental guidance, help with problems in living, and the psychodynamic exploration of the infant-parent relationship and the parents' relationship history, can help repair anxious relationships and improve the baby's chances for the most favorable developmental outcomes. The case of Lily and her parents illustrates how infant-parent psychotherapy can facilitate the development of secure attachments in families where there are multiple risk factors in the parents' histories and present lives.

Example of infant parent psychotherapy used with a drug-addicted mother

Karen was separated from her daughter, Lily, at birth because Karen had sought no prenatal care, she and Lily both tested positive for several substances (including heroin and methadone), and she had no stable home. Lily was placed in a group home where she was cared for by nurses and aides, including one nurse who was assigned to be her particular caregiver. Karen engaged in a day treatment program and visited Lily several times a week. Karen and her frequent comings and goings were confusing to Lily. The staff at the home noted that Lily cried frantically whenever Karen left her, but that when Karen was with her Lily was sometimes clingy and sometimes pushed her away or ignored her overtures.

When Lily was ten months old, Karen was admitted to a clean and sober house for mothers and young children, and Lily was transitioned to her care. The referral for infantparent psychotherapy was made to facilitate the transition and to support Karen in undertaking the fulltime care of her daughter. Karen was thrilled to have Lily with her every day, but told the therapist that she could not understand Lily. Lily cried, refused to sleep in her own bed at night, and turned away from Karen when Karen tried to comfort her. Karen was deeply hurt that Lily did not share her joy at their reunion and said, "Lily just doesn't love me. She wants to hurt me to get back at me for leaving her alone. "
Over time, the therapist helped Karen to see how difficult the transition from the group home to her care might have been for Lily. Although the group home had been imperfect, it had been Lily's home and filled with familiar figures. The therapist asked Karen about her own responses when she lost people who had been close to her. When Karen began to understand that Lily's behavior might be motivated by grief rather than vengeance, she was able to find ways to comfort Lily.

The therapist observed that in her eagerness to care for Lily, Karen was often intrusive. Rather than responding to Lily's bids for attention, Karen pressed her affection on Lily in ways that made Lily angry. Karen would then feel rejected and pull away. The therapist helped Karen focus on times when Lily turned to . her, and supported her response to Lily at those times. The therapist could then point out the pleasure that Lily took in Karen's attention. The therapist also supported Karen by giving her a place to talk about her hurt and frustration that Lily did not always want her affection when she wanted to give it. With this support, Karen became less intrusive, more aware of Lily's bids, and more consistent in responding to them. As Lily grew more confident that her mother would respond when she expressed her need she turned to her mother more frequently

and their interaction became more spontaneous and joyful. Within several months, Lily consistently turned to her mother when she needed help, and no longer pushed Karen away when Karen spontaneously offered her affection. her affection on Lily in ways that made Lily angry. Karen would then feel rejected and pull away. The therapist helped Karen focus on times when Lily turned to . her, and supported her response to Lily at those times. The therapist could then point out the pleasure that Lily took in Karen's attention. The therapist also supported Karen by giving her a place to talk about her hurt and frustration that Lily did not always want her affection when she wanted to give it. With this support, Karen became less intrusive, more aware of Lily's bids, and more consistent in responding to them. As Lily grew more confident that her mother would respond when she expressed her need she turned to her mother more frequently and their interaction became more spontaneous and joyful. Within several months, Lily consistently turned to her mother when she needed help, and no longer pushed Karen away when Karen spontaneously offered her affection.

SUMMARY

Attachment, an affectional relationship between mother and baby and, later, between other caregivers and baby, is central to the personality development of every infant. Secure attachment can be derailed in many ways. Economic and social stresses, mental illness, substance abuse, and the constitutional vulnerabilities of the child can all act to place difficulties in the path of the relationship between a baby and her mother. These relationships can, however, be healed, and the baby returned to a hopeful developmental path.

*Additions have been made to this article on 7/13/03.

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