Attachment Development and Communication Disorders: A Brief Overview for Therapists and Early Interventionists

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Abstract

The purpose of this poster is to provide early interventionists (EIs), speech-language pathologists (SLPs), teachers, and other professionals working with children who have hearing loss and/or communication disorders (CDs) an overview of attachment development. The rationale being that, in some cases, lack of improvement during intervention/therapy might reflect insecure attachment and/or poor parent-child interactions in the home. As key interactive (attachment) behaviors by both mother and child can impact the overall outcomes of therapy, it is important that EIs, SLPs, and other professionals know these behaviors and when to make appropriate referrals. In many instances, professionals working with young children do not receive sufficient training. Therefore, interventionist working with young children with CDs might not know when, or to whom, to refer children for professional evaluations and/or treatment of attachment issues. This poster presentation defines secure and insecure attachment. Examples of both parental and child behaviors for each type of attachment are presented. Lastly, red-flag behaviors and interactions that should result in referrals for an attachment evaluation are discussed.

Key words: attachment, communication disorders, secure and insecure

Learner Objectives

- Define attachment and identify the differences between secure and insecure attachment.
- Summarize attachment development of children with and without hearing loss and/or communication disorders.
- Identify behavior traits often present in insecure attachment for both mother and child.

Key Points

- Differences in attachment development have been noted for children with language and CDs.
- it is possible that attachment development, and the influence of child-parent interaction, plays a larger role in the development of language and communication abilities than documented thus far.
- When a child has limited progress during intervention, and negative interactions between the caregiver and child that are consistent with "insecure behaviors" are noted, a referral to an appropriate counselor should be strongly considered.

Table 1: Attachment Categories and Associated Child and Parent Behaviors

Attachment Category (North American Sample)	Child's Behavior*	Child's Internal Thoughts	Parent's Behavior	Parent's Behavior Displayed in Clinic/Home Setting
Secure (~65%)	Uses mother as 'secure base' from which to explore surrounding; explores area but will return to 'secure base' when unsure	Curious; content; enjoys interacting with parent; responsive to mother; safe; confident in caregiver's respond to needs	Responsive/sensitive to needs; physically and emotionally available to child; attuned to child; in-sync	Joint attention; follows child's lead; expands child's statements/ knowledge; interactive
Insecure: Avoidant (~25%)	Appear disengaged from care-giver; seeks out attention from strangers; lack of concern when mom leaves room	My needs aren't met; can find elsewhere/ from somewhere else; indifference regarding caregiver leaving/returning	Insensitivity and unresponsive to child's needs; disengaged; dismissive; harsh; verbally and physically resist child's initiation at interaction	Doesn't acknowledge child's communication attempts; ignores/deflects child's wants/needs
Insecure: Ambivalent or Resistant (7%-15%)	fussy; clingy; un-explorative; seeks close proximity while resisting contact; resistant to parent leaving room; unable to be comforted when parent returns	Unsure if needs will be meet; anxious; indecisive	Demonstrate sensitivity but are inconsistent in responsiveness; intrusive; overbearing	Doesn't follow child's lead; inconsistent in responding to child's communication attempts
Insecure: Disorganized (0% to 15% in typical population; up to 82% for high-risk populations)	Anxious; flat affect; withdrawn; disoriented; nonresponsive; repetitive gestures; disengaged; unexpected behavior for situation	Depressed; dazed; uncertain about world around them; apprehensive	Erratic; dominating; abusive	Abusive behavior; neglectful; lack of consistency; inappropriate reaction to situations/ child's request

*Descriptions of a child's attachment behaviors, birth through 3 years of age.

Discussion

Attachment is the bond that is formed between a child and the primary caregiver resulting in the child's desire of close-proximity to the caregiver for comfort (Ainsworth, 1973; Bowlby, 1969). Attachment is important for social, emotional, and communicative development in a child's life and is developed through infant-mother interactions during the first year of life (Bretherton, 1992; Bowlby, 1988). An outline and brief description (Bowlby, 1951; Kochanska, 2001) of the four attachment **classifications** is provided below:

- **Secure attachment**: child uses caregiver as a secure base from which to explore their world yet return for comfort.
- **Insecure avoidant attachment**: lacks comfort-seeking with caregiver; little anxiety upon separation; avoidant behavior upon caregiver's return.
- **Insecure ambivalent attachment:** child clings to caregiver; significant anxiety upon separation; unable to be consoled upon caregiver's return.
- **Insecure disorganized attachment**: due to severity of treatment, behavior can be erratic.

Healthy attachment grows from a comfortable and consistent relationship with the parent initiated by the child's proximity seeking behaviors (Bowlby, 1951). Proximity seeking (e.g., crying, eye contact, etc.), and the mother's responsiveness, forms the child's internal working model (IWM; Fenney et al., 2008). The IWM becomes the child's mental representation of the attachment relationship. The IWM is dependent on the mother's sensitivity to the child's needs, and this is important for children with a CD. The IWM is modified over time based on verbal and non-verbal communications between the mother-child pair. Communication about the role of each communication partner is important; however, this type of discussion is most likely present between mothers and children with secure attachment (Bowlby, 1973). Thus, it is possible that children with CDs might develop IWMs reflective of poor maternal sensitivity that are continuously reinforced by miscommunications (Bretherton & Munholland, 1999).

There is limited research on attachment development in children with communication disorders. However, neurological conditions, including hearing loss, have been shown to influence both attachment development as well as CDs (van IJzendoorn et al., 1992). Children with hearing loss have the same rate of secure attachment but demonstrate an increased rate of insecure ambivalent attachment when compared to their hearing counterparts (Beckwith et al., 2003; Ryan et al., 2012). Additionally, ambivalent attachment development is primarily seen in hearing mother – deaf child dyads.

As indicated, attachment development is influenced by parental responsiveness and interaction with the child. Parents of children with insecure attachment may display *authoritarian style* parenting behaviors in which they influence their child through control, direct management, and sometimes fear. Parents of children with secure attachment often model *authoritative style* parenting behaviors that include encouragement, affection and promotion of self-worth (Rutgers, et al., 2007). Examples of **parental behaviors** for each of the attachment classifications are provided below:

- **Secure attachment**: is attuned, sensitive, responsive, and coordinated with their child's emotional & physical states.
- **Insecure avoidant attachment:** is dismissive of a child's needs, is harsh, or relies on distraction when child is upset.
- **Insecure ambivalent attachment:** is inconsistent, intrusive; unable to sooth their child.
- **Insecure disorganized attachment**: a parent is scary, abusive, or disorienting to the child.

When considering a child's attachment behavior as potential influence on lack of progress during intervention, note that children who are insecurely attached tend to be easily frustrated and demonstrated less perseverance when presented with problems. In contrast, children who are secure demonstrate effective problem-solving skills and self-reliance (Ainsworth, 1979). Behavioral traits (See Table 1), of both parent and child, can reveal themselves during therapy and can potentially impact the likelihood of successful intervention.

While it is important for SLPs and EIs to understand attachment theory and its potential impact on treatment, it is also important to know when to refer for counseling. If the SLP or EI suspects that parental insensitivity might be causing significant problems in the child-parent relationship or preventing successful treatment of the communication problem, then the SLP/EI should refer for an evaluation and/or treatment. Professionals qualified to provide these services include clinical psychologists, professional counselors, and clinical social workers. Referring a family for counseling could induce defensiveness in a parent, so couching any referral by first acknowledging the client's strengths and then normalizing challenges can be helpful. It can also be helpful to discuss the kinds of challenges parents experience when having a child with a disability. This can help parents feel more willing to seek additional treatment.

References

References are provided as supplemental material.

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