DANGER IN MY HOUSE--A FAMILY SYSTEMS VIEW OF UNATTACHMENT

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ABSTRACT

This paper looks at five case studies of unattachment from a family systems perspective. It reviews the psychoanalytic theories of attachment and searches for new views within a framework of family systems. It was found that the five families involved in the study may share one or more of these common characteristics: intergenerational themes of unattachment; one spouse is seen to have attachment issues; mixed messages within the parental dyad leading to triangulation of the children; and/or a trend toward a centrifugal style of family interaction. It concludes with the formulation of nine questions that singularly or in combination might form the basis for future research using family systems as a framework of study.

INTRODUCTION

This paper will address the issues of unattached children from a psychodynamic perspective and compare these results with other views using a family systems framework. The tentative hypothesis that was used to conceptualize this paper was, "Attachment in some children (character disturbed children) may be attributed to dysfunctional interactions (mixed messages) in their families."

This paper will be based on John Bowlby's theory of attachment (Karen, 1990). The goal will be to look for patterns of interactions in family systems which relate to the phenomenon of attachment and to develop a hypothesis amenable to empirical testing. This paper will consist of five parts: (1) the definition of attachment; (2) a literature review of the development of the attachment theory and the major contributions of researchers in this area; (3) an examination from a family systems perspective of several actual case studies representative of the unattachment syndrome; (4) formulation of questions for further study; and (5) implications for family based treatment and education.

Attachment Defined

In order to understand attachment it is necessary to review several different definitions and classification systems. It may even be necessary to define one's audience, i.e., insurance companies, laymen, clinicians, professional counselors, etc., before using specific terms.

Two terms, bonding and attachment, have come to be used synonymously. However, they have quite different meanings. Bonding refers to the unique tie between the child and the biological mother. Bonding is said to begin with the onset of pregnancy (or the decision to become a mother) and continues through a complex psychological process after birth. Because of its prenatal origin, the primal bond is said to persist regardless of later separations and accounts perhaps in part for separated children seeking out their biological parents. Bonding sets the stage for the building of trust. It provides the environment of comfort and nurturing conducive to achieving the trust base. It is conceptualized that bonding can be maintained without physical proximity. It may answer the question of why a child may attach easier to a biological mother than an adoptee can attach to a foster mother. Bonding is the bridge between trust and attachment. Bonding begins with the onset of pregnancy and smoothly flows into the attachment process (Stuart, 1990).

Attachment, on the other hand, refers to the psychological tie between two people that permit them to view each other with some significance. Attachment is trust that an infant's individual needs will be met. It's a feeling of security and safety, a feeling of being cared for and cared about, and a feeling of being loved and protected. A child can attach to more than one person. Attachment is a process of testing the environment to see if it's friendly or hostile. Attachment is stability, consistency, responsiveness to meeting needs of another, and attachment is love. Attachment can also be damaged in the process of development and an attachment disorder (defense against needs not being met) can result (Stuart, 1990; Magid & McKelvey, 1989; Bowlby, 1986; Karen, 1990; Cline, 1990). This is the definition of attachment that will be used in this paper.

It follows then that unattachment refers to the feeling of not being emotionally connected to another human being. It is the failure to develop basic trust so that a relationship of caring, love and acceptance can be maintained. Unattachment is present centered without the emotional ties to past relationships nor are there any expectations of sharing them in the future.

Most attachment theorists refer to children having attachment disorders as character disturbed children, unattached children, or children suffering from an antisocial personality disorder (Crawford, 1989; Magid & McKelvey, 1989;

Cline, 1990; Bowlby, 1976). These differing terms cause further confusion when compared with the many classifications used by the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, 1988). The DSM-III-R itemizes several classifications that are all part of the unattachment disorder. Some of these are listed as "Reactive Attachment Disorders of Infancy or Early Childhood," "Conduct Disorders," or "Personality Disorders." The authors of the DSM-III-R recognize this confusion and have cautioned the user to examine the criteria carefully as to age group and behavior. Many contemporary attachment clinicians use the designation DSM-II-R 313.89, Reactive Attachment Disorders of Infancy or Early Childhood. Many clinicians recognize that children with attachment problems in childhood may be classified in later life as having more familiar mental or personality disorders. No claim is being made in this paper that children with attachment disorders may in adult life become borderline personality or schizophrenic, although this assertion has been suggested by others (Magid & McKelvey, 1989).

Unattachment disorders contain elements of three types of developmental disorders that are identified by the DSM-III-R, which are conduct disorders, reactive disorders and antisocial behaviors. Conduct disorders are typified as consistent patterns of conduct in which the basic rights of others are violated. They may include physical aggression,

stealing, or lack of feelings, guilt or remorse. Reactive disorders have poorly developed social responses, lack of interest or activity, failure to thrive, and poor motor skills. Antisocial personality disorders contain patterns of irresponsibility and antisocial behavior (American Psychiatric Association, 1988).

Most attachment therapists agree that the breaks in the attachment process occur through the actions of some traumatic event occurring in the life of the infant. These actions may be physical abuse, sexual abuse, loss of a caregiver, adoption, foster care, divorce, or death (Magid & McKelvey, 1989). The DSM-III-R states that the diagnosis of reaction attachment disorder of infancy or early childhood may only be made in the presence of clear evidence of grossly pathogenic care (APA, 1988). The implication is that if the child presents the symptoms of attachment disorder and the caregiver is not grossly pathogenic, then the child must be suffering from some other disorder. It may be reasonable to assume that children seen to be most severely unattached probably have suffered some traumatic experience in their lives. However, it is possible that trauma is in the eyes of the child, not the therapist, the parents or society, and what may appear as appropriate behavior may be traumatic to the developing child.

Some clinicians describe unattachment as the inability to integrate two sets of images into a single realistic image

(Kirschner & Nagel, 1988). To understand this concept, it is necessary to understand a little of how unattached children see themselves in relationship to their environment or to others. Early in life, these children fail to make the connection of the whole being made up of the sum of its parts. There is no future nor is there a past, only the present moment. Such children do not understand connections or results of actions. What happened yesterday or what will happen tomorrow simply does not exist. Unattached children may seek pain because it is the only sensation strong enough to penetrate their emotional defense system. Consequently, they do not relate to pain as do normal children and may inflict pain on others as a way of making an emotional connection. They do not put the many pieces together into one whole, unique, composite article (Kats, 1990). According to literature, this failure to integrate is learned in part from the child's failure to differentiate his primary caregivers from others (Bowlby, 1976). Dr. Loretta Bender states that "those children have no idea of time, so they cannot relate past experience and cannot benefit from past experience or be motivated into future goals" (Cline, 1990).

John Kennell (1976) defines attachment as an affectionate connection between two individuals that endures through times and serves to join them emotionally (Magid & McKelvey, 1989). The formulation of attachment allows infants to develop trust in others and reliance upon

themselves. Many believe that the connection that forms between the infant and the caregiver is the foundation for future psychological development and governs the extent for future relationships to be formed. Attachment may well be the single most critical event to happen with infants during their development (Magid & McKelvey, 1989).

REVIEW OF LITERATURE

What is attachment? Why is it important? How does it occur? These questions have been asked in the past and are continuing to be explored by researchers the world over as new awareness of children suffering from attachment disorders and the possible tie to psychopathology in adults is being investigated.

A history of the theories of Sigmund Freud, Erik Erikson, John Bowlby, Mary Ainsworth, Ken Magid and Carol McKelvey will show how the concept of attachment evolved over time. Present day implementation of these theories into new concepts for treatment are being fostered by clinicians such as Foster Cline, Thomas Verny, A. J. Courts, Richard J. Delaney, and Martha Welch that add the dimension of future understanding and prediction.

Sigmund Freud (1900) was probably the originator of the concept of attachment, although it was not labeled as such until some time later. Consequently, attachment theory is well grounded in psychoanalytic concepts. Freud refers to "inherent dispositions" and "external influences" in childhood as determining the human capacity to trust and love. These are the essential ingredients that form the boundaries of the attachment theory to be later formulated by

Bowlby. Freud firmly believed that the seeds of mental dysfunction are sown in early childhood and that the lack of fulfillment of basic needs during these years of development would result in a maladjusted behavior of the child.

Erik Erikson (1968), a student of Freud's, developed his psycho-social theory in terms of the epigenetic principle, a belief that development is analogous to that of embryogenesis, anything that grows has a basic plan. Erikson conceptualized life's development as a series of psychosocial crises between the individual and society that give the individual "choices" during development. The first two of Erikson's eight stages, stage one (trust versus distrust) and stage two (autonomy versus shame and doubt), are pertinent to this discussion (Erikson, 1968). Erikson theorized that during the first year of development an infant's needs are for continuous care, constant care, attention, and protection where the infant can achieve peaceful satisfaction and security (Green, 1968). The key words here are "consistency" and "dependability," concepts further developed by other theorists. Failure to meet these basic needs may result in a crisis between "trust versus distrust" and result in some sort of disruption to the progress of later personality development (Reber, 1985).

John Bowlby's attachment theory (1958, 1969, 1975, 1980) may be seen as a coherent part of the theoretical evolution proposed by Freud and continued by Erikson and others.

Bowlby's theory concentrates on the overall quality of care (availability and responsiveness) as a central issue for the infant (Sroufe, 1986).

Bowlby's concept is that attachment is not derived from baby's association with food, nor is it part of human sexuality. Rather, it is a biological factor to assure survival (Sroufe, 1986). According to Bowlby, attachment behavior is conceived as any form of behavior that results in a person obtaining or retaining proximity to some other differentiated or preferred individual who is usually perceived as stronger or wiser (Bowlby, 1976). Bowlby believes that attachment is necessary for the developing individual to be later capable of forming affectionate bonds. Those that are unattached may develop into anxious, insecure individuals who are apt to have neurotic symptoms or be depressed and phobic, or otherwise fail to develop into healthy, caring adults. Many attachment researchers feel that continuous but constantly changing contact with the same family members is paramount to providing a solid base for development into healthy children.

Mary Ainsworth (1968), using a technique called the Strange Situation, labeled three distinct patterns in baby's reaction to the primary caregiver. These patterns she called securely attached, insecurely attached, and anxiously attached. Researchers now label these as secure, avoidant, and anxious/ambivalent (Pistole, 1989). During the course of

the observation she was able to make specific associations between the baby's attachment styles and the mother's style of parenting. The securely attached infants were found to be more responsive to mother's signals, more content, and cried less. The insecurely attached seemed to lack any sense of a need for mother herself. They responded to biological needs but remained emotionally flat. The anxiously attached infants were inconsistent, unresponsive, clinging and/or rejecting (Karen, 1990).

Ainsworth was the first attachment researcher of record to study mother and infant together. Ainsworth's team observed mother/child pairs over the course of a year. They were able to make specific associations between the baby's attachment style and the mother's style of parenting. Ainsworth's conclusion was that by age two the die for personality behavior seemed to be cast (Karen, 1990; Sroufe, 1986).

Ken Magid and Carol McKelvey formulated a slightly different approach to the first year of an infant's life cycle. This cycle consists of the elements of need, rage, reaction, relief and trust. Magid and McKelvey theorized that the infants initially expressed their need by crying. Should these needs not continuously be met, a rage reaction results. Failure to consistently provide gratification is where things go wrong and basic trust may be compromised. This basic trust, composed of trust of self, trust of others,

and trust of humanity, comprises the necessary elements for a normally responsive environment. The interaction of mother and infant then spirals into a pattern that Magid and McKelvey depict as a vicious cycle. This cycle consists of the physical unresponsiveness of the child → causing an anxiety in the mother → in turn causing mother to become nervous → in turn causing the child to become nervous and anxious → resulting in the child's increasing withdrawal from mother and the child not being physically responsive → thereby repeating the cycle. Once the vicious cycle has begun, it is very difficult to repair (Magid & McKelvey, 1989).

A withdrawal from parental authority and control leads to the children assuming that responsibility for themselves as they become self-parenting. A distinction should be made between the term self-parenting and the parentified child syndrome. Self-parenting is a term that also relates to pathological behavior that has its origin in unattachment. Self-parenting is assuming the parental role over oneself, usually because one or both parents have failed in that responsibility. Self-parenting is dysfunctional because the child has not developed to the stage where this could be properly done and because it seems to be an early seed of control and rejection of authority. As a result, children have assumed the responsibility for meeting their own needs (Cline, 1990; Magid & McKelvey, 1989).

The parental-child or parentified child syndrome is a term from experiential family therapy coined by Carl Whittaker (Nichols, 1984). This essentially means that a child has been allowed to take care of a younger sibling. According to Whittaker, this is an adaptive measure when done deliberately in single-parent or large families, but maladaptive when the parents fail to assume responsibility. This term has grown in colloquial usage to mean any parental type of behavior that has been assumed by the child and is a symptom of recognized pathology.

Martha Welch began her interest in techniques of holding children while studying at the Albert Einstein College of Medicine. She was a trained fellow in child psychiatry working with autistic children. Welch was working with a seriously disturbed family with a long history of mother/child disruptions. By chance, the mother revealed that she had never been held as a child and that she had never been able to bring herself to hold or cuddle her son while he was a baby. The result was that her child screamed and cried endlessly for several months, then went into autistic withdrawal. Welch decided to experiment and began to hold the children in her charge, sometimes forcibly. The children did not want to be held. They fought, cried, bit and screamed; then suddenly they calmed down. It was found that holding therapy produces a crisis of intimacy and facilitates attachment between the child and the therapist.

The child was held securely so that s/he could safely pass through stages of bargaining, anger, rage, acceptance, and attachment. As these children began to improve, Welch theorized that the developmental problems of these children was caused by a break in the mother/child attachment or bonding process and that systematic holding might repair that relationship. Her first three patients treated in this manner all responded favorably within the same time frame. The objective of holding then becomes an effort to break down dysfunctional barriers of defense in order that the child might experience the feeling of attachment with another human being. Having had that experience with the therapist, they hopefully could reproduce that emotion with others. The treatment now widely used today for autistic children was then born (Welch, 1989).

Foster Cline is a family and child psychiatrist at the Attachment Center at Evergreen, Colorado and has been responsible for the introduction of many of the techniques currently in use today for the treatment of unattached children. Cline uses a form of "Z" therapy (or rage reduction therapy) originated by Dr. Robert W. Zaslow, a professor of psychology at San Jose State College. One of Dr. Zaslow's teachers was Erik Erikson. Therefore, Zaslow's thinking follows basic Freudian and Eriksonian approaches. "Z" therapy employs a method of the forceful holding of a child by several attendants intended to force a sense of

attachment. The child is held securely and stimulated by tickling along the rib cage. The tickling, together with being restrained, leads to a high arousal stage producing an expanded emotional experience free from mind blocks. According to this approach it is then possible for the child to handle interrelational problems in an open and receptive state. Following the "Z" therapy, muscular tension, facial expression and personality mannerism are markedly altered. This method of therapy has been found to be very effective with unattached children or other children with mental disorders who are extremely hard to reach (Cline, 1990).

To summarize, Freud was the first to conceptualize the attachment process in his psychoanalytic theory. Freud developed his theory of psycho-sexual development around erogenous zones. These were oral, anal, phallic and genital areas. If the child's needs were deprived in any of these areas, a fixation would result and anxiety or rage would be produced. Erikson thinking reflects the influence of society in his theory of psychosocial development where he equates Freud's oral phase with a stage of development he calls trust versus distrust and Freud's anal phase to a time when the child learns autonomy or shame. Erikson emphasized consistency, dependability, and the fulfillment of the infant's basic needs to avoid a crisis between trust and distrust. Bowlby expanded on these concepts and viewed basic trust as the foundation for all healthy, fulfilling and

rewarding human relationships. He delineated most completely the effects of loss and nonattachment on further character development. Ainsworth furthered Bowlby's concept by defining connections between baby's attachment and mother's style of parenting. Magid and McKelvey added the concept of rage rejection and the spiraling effects of the nonresponsive infant to further explain this process of attachment. Martha Welch, in her work with autistic children, began the holding technique and found that the break in the mother/child relationship could be repaired. Foster Cline, studying under Robert Zaslow, began experimenting with another technique called "Z" therapy and began to forcefully break down the barriers of resistance formed by children in infancy that impaired their ability to form emotional attachments. All of this work is well grounded in psychoanalytic concepts of early childhood development of severe childhood disturbances.

Recognizing Unattachment

It is no secret that a difficult child is difficult for everyone, including mother, father, the family, the neighbors, and even society at large. For whatever reason, the attachment bonds do not form and the child is left vacant, unable to love, unable to trust, and unable to form affectionate bonds. There are many symptoms of this emotional difficulty. Magid and McKelvey (1989) describe the following symptoms of character disturbed children:

1. Lack of ability to give and receive affection--cannot be touched or helped.
2. Self-destructive behavior--takes risks in play, beats head, cuts on self.
3. Cruelty to others or to pets--bites, kicks, hits, may kill pets.
4. Phoniness--not real, cannot relate to others.
5. Stealing, hoarding and gorging--may achieve highs on sugar.
6. Speech pathology--may scream, baby talk, or speech may be unclear.
7. Extreme control problems--cannot tolerate limits or boundaries.
8. Lack of long-term childhood friends--peers avoid them.
9. Abnormalities in eye contact--motor eyes or anger in eyes.
10. The parents seem unreasonably angry--parents are fed up.
11. Preoccupation with blood, fire or gore--may draw pictures of monsters or set fires.
12. Superficial attractiveness or friendliness with strangers--adult life show no fear to strangers.
13. Learning disorders--may refuse to learn.
14. Crazy lying--lies about the obvious.

The literature does not suggest how many of these behaviors must be present before the diagnosis of unattachment is made. However, where extreme control issues, lack of trust and bizarre behaviors were present in this study, supported by a family history, the diagnosis of unattachment was given.

Other symptoms have been added for clarification in particular clinics as follows (Nordstrom, Starr & Williamson, 1990):

10. Lack of cause and effect thinking.

11. Lack of a conscience.

15. Persistent nonsense questions and incessant chatter.

16. Inappropriately demanding and clingy.

18. Cannot tolerate limits or external controls.

21. Blames others for problems.

22. May be manipulative.

The DSM-III-R (APA, 1988) also compiles a list under the heading 313.89, Reactive Attachment Disorder of Infancy or Early Childhood, as follows:

- Marked disturbed social relatedness.

- Persistent failure to initiate or respond to social interactions which may include visual tracking, reciprocal play, apathy, lack of vocal initiative, spontaneity, or lack of social intent.

- Grossly pathogenic care which may include harsh punishment, consistent neglect, disregard for child's needs including food and housing, etc., or a change in the primary caregiver.

Early in life most children with attachment disorders present some form of distrust coupled with an inability to allow appropriate control by others. If this is accompanied by physical or sexual abuse, control may be an understandable issue that weaves its way into all facets of the child's personality. The children become angry, and power struggles

between the child and parents, the child and school, and the child and society may begin to emerge.

Cline (1990) offers the following description which summarizes the typical symptoms of a child suffering from some form of attachment disorder:

> Such a child might be 6 to 12 years old. He or she would be hyperactive or controllingly passive. Eye contact would definitely be down or lacking. The parents describe inability of the child to relate to them in a positive way. Parents often make comments such as ... "It's like living with the enemy" ... "Our love never mattered" ... "When we tried to hold him, he became stiff as a board." Stealing or lying are almost always present. Cruelty is often present. They may on initial examination appear sweet and loving and affectionate to the therapist whom they never met. Control problems are paramount. The parents do not trust them long enough to leave them unattended (Cline, 1990).

Treatment

Holding therapy or rage reduction therapy is suggested as a treatment for unattached children. Such therapy is designed to produce a crisis of intimacy between the therapist and the child (Crawford, 1986). Rage reduction therapy, also called "Z" therapy after its originator, Dr. Robert W. Zaslow, is usually conducted only by the therapist. The "Z" process uses Freud's concept of "catharsis" as an important factor in the success of this procedure. In Freud's psychoanalytic theory the meaning of catharsis was borrowed to refer to the release of tension and anxiety resulting from the process of bringing repressed

ideas and memories of the past into consciousness. Those who are familiar with Gestalt therapy have long recognized the possibility of using catharsis as the corrective emotional experience to access pent up rage (Corey, 1986). The "Z" process forces regression of the child to an early infant state. On a very primitive level, the child is helped to experience an emotional crisis at a very high level of intensity which enables the child to express the full measure of his or her repressed rage. This repressed rage is vented at another human being (the therapist), expressed face to face, experienced and then resolved. From this experience, a sense of attachment and trust are developed (Cline, 1990).

It is understood by both the therapist and the client that there must always be someone to assume responsibility so that rage can be freely expressed. This "observing ego" helps the child from getting completely out of control no matter how angry s/he may become. This is an important and necessary part of "Z" therapy. The infant does not have an observing ego and lashes out in all directions in his rage. In functional families, mother becomes the calming influence and alleviates the child's rage by her compassion and understanding. In "Z" therapy the therapists become the calming influence by assuming control. The child learns that s/he may express their rage in an atmosphere of safety.

Many clinics are offering some version of holding therapy as a treatment for unattached children, but the most

successful treatment indicated by the literature is practiced at the Attachment Center at Forest Heights Lodge by Foster Cline and his associates.

The model used by the Attachment Center consists of two components, treatment parenting and therapy.

Treatment parenting takes place in conjunction with therapy and, at times, becomes part of therapy. The child undergoing treatment at the clinic is placed in a foster home for care while in Evergreen. The center provides training, advice, and emergency service to treatment parents while the child is in attendance. These treatment families are not the biological parents but are licensed foster families living in the area. They are trained by the clinic, licensed, and are subject to minimum rules and regulations as formulated by the State Department of Social Services. Treatment families keep records and provide a controlled atmosphere for reinforcement of therapy. The holding therapy is done in the clinic by the therapists and their assistants.

Family Systems Perspective

To this point, we have been discussing unattached children from the psychoanalytic standpoint; however, this model still leaves unanswered questions. Another way to view attachment might be to consider the family systems perspective. Where the psychoanalytic model concentrates on individual development and the impacts that traumatic events

have on shaping the personality, family systems theory dwells on how the behavior of the unattached child fills a need within the family. From the family systems perspective unattachment would be viewed as behavior embedded in the context of interpersonal relationships and for fulfilling specific needs of the system.

Family systems theory has many authors and is generally considered to have derived from group studies on schizophrenics, clinical and research in hospital psychiatry, and the child guidance movement (Nichols, 1984). New concepts of family theory continue to be formulated from studies of families, child development, and as a result of civil rights and the feminist movement. The treatment approaches developed from a family systems perspective focus on changing the organization of the system as a means of solving problems.

Systems theory refers to thinking of the family with a systemic (circular) view of organization of interacting relationships, each acting on the other and each affecting the other in their behavior. Systems theorists propose theoretical principles that apply to all living things which are viewed to be in constant change within their environment and existing in a hierarchy of levels. The family is one such unit composed of several members, each being a part of several subsystems, including the extended family. The individual is connected to and influenced by all of these

interactions, patterns, regulating processes, changes, oppositions to change, behaviors, ideas, feelings and traditions of the family, both past and present.

One of the enduring concepts of family therapy is the assumption of circular causality. It suggests that each member of the family influences other members and is in turn influenced by them. If we want to understand the individual, we must look at the system that surrounds them (Nichols, 1984; Teichman, 1986).

Another important concept within systems theory is that of hierarchy. Hierarchy refers to any system of things, events, persons, or concepts structured in rank order (Reber, 1985). Hierarchy provides a vehicle by which things are passed from generation to generation and provides a source of control and authority. As an example, a beehive is a family system that has a hierarchy consisting of the queen bee, the worker bees and the drone bees.

The structural school of family therapy is concerned with structure, boundaries and subsystems. Structure is the organized pattern in which family members interact. Structure can be seen and is often diagrammed in therapy with the family as an aid in solving problems. Structure has rules, both visible and covert, that tend to govern the family. In a healthy family, both the structure and the rules are subject to change and react to pressures both internal and external to the family.

Family systems function on clear generational boundaries. Boundaries are those invisible barriers that regulate the amount of contact that individual family members have with others. Boundaries are recognized and respected by all members of the extended family and form the control and authority within the nuclear family. Jay Haley's strategic approach to family therapy emphasizes the importance of maintaining generational boundaries to provide open family alliances, transmit information from generation to generation, and provide controls for avoiding covert cross-generational coalitions (Nichols, 1984).

The family structure also consists of subsystems. These are the smaller groups within a family and may consist of any mixture of individuals that, for a time, share a common interest.

The last systemic concept which is important to the discussion of attachment is triangulation. Triangulation is the recruiting of a third member of a family into the triangle to stabilize tensions between the other two. Triangles tend to cool emotions but seldom get to the root for the reasons that emotions get out of hand. Children are often triangulated into the problems of the parents.

Family Systems in Action

There are many unique behaviors of specific groups that have been extensively studied and documented that may help to

understand the unattached family. One of these behavioral groups is the alcoholic family. The concept of an unattached family is used here rather than a family with an unattached individual because, like alcoholic families, unattached families seem to acquire certain patterns of behavior that set them apart as unique. Alcoholic families develop patterns of behavior that compromise healthy development in favor of the alcoholic (Steinglass, 1987).

One such concept of alcoholic families that is noteworthy because of the implication to unattached families is the potential of the intergenerational transmission of alcoholism from past to present. Even families that do not have an alcoholic member often exhibit behaviors of alcoholic families that are carried down from generation to generation. The literature discusses the powerful influence that family rituals have in transmitting alcoholism from one generation to the next (Steinglass, 1987). For example, an alcoholic family may have a tradition of "working hard and playing hard," with a pattern of working from sun-up to sun-down six days a week, then binge drinking at the end of the week. The next generation may produce a problem drinker that binge drinks at the end of the workday. Alcoholic families have other behaviors that bear witness to their addiction, such as, lack of short-term problem solving, closed boundaries, denial and avoidance behaviors, regulatory behaviors of accommodation and homeostasis (resistance to change)

(Steinglass, 1987). The case studies in the next section suggest that attachment, like alcoholism, may at least be partially transmitted from generation to generation.

Circular causality plays out in many ways in the family context. What mom and dad do affects the children and this in turn affects mom and dad. As trouble and anxiety invade the marital dyad, couples often pull apart from each other and turn to the children in a dysfunctional manner. In so doing, they triangulate power to the child that usually resides within the parental boundaries.

The child neither wants nor knows what to do with this power. As mother or father inappropriately triangulate the child into their marital difficulties, so, in turn, does the child influence the parents. The child may begin by gently scolding or manipulating the parents. The interpersonal boundaries of the parents and of the parental dyad are weakened and become diffused. The child, not now having a strong boundary to test against as a guiding and learning device, pushes more assertively into the parental role. S/he may become more demanding, the scolding may turn to mild punishment, and anger towards the parent becomes visible.

Having been vested with power by triangulation, the child begins to manipulate the parents to achieve his/her own desires. Often this takes the form of pitting the perceived stronger of the two against the weaker. The child is then able to discipline the other spouse. The child receives

these mixed messages and, not knowing the appropriate role, chooses the one that seems to most favor his/her own wants and desires, and the seed of distrust is sown. The child learns to make his/her own decisions and to take on the role of the parent because the parent is either not dependable or is not found to be reliable. Trust that the child's needs will be met has been impaired, and parental control has been damaged. The child takes what s/he may want, punishes the parent and perhaps his/her peers, becomes aggressive, controlling, and develops deep-seated anger. The child begins to self-parent because the marital couple cannot be trusted to consistently fill that role.

Unattached families, like alcoholic families may also have visible dysfunctional patterns of behavior. The key concepts of unattachment behavior that almost always seem to be visible are extreme control issues, lack of trust and bizarre behavior. In this study these were the symptoms that were used in diagnosing unattached children. The five case studies which follow show how the child's symptoms of unattachment are part of the larger context of interaction within the family system. These families are identified as the Brown family, the Greens, the Yellows, the Reds and the Blue family.

CASE HISTORIES

The Brown Case

The Brown case shows how triangulation works in the family and how self-parenting can begin. Mom and Dad have been divorced for two years. Son, age 4, is acting out in daycare, displays aggressive behavior towards his playmates, and has temper tantrums. Dad requested therapy because he was concerned about Son's behavior and was running out of daycare centers that would accept him.

Dad's business in recent years had been bad, and Dad was facing bankruptcy. Dad is quiet and soft spoken and avoids conflict by either not acknowledging it or not dealing with it. He has a laid-back personality, and appeared to be more of a friend and companion to Son than a father to him. He rarely spanks Son, although he says he will sometimes swat him on his rump when he severely misbehaves. Dad and Son seem to enjoy each other. They spend weekends going places and sometimes get together on weekdays when Mom has a date or Son asks to see his dad. Dad and Son even sleep together.

Mom is currently a student and has joint custody of Son. Mom is very angry at Dad and takes him to court frequently when Dad fails to live up to his responsibilities as assigned by the court at the time of the divorce. Mom seems to be

enjoying the academic life and is in a new relationship. She had another relationship following the divorce that lasted a short time. Mom spanks Son and gets angry at Dad because he neither spanks nor approves of Mom spanking. Mom is convinced that more strict discipline is just what Son needs to correct his behavior. Mom has many unresolved issues from the marriage and blames Dad for the failing business, failure to be responsible as a parent, failure to make child support payments, and failure to meet her expectations. Mom has a need to be cared for in the traditional sense and feels a woman's world is one of home and children.

Son is a lively and highly intelligent boy. He is very much aware of the part he plays in the relationship between Mom and Dad. When Mom gets angry at Dad and yells at him, Son takes his father's side and argues with Mom, although he may not know what subject is being discussed. As an example, when Mom yelled at Dad in therapy about not paying child support, Son cried out, "Mom, don't get mad. We paid it." He repeated this several times, at first in a pleading tone of voice, then changing to a command when Mom continued the argument. Son then took a wooden block and struck Mom sharply on the foot. There is a strong coalition between Dad and Son against Mom.

Son exhibits 12 of the 14 symptoms itemized by Foster Cline for character disturbed children (Cline, 1979). It is important to note that while Son was reacting to the loss and

separation produced by the divorce, he was not found to have been a victim of any childhood trauma, physical or sexual abuse, or severe psychological stressors.

This is an enmeshed family with rigid boundaries. Though unlikely partners, Mom and Dad perceived each other as each meeting their personal expectations. When these needs were not met, a pattern of aggression and anger was established that was played out in accusations and blaming. This may have been an intergenerational theme, and Mom may have been unattached in her family of origin.

Mom had the power in this family, at least over Dad. When Mom would attack Dad, Dad would withdraw and Son would come to his rescue. Dad saw himself as a failure both in business and in relationships. Dad also drinks, and this may be perpetuating the concept of seeing himself as a failure. A state of anxiety was maintained as each member of the family influenced the other and was in turn influenced by them. As Son came to the rescue of Dad, Mom became angry. She blamed Dad for being a poor role model for Son, which encouraged Son to rescue him. At the same time, she was angry at Son for taking Dad's side against her. Dad secretly enjoyed Son coming to his rescue and influenced him to continue this behavior by shyly smiling at Son during the rescue attempts. Son received many mixed messages that Dad is bad (even though he loves Dad), to protect Dad and not to protect him, to love and not to love Mom, and most of all

that neither parent is dependable nor able to meet his needs. Son felt rejected by Mom, and may be fearful of women in general. Son may be getting a message that women are not to be trusted and dads are not very dependable.

Son had a primitive instinct to protect himself from both parents. To survive, he must learn skills to take care of himself. As he learned to care for himself he met resistance from Mom, but not from Dad nor from the daycare. Dad called him his "little man" and daycare commended him for taking care of the other children, getting out the toys, turning off the lights, supervising others in play, and even managing conflict. They scolded him for hitting other children or biting the daycare supervisor, but they did not see the connection that he was assuming in his new role. Son in his new role was learning to be self-parenting, assuming the responsibilities for himself and for meeting his own needs. He learned manipulation to take the focus away from himself. To achieve this objective he had to keep Mom and Dad mad at each other. He became parent to two disobedient children that could not be trusted and that he had to punish from time to time. He also parented the children at daycare and hit them for disobedience.

By giving up the need for parental support Son built a resistance to control and authority as he distanced himself from his parents. He may also have learned a behavior that in adult life will be called spouse or child abuse. This

negative behavior, coupled with the skills of manipulation, may lead to a learned pathology (Cline, 1990; Magid & McKelvey, 1989; Maccoby, 1980).

Several treatment strategies are being used simultaneously that require the involvement of the whole family as well as Mom's partner in the relationship. Son must learn to trust his parents, become dependent, give up control, and become a child again. He must develop trust that his needs will be met, that he will be safe, and that he will be taken care of. He must learn that he cannot divide his parents and, in so doing, control them. By reattaching himself to his parents he will no longer feel the need to be in control.

The parents must become dependable and consistent by providing an environment of safety, love and unity. To accomplish this the parents must realign themselves and develop new boundaries as individuals while still providing direction in the parenting role. Parents are being shown in therapy how they contradict each other and send mixed messages to Son. Personal boundaries are being reinforced and intergenerational patterns are being displayed.

It may be necessary to attempt to resolve some aspects of the past relationship between the parents by providing an atmosphere where past and present grievances can be freely discussed. Interaction between the family during counseling is clarifying how Son is triangulated into their personal

disappointments and how this serves to guide Son in his behavior. They learned to recognize their own needs and issues as individuals. Son's learned negative behavior was monitored in both households and at daycare. The reinforcing of Son's control issue and sabotaging by Dad was discussed in family therapy. It was recommended that Dad quit sleeping with Son. It was also recommended that daycare be discontinued temporarily and that one parent stay home with Son until he began to show a change in his behavior.

The Green Case

This case will show how the control issues of the parents affected the sense of safety and well-being of the son, and how mixed messages played a part in separating the parents from their son. This couple came into therapy with the complaint of an out-of-control four-year-old. The family consisted of Mom, Dad, and Son, age 4. This couple had issues of control and boundaries. They continuously manipulated and coerced each other to establish control. Dad preferred close contact and wanted Mom at his side in both work and play. Mom preferred some distance in the relationship. This push and pull for closeness and distance caused a great deal of anxiety. Neither seemed able to make independent decisions. They learned to triangulate Son in their personal struggles by focusing on his behavior. They contradicted and countermanded each other regarding Son in

his discipline matters. This caused Son to distrust his parents and to ignore their directions. He also learned that he had a great deal of power in this family and through manipulation he could exercise that power to get what he wanted.

Mom has a professional career and is quite successful. Her dad's advancing age, and how the estate is going to be split up when dad dies, is a source of continual bickering in the family. Mom is the only member of the family that is not working in the family business. This caused some anxiety with her husband, as did the distribution of the family wealth. They fight over money because Mom gets money from her dad. Dad has difficulty with authority and control and has anxiety about Mom doing things alone. His trust issue is very pronounced. Dad has his own business but is not very successful. Mom would prefer that Dad get a job with regular hours and a steady income.

When this family came into therapy Son had been kicked out of over a dozen daycare centers for assaulting the other children. He was demanding, aggressive, oblivious to parental control, cruel to pets and playmates, superficially engaging and charming, over friendly with the therapist, would not be held, lied about everything, and was obsessed with drawing, watching and living in a fantasy world. Son was an unattached child rapidly reaching a state of being completely unmanageable.

The goals of therapy were much the same as in the Brown case. Treatment goals consist of three parts: detection of the family dysfunctional behavior that supported the unattachment behavior; intervention in the behavioral patterns; and reattachment and reconsolidation of the family. Son had to be removed from the parental conflict, and the balance of power between the parents and the child restored. In this case a re-balancing of power within the marital dyad was also emphasized. Son had to give up control and develop trust in his parents that his needs would be met. . By reattaching to his parents he would no longer feel the need to be in control and could again become a dependent child. As the parents began to exit from the dysfunctional behavior of triangulation, new parenting skills of validation and reinforcement of Son were necessary.

The Yellow Case

This case demonstrates the possibility of family patterns of unattachment being passed from generation to generation. The family consisted of Mom, Dad, Son, age 4, and Sister, age 18 months. The presenting problem was threefold: marital and individual issues and Son's behavior. Mom requested therapy with the concerns that she was feeling trapped and Son was out of control. Each had brought up the possibility of divorce.

Mom was an adopted child and from her description of herself as a child and as an adolescent was most probably unattached. Mom appeared to have suffered and continues to suffer trauma due to separation from her natural mother. She spent the first three months of her life in an institution and came to her adopted family suffering from failure to thrive syndrome. Infants with this disorder present with poorly developed or absent social skills. They may not track with their eyes and they show little attention to the caregiver's voice. They are usually unresponsive to any stimuli including food, and are generally underweight (APA, 1989).

It would be expected that Mom would not do well in an intimate relationship if in fact she suffered some attachment disorder. Her lack of trust and ability to receive and give affection could be devastating to a marriage. Mom has a brother that was also adopted. Mom and her brother share many of the same emotions and feelings for the family. Mom seemed to have more power in this relationship than did Dad.

Dad is very devoted to Mom and the children. He is quiet and does not communicate as well as Mom would like. Dad has temper outbursts when he perceives that Mom is flirting or acting inappropriately with other men. He is often depressed, a workaholic, and avoids conflict whenever he can. Dad has a control issue with his mother and is

remote with his father. He does not consider his family to be very close.

Son is four years old and was a problem to both his parents. He displayed many of the symptoms of the anxiously attached child. He had bouts of rage and often acted aggressively to both his mom and younger sister. He would cling to his mother at times and then completely reject her. Son lied to both his parents, had difficulty with parental control, was manipulative, and was often inappropriately demanding. Interestingly, although Son was the focus of this family problem, Sister also showed many of the same characteristics.

This is an intact family that seemed to be struggling with family of origin problems. Neither of the parents seemed to have disengaged from their parents and still see themselves as under their control. They both see themselves in their children's behavior (especially Mom) and are determined not to continue the family legacy into another generation. This is a middle class family, young and handsome, and are at the stage in their relationship of questioning marital intimacy. Issues of financial need, parental identity and autonomy, fear of commitment, and the task of striking some balance of separation from their parents are all part of this couple's struggle (Erikson, 1963).

The couple triangulated their son into their marital conflict by comparing the son's bad behavior with their own expectations. They sometimes triangulated Son in a way to reflect on their own behavior when they were displeased with themselves. Mom might say, "That's just the way I would act when I wanted something or when I was mad at my dad." Dad also compared himself with Son's acting out by remembering his conflicts with his mother. Both used Son against the other and tried to pass the chore of his care away from themselves. Thus, Son saw himself as a bad reflection of his parents' dysfunctional characteristics. Son was also compared with his sister. Sister was good; Son was bad. The action of comparison probably accounted for Son's treating Sister in an aggressive way.

There may be another dimension of this puzzle that has its roots in the parents' intergenerational ties. Like the alcoholic family, the unattached family may have patterns of dysfunction that they use to maintain homeostasis. As couples come together to weave the fabric of the new relationship, traditions from one side or the other will be predominant. This will determine which spouse's past relationships are to provide the model for the new family's rules, choice of friends, patterns of communications, roles and family traditions (Steinglass, 1987). Like alcoholism, unattachment may have the capacity to become a central organizing principle around which family life is structured.

Intergenerational organizational patterns of unattachment may be detectable. An example of this may be a couple who chooses to live together rather than marry because of their fear of failure in the relationship. The implication of this is that if these patterns could be recognized early on in the marital dyad, an intervention could be possible.

Mom's family history has many characteristics of unattachment. Perhaps even Mom's father was an unattached child. Mom was adopted. According to psychiatrist Foster Cline, fully two-thirds of the sociopathic youngsters seen in treatment for bonding or attachment difficulties are adopted children (Magid & McKelvey, 1989). Mom related how even as a little girl she acted inappropriately with dad's male friends, sometimes to the point of embarrassing her father. Mom was an unmanageable child prone to chronic temper tantrums, fights, and aggressive behavior. She continually ran away from home and eventually ended up in an institution for unmanageable children. Mom was not held or cuddled as a child and still feels uncomfortable touching her dad. Mom was a loner and had poor peer relationships. There is little doubt that Mom was unattached and, like the alcoholic family, carried the dominant pattern of that dysfunction over into her own family.

Some of the treatment goals for this family will be the same as in the previous two cases and will not be reiterated. However, the detection of the dysfunctional behavior may be

found in the intergenerational behaviors of the adults. If the problem is in the organizing principles built around the fear of attachment, the intervention for the son will also be the intervention for Mom, a truly systemic intervention. Thus, the treatment goals of reattachment and the reorganization of the family patterns become one and the same.

The Red Case

This case shows how the family interactions can have a negative effect on the child and how the parents use the child to avoid facing their marital problems. When the family came into therapy, Son immediately came up to me and started a conversation. He has a cute way of cocking his head and flashing his dark eyes when he wants your absolute attention. This is a delightful mannerism but may be an early clue to other problems.

This family consisted of Mom, Dad, and Son, age 2½. The presenting problem was Mom's depression. Mom had been depressed most of her adult life and twice had attempted suicide. This couple had a fear of intimacy probably having roots in some sort of sexual abuse that occurred during Mom's adolescence. While this hypothesis was not validated, many of Mom's personal issues suggest the possibility of abuse. The pattern of dysfunction goes something like this. Mom fears intimacy → gains weight → becomes depressed → thinks

about suicide → worries about losing spouse → goes on diet and loses weight → spouse begins to notice → makes sexual advances → Mom fears intimacy. Mom is obese and has limited energy. Mom's depression also filled Dad's need of wanting to care for someone. Dad's previous wife committed suicide, and Dad carries guilt from this event into his present marriage.

During the course of family therapy I began to notice how the couple used Son as a defense when one partner would get too close. By focusing on the child, the attention could be shifted away from the individual. Son became the core of Mom's depression. The hidden agenda of intimacy was much too sensitive to discuss as a source of depression, but the demanding behavior of Son was easy to see and acceptable to discuss. Thus, Son became the focus of the family.

In the meantime, Son became more demanding, more angry, more aggressive, and began to develop extreme control problems. Son seemed to be assuming a parental role. His instincts told him that Mom and Dad were not dependable, not to be trusted, and were easy to manipulate. He enjoyed being triangulated into parental conflicts and learned to take sides in an effective and self-satisfying way. He also was building a resistance to control and no longer had the need of maintaining a safe haven from which to operate and explore. He was becoming a risk taker and was learning the

thrill of the unknown. Son's unattachment seems to be a functional response to the breakdown of the parental role.

The goal of therapy followed the previous procedure of detecting the dysfunctional behavior in the family that seemed to be supporting the unattachment, intervening in that behavior and then providing a way for the family to re-attach.

The Blue Case

In contrast to the previous four cases where there was no evidence that the children with symptoms of unattachment suffered abuse or a traumatic event, the Blue case is an example where such events did occur in the context of intergenerational patterns.

The family consisted of Mom, Son, age 15, Daughter, age 9, and Younger Son, age 7. This was a single parent family. The presenting problem was the family's fear of Son and his unpredictable behavior. This family came to therapy by a court order pending civil charges of rape against Son.

This family had many problems and appeared more as a group of individuals that shared the same space than they did as a family. They were so disengaged that often they were not aware of the needs and desires of any of the other members. Fear and distrust permeated the daily family pattern. The family hierarchical structure was confusing and

seemed to be constantly changing. Interpersonal boundaries were very diffused.

When one reviews the family history, some of the reasons for this family's plight can be seen. Intergenerational themes of abuse and unattachment, lack of defense mechanisms, lack of parenting skills or supporting family members, loss and abandonment, lack of trust, hope or caring were all contributing factors to this family's unattachment behavior. An intergenerational myth might be that women and children have little value. The tradition of unquestionable service, hard work, and reward of abuse and violence is the intergenerational family theme.

Mom was raised on a remote ranch and developed few social skills. Hard physical labor was the rule and all forms of abuse were the rewards. This pattern was to persist throughout Mom's life. She married a man after becoming pregnant and discontinued her schooling to carry on the family pattern of ranch life. Her husband had problems of his own. He was violent, had bouts of rage, was abusive, and often had delusions. Mom had long since ceased to care about either herself or her family as she traded her reality for drugs.

This was the environment that greeted Son when he was born: no extended family, Mom on drugs, and Dad not in touch with reality. Dad did not allow Mom to hold Son except to feed him. She reported that when he was picked up he would

stiffen his body like a board. He never cried as normal children do. If Son entered Dad's reality, Dad would abuse him, so Mom kept him in the closet. When Son was three, Dad gave him a gun and tried to get Son to shoot him. Dad heard voices and often responded to them with violence. During one violent episode Mom, with Son in her arms, fled into the night and made her way to a neighboring ranch. Dad was diagnosed as a paranoid schizophrenic and committed to an institution where he was to remain for some years. Mom remarried and had the two remaining children. This second marriage also ended.

Daughter is from the second marriage as is Younger Son. She also had problem behavior with periods of withdrawal, bed wetting, and bursts of anger and difficulty relating to the other children in school. She had adapted her behavior to focus on Son. She did not communicate well and appeared arrested developmentally. For a time Daughter lived with Dad until he no longer wanted her. There is a suggestion of abuse in Daughter's background and her pronounced fear of men. She was sexually molested by an older girl in the not too distant past.

Younger Son also seemed anxiously attached, talked in whispers, clung to Mom, and tried to be the peacemaker. He would climb into Son's lap on occasion to be held. This was an unusual demonstration of affection in this family but seemed tolerated by Son.

Son grew as nature demanded, but with a malformed personality. His mother described his emotional system as flat. He rarely laughed and never cried. He once broke his arm and because he never complained, it remained unset for several days. Son liked to draw and drew pictures of demons and monsters. Some of Son's recent drawings are shown on the following pages. At one point in Son's life he went to live with his father following his father's release from the institution. His mother couldn't handle him and said she was afraid he would harm the other two children. Son was severely beaten, kicked and abused on a regular basis by his father, literally thrown out of the house and told not to return. He returned to live with his mother. At 15 Son became sexual and now has a pending rape charge involving a 12-year-old girl. He has also been charged with molesting a woman friend of Mom's while the friend was passed out on their couch. Son has also been kicked out of school for beating a peer with a skateboard and is now in a halfway house until his trial. Son continues to break the rules and cause dissension and chaos.

Son is an unattached child. He cannot stand affection. He cannot stand to be touched. He has no friends. He has a diagnosed learning disability and is becoming increasingly a concern to both his mom and to the authorities. When Mom called the school after Son was expelled, the principal told

her, "I hope Son survives." I too hope Son survives, but his future does not look promising.

This family has a potential for violence that must be recognized. It is clear that Son is unattached but it is also possible that unattachment is the organizing principle around which this family is structured. Son's behavior has become the focus of the family and has allowed Son to be scapegoated. Each family member contributes to this behavior. Although Daughter fears Son's behavior, she also has learned to manage it after a fashion, and in a sense has become part of the trigger mechanism. Son says that Daughter "drives him crazy," even though he tries to get her to stop. It is possible that Son has become the focus of Daughter's anger toward all men and that she uses Son's position of scapegoat to punish him. It is also possible that Daughter is trying to bring outside help into the family and is using her own dysfunctional behavior to accomplish that means.

Two things are clear: the family is at risk for violence and no one in the family is in control. It is also interesting to note that when Son is removed from the family, the family becomes more receptive to therapy and to change. Mom speaks of these times as periods when she can get stronger so she can better cope when Son returns.

Family therapy has been useful in helping to restructure the family, but it has not been successful in intervening in Son's behavior. However, it has shown the degree of power

Son has over the family and how each contributes to the behavior.

The goal of therapy is to restructure the family in a more positive direction, provide for the safety of family members, help with problem behavior, teach parenting skills, and help facilitate reattachment. It may be necessary to remove Son from the family, at least temporarily, before this can be accomplished.

Following are some of Son's drawings. Drawings made by unattached children may reflect how they feel inside but are unable to express.



Figure 1. "The Blue Family." Son's perception of his inner self.



Figure 2. "The Blue Family." Son's view of father.



Figure 3. "The Blue Family." Son's view of women (note the mask).

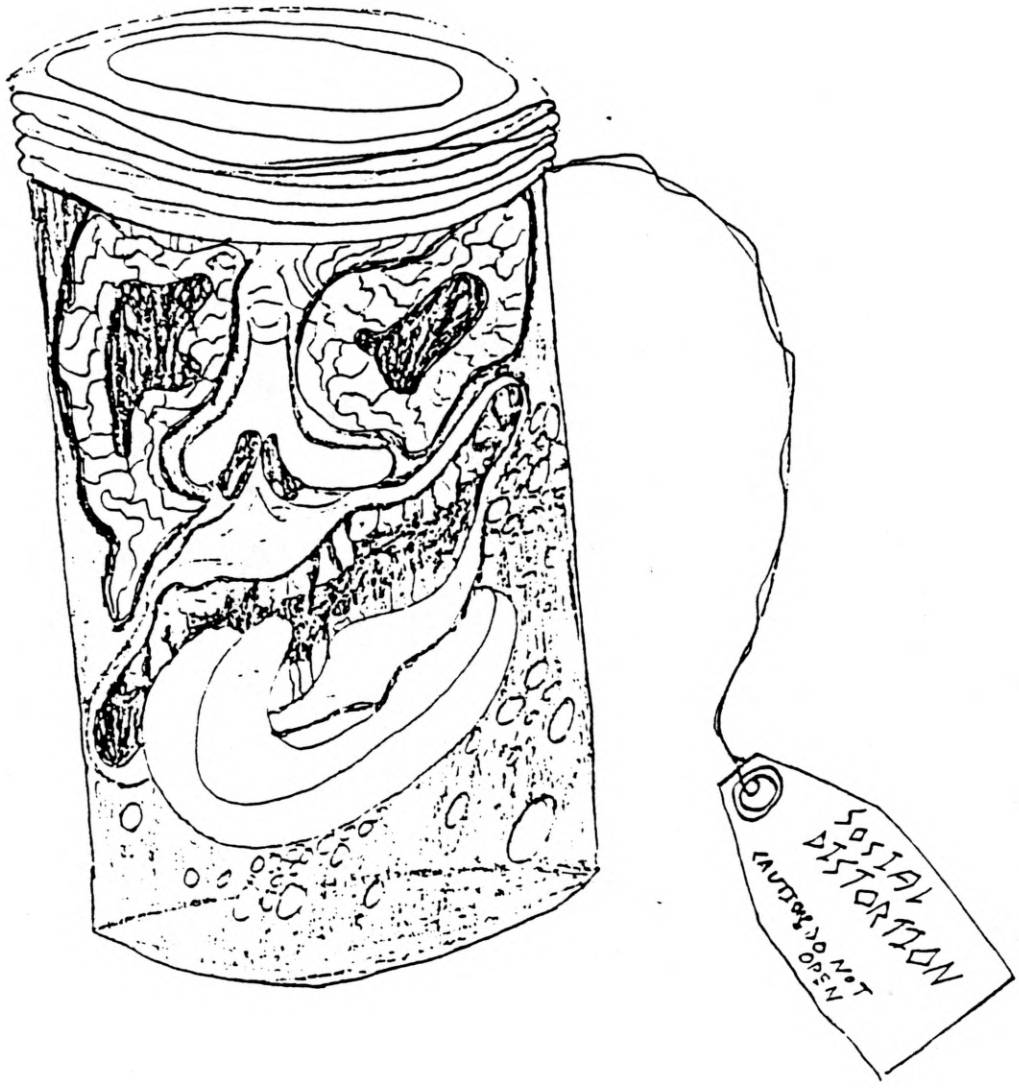


Figure 4. "The Blue Family." Son's view of the difference between society's perception and his own.

DISCUSSION OF CASE HISTORIES

Intergenerational Patterns

There are many differences between the psychodynamic model of attachment and family systems theory. The first may concern the origin of the dysfunction: how does unattachment occur? In most of these cases the children were never beaten, suffered no experience of loss, were the products of natural biological parents and had not been sexually or physically abused. Is unattachment the result of these traumatic childhood experiences as portrayed in the psychodynamic model, or does it also have its origin in the family interactional patterns? Like alcoholic families, unattached families appear to carry the behavior from generation to generation. Certainly in the Yellow family and the Blue family, this appears to be the case. Childhood histories and the record of events verify that this was at least a distinct possibility.

In the Green family Dad presented a new facet of behavior that heretofore had not been brought to light and may be significant. Dad stated that he didn't know why he behaved in the manner he did, but that he became extremely agitated by criticism and always reacted in a hostile manner when he felt he was being controlled. He had a lack of trust

that seemed to permeate all of his relationships, both business and personal, and while aware of his behavior seemed not to be able to control it. It may be possible that Dad's behavior was the result of being an unattached child. Based on Dad's family history, unattachment appears to be a symptom that is carried over from generation to generation: impossible to maintain intimate relationships, lack of trust, extreme aversion to control and criticism, patterns of manipulation and triangulation, and not having a sense of why this is happening or how to cope with it. The cycle of unattached families continues to spiral through our society, almost having an energy of its own, perpetuating itself and reinfecting each generation.

Triangulation

In most of these five examples, the common pattern seems to be poor parenting. The parents could not solve their intimacy problems with each other and triangulated the children into these issues in an attempt to stabilize tensions. Intervention then requires that parents learn not to triangulate their children into their problems. Issues of control between the parents seem to result via triangulation into issues of control with the children, and the attachment to the parents is damaged.

The Green family's problem is an example of how triangulation damaged the functioning of a family and how

difficult it was to form an intervention to correct dysfunctional behavior. Dad took off work for two months and removed Son from daycare. When he returned to the job, he made arrangements for Son to be with him on a part-time basis. Mom enrolled in a parenting class to learn how to better relate to her child and to give her a better sense of how to handle control situations. The parents became aware of how they used Son in their arguments, countermanding each other's directions and triangulating Son into a position of power. When the parents had control of themselves, they were able to recognize how their actions were affecting Son. Interestingly,, the therapy not only was effective with Son, but it seemed to draw the parents closer together. Mom and Dad began to communicate in a new way, both with Son and with each other.

Hierarchy of Attachment

The first born has been identified by many researchers as inheriting certain unique characteristics, as has the second and third born (Bradshaw, 1988). In the Yellow and Blue families different degrees of unattachment were thought to be present. My sense is that the firstborn is more deeply affected by these family dynamics but additional study is needed to clarify this possibility. However, the firstborn may be a key to insight into the other children's unattachment behavior. Even if the family actions or

structure changes between births of the various children, it is suspected that the children will retain symptoms of unattachment. This pattern of dysfunction seems to moderate with succeeding children in birth order. If this hypothesis were true, the firstborn would display a greater degree of dysfunctional behavior than the second born, and the second would display less than the third. On this very small sample of families in this study, this was the observation.

Types of Unattachment

Assuming that the symptom list as proposed in the psychodynamic model for unattachment adequately recognizes attachment symptoms, how does the therapist decide whether the child suffers from this dysfunction or possibly another. Mary Ainsworth's "strange experiments" (Karen, 1990) attempted to classify attachment in three categories: securely attached, anxiously attached, and unattached. She recognized that there were "degrees" of unattachment and that the dynamics between the mother and the infant changed between these three categories. It is possible that there are other different degrees of unattachment, and the way that this behavior is played out may depend on the particular dynamics of the family.

The very recent work of Mary Main, Judith Soloman and Erik Hesse discussed another dimension of the attachment disorder: Type D - disorganized-disoriented. This disorder

is marked by two conflicting drives: one to approach and one to flee the caretaker. Type D is reported to be the most confusing and contradictory form of attachment behavior yet encountered in research. Dr. Delaney believes that the family is the primary attachment builder (Delaney, 1991).

Patricia Crittenden's research suggests the expansion of childhood attachment behavior classifications to include a form of dysfunction called compulsive compliant behavior in children. This behavior is found in abusing mothers and abused children who do not dare to challenge their families concerning their own safety or treatment. They tend to become severely withdrawn from their families and members of society.

Method of Treatment

The method of treatment under the psychodynamic model has been explained in previous sections of this paper. In most cases the focus seems to be on the individual rather than on the family. The family systems perspective would view and treat the entire family utilizing interventions in therapy as deemed appropriate. It would seek to discover pathological triads and unearth the pathogenic family conflicts that have been lodged in the intrapsychic life of the symptomatic member. It would also address the structure of the family, putting parents in charge and enabling an effective parenting coalition (Nichols, 1984).

There is a sense of urgency to the treatment of unattached children. The statistics surrounding the delay of treatment are alarming. Under the age of seven the reported success rate is as high as 85%. After the age of seven success goes down by 50%. Over the age of eleven the chances of recovery for unattached children is not good, some say as low as 5% (Magid & McKelvey, 1989). The reason for this success rate is not clear, but the message to therapists and parents alike is. The overcautious therapist or the parent that thinks, "They will grow out of it," are running great risks.

Teaching parents to apply a form of holding therapy can be one type of structural intervention which helps re-establish parental control while giving the child the experience of being attached. With proper assessment and instruction, holding in most cases can be done with younger children (ages 2-9) by the parents within the family context in a loving and caring way, much as Martha Welch held autistic children. However, for this method to be effective the family must first be able to provide an atmosphere of stability, love and safety. There are, of course, families who are unable--even with help--to provide this important prerequisite.

Having the complete family in therapy helps to ensure that dysfunctional family patterns that may be contributing to acting out behavior have been recognized and allows

attachment to occur with a parent rather than with the therapist. Working within the family allows the therapist to intervene in the dysfunction of the family while providing for treatment of the symptomatic member. It also allows the therapist to coach the family members in the holding techniques both prior to and during the holding sessions. Family centered treatment attachment is a three-way street between the child, the family, and the primary caregiver.

Holding therapy within the family unit could provide other possible benefits. Systems theory suggests that the family is not sick but only stuck in time, and that the therapeutic goal is to assist the family in solving their own problems (Nichols, 1984). If the family is tied to the therapist by treatment, dependency or emotion, then family therapy has failed. Holding could restore order and control in a family in a loving, safe and caring way that is not dependent on the therapist. Holding could allow families to break down barriers created by unattachment, establish communication, and to express their most hidden fears and anxieties. Holding could work for parents also. The emotional energy created by the process is intense, sufficient to break down the emotional barriers created in prior dysfunctional behavior. When this type of holding therapy has been used, the energy level created by this intervention reaches not only the child being held but the parent as well. It should also be noted that holding is but

a part of the total family therapy. It is only one intervention used to accomplish a specific goal.

Implications for Research

This preliminary analysis of five case studies suggests a number of questions for future study.

(1) Are unattached families similar to alcoholic families in that the behavioral patterns are passed from generation to generation even in absence of a traumatic experience such as abuse, loss or separation?

(2) What value could be gained by treating an unattached family from a systems perspective rather than treating an unattached child from a psychodynamics perspective? Does this have therapeutic value to the unattached parents as well as to the unattached child?

(3) Is the anger and hostility which unattached children often express towards their mothers the beginning of behavior patterns that leads to spouse abuse in adults even in the absence of an actual role model of abuse?

(4) Does unattachment occur predominantly among boys, or do girls merely display this dysfunctional behavior in a different manner?

(5) Is the first born male more at risk for severe attachment problems than other siblings?

(6) Is dysfunctional interactive family dynamics also responsible for perpetuating unattachment in addition to

the psychodynamic perspective of loss, separation and abuse?

(7) Can unattachment be diagnosed in adults and be treated using the concept of treatment being used for children, or are the adult implications for treatment different?

(8) Are the learning disabilities being diagnosed in unattached children an unconscious refusal to learn as a form of resisting control and authority or is attachment necessary to cognitive development?

(9) Are there different types of attachment disorders depending on the family context in which it occurs?

CONCLUSION

It has long been recognized by researchers that the phenomenon of bonding and attachment between child and primary caregiver is a foundation from which all future development of the individual occurs. If this attachment is strong and the emotional needs of the child are met, other aspects of development, trust, autonomy, and identification of self are allowed to develop in a normal fashion. However, if this attachment is weak or nonexistent, trust is not established as a cornerstone and the personality becomes twisted and malformed. Thus, the bonding and attachment is a vital link in a child's development.

It is important to detect and treat children suffering from unattachment when they are young. As a child's age increases, current methods of treatment appear to become less effective until eventually they are virtually unsuccessful. Children over the age of 12 are not accepted in many clinics because of the low success rate. Daycare workers and elementary school teachers represent our current early warning system. Information to help detection both in the schools and in the home is needed. Parents need help in knowing how to parent and where to go for help.

Detection may come also by discovering the unattached adults. If the theory that attachment is intergenerational is found to be valid, a complete new area of prevention and detection may be possible. The symptoms are subtle and difficult to uncover and usually only discovered after marital problems begin. Counselors need to address parenting issues when working with adults who show signs of attachment disorders.

To the poor falls the greatest burden. Those without funds, without resources, without insurance, without extended family, and without social services are the real victims. For those that were detected too late, like Son in the Blue family, society must find a way to provide help.

Certainly a knowledge of attachment theory in a systemic perspective provides counselors with a framework for conceptualization, directing interviews, and invoking therapeutic change. Armed with these concepts and understanding, a counselor might be able to redirect lives and have a positive influence on future intimate relationships. A counselor might be able to recognize the inconsistent and distorted conceptions adult clients have of intimate relationships and see how their present behaviors fit with earlier childhood experiences. As a counselor interacts with the family, s/he can facilitate change in the way persons perceive and interpret their behavior and their

actions with others and be aware of behaviors that reflect attachment disorders.

Caregivers need to find ways to search the schools, the homes, the hospitals and society to identify the children at risk. Hospitals need to be encouraged not to separate mother and child at birth. Certainly the early separation of infant and caregiver in all walks of our society needs to be viewed with an eye towards disruption of the attachment phenomenon. Separations take place every day in our court systems during custody battles, in hospitals, in adoption agencies, and for other more obscure reasons without a thought as to what might be happening to the child.

Family systems theory offers hope. It offers a framework for increasing the effectiveness of counselors and a conceptual strategy for possibly relieving distress in adult relationships. It offers a new insight into the bond between men and women and in the raising of their families. But, most importantly, it offers hope to the "trust bandit," to the lost child, to the child without a past, and to the child with no promise for the future.

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