ATYPICAL CAREGIVER BEHAVIOURS AND DISORGANIZED INFANT ATTACHMENT

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Growing prospective and retrospective evidence links the quality of the early caregiver-infant attachment relationship with later emotional and behavioural problems (Dozier, Stovall & Arbus, 1999; Greenberg, 1999). Of the four existing patterns of infant attachment (secure, avoidant, resistant, disorganized), the disorganized (D-) classification has been most clearly identified as a strong childhood risk for socio-emotional maladjustment and psychopathology (Carlson, 1998; Lyons-Ruth, 1996; Lyons-Ruth et al., 1993; Main & Cassidy, 1988). Children with D- attachment are more vulnerable to stress as measured by salivary cortisol (Hertsgaard et al., 1995; Spangler & Grossmann, 1993), have problems with regulation and control of negative emotions (van IJzendoorn et al., 1999), display oppositional, hostile-aggressive behaviours and coercive styles of interaction (Lyons-Ruth, 1996; Lyons-Ruth et al., 1993), are vulnerable to altered states of mind such as dissociation in young adulthood (Carlson, 1998), and are overrepresented in groups of children who have clinical problems and who are victims of maltreatment. For example, over 80% of maltreated infants have D- attachment (Cicchetti & Barnett, 1991; Lyons-Ruth et al., 1991). One recently identified pathway to D- attachment includes caregiver behaviours toward the child that are referred to as “frightening, frightened, dissociated, sexualized or otherwise atypical” or “Fr-” (Lyons-Ruth et al., 1999; Schuengel et al., 1999).

Organized and Disorganized Attachment

The quality of the attachment bond between infants and their caregivers has long-term consequences for socio-emotional adjustment (Ainsworth et al., 1978; Bowlby, 1969/82; Sroufe, 1988). To a large extent, the quality of that bond is determined by the caregiver’s response to the infant when the infant’s attachment system is “activated” (i.e., when the infant’s feelings of safety and security are threatened, such as when ill, physically hurt, or emotionally upset). Based on daily interactions with their caregivers, infants come to anticipate caregivers’ responses to their distress and shape their own behaviours accordingly. In this way, they develop strategies for dealing with distress (Ainsworth et al., 1978; Sroufe, 1988; van IJzendoorn et al., 1999).

Three major patterns of response to infant distress have been identified as leading to specific “organized” attachment patterns in infants. These three “organized” strategies are assessed in the Strange Situation (Ainsworth et al., 1978), a 20-minute laboratory procedure in which patterns of infant behaviour toward the caregiver following two brief separations are categorized as secure or insecure (avoidant or resistant).

1. Secure infants whose caregivers consistently respond to distress in “loving” ways (e.g., by picking up and reassuring) feel secure that they can freely express negative emotion and that these will elicit comforting from the caregiver (van IJzendoorn et al., 1999). Their strategy for dealing with distress is “organized”: they seek proximity to and maintain contact with the caregiver until they feel safe. In the Strange Situation, they greet and/or approach their caregiver and may maintain contact but are able to return to play.

2. Insecure, avoidant infants whose caregivers consistently respond to distress in “rejecting” ways (e.g., by ignoring, ridiculing or becoming annoyed) develop a strategy for dealing with distress that is also “organized”: they avoid their caregiver when distressed and minimize displays of negative emotion in the presence of the caregiver (van IJzendoorn, 1999). In the Strange Situation, they fail to greet and/or approach their caregiver and appear oblivious to the caregiver’s return, instead remaining focused on toys.

3. Insecure, resistant infants whose caregivers respond in unpredictable and/or “involving” ways (e.g., by expecting the infant to worry about the caregiver’s own needs or by amplifying the infant’s distress and being overwhelmed) also use an “organized” strategy for dealing with distress: they display extreme negative emotion to draw the attention of their inconsistently responsive caregiver). In the Strange Situation, they show extreme distress during separations and cannot be soothed at reunions.

Approximately 15% of infants from low psychosocial risk and as many as 82% of those in high risk situations do not use any of the three organized strategies for dealing with stress and negative emotion (van IJzendoorn, 1999). As with the “organized” strategies, disorganization is measured using the Strange Situation and Main & Solomon’s (1986, 1990) scoring system for disorganization. When distressed, these infants display disorganized behaviours, which may include the use of redirected or stereotypical behaviour, simultaneous display of contradictory behaviours, stilling and freezing for a substantial amount of time, and direct apprehension or even fear of the parent. Such behaviours are particularly meaningful when they are intense and occur in the presence of the parent (Main & Solomon, 1990; van IJzendoorn et al., 1999). They reflect D- infants’ inability to find a solution to fear and distress, resulting (momentarily) in a display of bizarre or contradictory behaviour. D- infants face an unsolvable dilemma: their haven of safety is also the source of their fear and distress (van IJzendoorn et al., 1999). When infants face this dilemma, the three “organized” strategies are not efficient.
Mechanisms associated with infant disorganization

Figure 1 illustrates mechanisms postulated to be associated with D-attachment. Maltreatment by the caregiver is easy to understand as an event that may be frightening to an infant and thus associated with disorganization. Domestic violence too has been associated with disorganized attachment (Zeanah et al., 1999). Caregiver’s unresolved mourning and unresolved physical or sexual trauma as assessed by the Adult Attachment Interview (George et al., 1985) have also been found to be precursors of D-attachment. This may not be as easy to understand (Schuengel et al., 1999; van IJzendoorn et al., 1999). It has been hypothesized that caregivers with unresolved mourning or trauma display atypical behaviours (Fr-) when interacting with their infants. Future research may identify other factors associated with the display of Fr-behaviours. Parental depression and mothers’ psychological adjustment does not predict disorganization (van IJzendoorn et al., 1999).

Caregiver Atypical (Fr-) behaviours

Atypical behaviours can be assessed by various rating scales. One such comprehensive coding system, the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE; Lyons-Ruth et al., 1999) categorizes caregiver Fr-behaviours in five dimensions: affective communication errors, role/boundary confusion, disorientation, negativity/intrusiveness, or withdrawal. Depending on the nature and frequency of the Fr-behaviours exhibited by the caregiver, the caregiver’s behaviours are then categorized as “disrupted” or “not disrupted.” A brief description of the types of caregiver behaviours considered atypical (or Fr-) in each of the five dimensions is provided below.

Affective communication errors consist of three major types of caregiver behaviours. The first type is characterized by the display of contradictory signals to the child such as inviting the infant to approach and then distancing, or directing the infant to do something and then not to do it, or using a friendly tone while maintaining a threatening posture. The second type is characterized by a failure to initiate responsive behaviour to an infant’s cues, such as failing to attempt to soothe the infant when distressed or failing to set appropriate limits around safety or failing to offer comfort when the infant falls. The third type consists of other inappropriate responses to the infant’s signals or needs such as laughing while the infant is crying or distressed.

Role/boundary confusion essentially includes behaviours that represent various forms of role reversal such as eliciting reassurance or affection from the infant, or pleading with the infant, or asking the infant’s permission to do something, or threatening to cry. Some behaviours in this dimension can be sexualized such as speaking in hushed intimate tones to the infant, touching or stroking in a sexualized manner, or behaving or speaking in a manner more appropriate for a spouse than an infant.

Fearful behaviours include behaviours suggesting that the caregiver appears frightened, hesitant, or deferential in relation to the infant. For example, the caregiver may exhibit a frightened expression, or stammer, or use a voice that is “haunted”, frightened, or high pitched and squeaky. The caregiver may also display behaviours that suggest disorientation or dissociation or disorganization. For example, the caregiver may handle the infant as though inanimate or exhibit sudden changes in mood unrelated to the environment.

Intrusiveness/negativity can be displayed in various contexts. For example, in the context of physical communication, the caregiver could pull the infant by the wrist. In the context of verbal communication, the caregiver could mock or tease the infant, hush the crying infant in a way that is not comforting, or use a voice that is loud, sharp or angry. The caregiver could also inappropriately attribute negative feelings or motivations to the infant, or exert control over objects by such actions such as withholding a toy from the infant or removing a toy with which the infant is engaged.

Withdrawal consists of behaviours that create physical distance from the infant such as the caregiver holding the infant away from her body with stiff arms. It could also include the use of verbal communication to maintain distance, such as failing to greet the infant after a separation or interacting silently with the infant or using words to create distance (e.g., “I won’t pick you up”). Withdrawal should also be considered when a caregiver directs the infant away from him or herself with toys.

Caution should be used in using the AMBIANCE. Proper training is required to use the instrument appropriately. In addition, one should keep in mind that the AMBIANCE, like any other rating

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<th>Caregiver</th>
<th>Infant</th>
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<td>Unresolved mourning trauma (Domestic violence)</td>
<td>Disorganized attachment</td>
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<td>Caregiver Frightening, frightened, dissociated, sexualized or otherwise atypical behaviours</td>
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Figure 1. Hypothesized mechanisms leading to infant disorganization
scale focusing on the assessment of atypical or Fr- caregiver behaviours, is still in the early stages of development. Nonetheless, tools such as the AMBIANCE allow clinicians and researchers properly trained in its use to identify caregiver behaviours that have been associated with D- attachment in infant. The identification of precursors of D- attachment (such as atypical or Fr- behaviours) has important clinical implications. Specifically, it could lead to the early identification of caregiver-infant dyads who are at high risk for D- attachment. In addition, it might help in the development of interventions aimed at reducing and eliminating these behaviours, which may then eliminate D-attachment. In turn, the elimination of D-attachment might eliminate one of the strongest childhood risks for the most serious forms of emotional and behavioural problems and psychopathology. The AMBIANCE has already been shown to be a useful tool in assessing change and treatment efficacy (Benoit et al., submitted). The fields of infant D-attachment and caregiver atypical/Fr- behaviours are constantly evolving and being refined. The knowledge that will be acquired over the next decades will likely modify our current conceptualization of D-attachment, its antecedents and outcomes, and what interventions can be used to modify these attachments. Coding systems such as the AMBIANCE represent early attempts at quantifying and understanding complex behaviours within the caregiver-infant attachment relationship.

References